CMS Manual System

Pub 100-05 Medicare Secondary Payer

Transmittal 47

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: MARCH 10, 2006

Change Request 4304

SUBJECT: MSP Debt Collection and Referral Updates

I. SUMMARY OF CHANGES: This CR includes updates and clarifications to the existing contractor instructions specific to MSP debt collection and referral.

NEW/REVISED MATERIAL
EFFECTIVE DATE: April 10, 2006
IMPLEMENTATION DATE: April 10, 2006

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	7/60/Medicare Secondary Payer (MSP) Debt Collection and Referral Activities
R	7/60.1/Background
R	7/60.2/Debt and Debtor Definitions
R	7/60.3/Debt Selection and Verification
N	7/60.3.1/Debt Selection Criteria
N	7/60.3.1.1/Debts Excluded From Referral
N	7/60.3.1.2/Monitoring Debts Excluded From the DCIA Referral Process
N	7/60.3.2/Validation of Possible Eligible Debts for Referral
R	7/60.4/Issuance of the "Intent to Refer" (ITR)Letter and Inquiries/Replies Related to DCIA Activities
N	7/60.4.1/Issuance of the "Intent to Refer" to Treasury Letter
N	7/60.4.2/Responding to Correspondence as a Result of the Issuance of the

	ITR Letter
R	7/60.5/Debt Collection System (DCS) and DCS Entry
N	7/60.5.1/DCS
N	7/60.5.2/DCS Entry of Delinquent Debt
R	7/60.6/Contractor Actions Subsequent to DCS Entry
R	7/60.6.1/Steps Contractors Shall Take Upon Knowledge or Receipt of Certain Information
R	7/60.7/DCIA Treasury Collection (Placeholder)
R	7/60.8/Financial Reporting
R	7/60.9/Exhibits
N	7/60.9.1/Exhibit 1 DCIA "Intent to Refer" to Treasury Letter
N	7/60.9.1.1/Exhibit 1A Cover Instruction Sheet When contractor Sends Multiple "Intent to Refer" Letters to the Same Debtor in One Package
N	7/60.9.1.2/Exhibit 1B Valid Documented Defense for All Claims Included in the Intent to Refer Letter-Reply
N	7/60.9.1.3/Exhibit 1C Unacceptable Defense for All Claims in the Intent to Refer Letter - Reply
N	7/60.9.1.4/Exhibit 1D Payment and/or Acceptable Defense for One or More but Not All Claims in the Intent to Refer Letter - Reply
N	7/60.9.1.5/Exhibit 1E Enclosure for DCIA "Intent to Refer" Letter to Employer, Insurer, Third Party Administrator, Group Health Plan (GHP), or Other Plan Sponsor
N	7/60.9.2/Exhibit 2 Treasury Addresses
D	7/60.10/Exhibits
D	7/60.10.1/Exhibit 1 - DCIA "Intent to Refer" Letter
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D	7/60.10.2/Exhibit 2 - Instructions for the Required Format and Content of the Monthly MSP DCIA Status Report for Referral/Collection Monthly

	MSP DCIA Status Report
D	7/60.10.3/Exhibit 3 - Treasury Address

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-05	Transmittal: 47	Date: March 10, 2006	Change Request: 4304

SUBJECT: MSP Debt Collection and Referral Updates

I. GENERAL INFORMATION

A. Background: CMS is updating and clarifying contractor instructions specific to the collection and referral of MSP debts.

B. Policy: N/A

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4304.1	Contractors shall implement the Debt Collection and Referral processes detailed in this instruction to refer all eligible delinquent MSP debts.	X	X	X	X					
4304.2	Contractors using the HIGLAS system shall comply with prior instructions when addressing jointly and severally liable debtors in the pursuit of a Group Health Plan (GHP) debt.	X	X	X	X					
4304.2.1	Contractors using the HIGLAS system shall incorporate these operation instructions within their HIGLAS functional processes.	X	X	X	X					
4304.2.2	Contractors using the HIGLAS system shall no longer update the Debt Collection System (DCS) to refer debts initially to Treasury.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4304.2.3	Contractors using the HIGLAS system no longer update DCS with initial referrals to Treasury for cross-servicing, or downward adjustments and collections received at the contractors subsequent to the initial referral.	X	X	X	X					
4304.2.4	Contractors using the HIGLAS system shall document all financial transitions within the HIGLAS.	X	X	X	X					
4304.3	Contractors shall select eligible delinquent debts for referral from the universe of **ALL** outstanding debts specific to Data Match, non-Data Match GHP, liability, no fault, and workers' compensation cases.	X	X	X	X					
4304.4	Contractors shall not include claims having dates of services within a litigation settlement period (for example, Aetna/CIGNA, Blue Cross Blue Shield Association, etc.,) as part of a valid eligible debt for referral.	X	X	X	X					
4304.4.1	Contractors shall follow all CMS communications specific to litigation or negotiation activities.	X	X	X	X					
4304.5	Contractors, including HIGLAS users, shall bring closure to all checks related to an established debt, posed defenses, waiver requests or compromise requests prior to the sending of an Intent to Refer (ITR) letter or actual referral to Treasury. Note: See the manual update for procedural details.	X	X	X	X					
4304.6	Contractors shall ensure system capabilities exist to retrieve/recreate case information within two (2) business days of a request.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4304.7	Contractors using the HIGLAS system shall receive from HIGLAS, versus PC, the ITR letters at the contractor identified print location; therefore, contractors using the HIGLAS system shall not issue a PC generated first or second demand.	X	X	X	X					
4304.8	Contractors shall update MPaRTS with an "IL" status within one business day AFTER an ITR has been sent (includes debts which were converted into HIGLAS).	X	X	X	X					
4304.8.1	Contractors using the HIGLAS system shall no longer update MPaRTS on ReMAS-identified and HIGLAS interfaced Data Match debts.	X	X	X	X					
4304.9	Contractors shall issue ITR letters for eligible delinquent no fault and workers' compensation cases.	X								
4304.9.1	Contractors shall attach a copy of the initial demand package with an accounting of the amount of debt still owed to Medicare.	X								
4304.9.2	Contractors shall copy the beneficiary on all correspondence sent to the no fault insurer or workers' compensation carrier when the insurer/carrier is the current debtor.	X								
4304.10	Contractors shall use the CMS-supplied ITR response letters within the manual instruction.	X	X	X	X					
4304.10.1	Contractors using the HIGLAS system shall send the ITR response letters via PC. Note: These letters will be part of a future HIGLAS release.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4304.10.2	Contractors using the HIGLAS system shall provide a copy to the non-responding joint and several debtor of all replies to the responding debtor.	X	X	X	X					
4304.11	Contractors shall notify debtors early enough so that debtor(s) will have the required response time and contractors can refer debt to Treasury on or before the debt becomes 180 days' delinquent.	X	X	X	X					
4304.12	Contractors shall cease MSP recovery efforts once a debt has been referred to Treasury for cross-servicing.	X	X	X	X					
4304.12.1	Contractors shall copy and send to Treasury all waiver requests or compromise requests received directly from the debtor after a debt has been referred to Treasury.	X	X	X	X					
4304.13	Contractors shall record a Treasury/TOP collection ONLY after notified by CMS Central Office (CO).	X	X	X	X					
4304.14	Contractors shall make appropriate adjustments to accrued interest dollars when the contractor receives information from a debtor in a non-GHP case that proves that settlement proceeds were received after the date of demand or 60 days after the date of actual receipt of the proceeds, whichever is later.	X								
4304.15	Contractors shall refer a previously excluded debt to Treasury within 15 calendar days after the date of a status change and an outstanding receivable exists (applies to HIGLAS users, also).	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)

		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: April 10, 2006 **Implementation Date:** April 10, 2006 **Pre-Implementation Contact(s):** Tina Merritt **Post-Implementation Contact(s):** Deb Pujals	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Secondary Payer (MSP) Manual

Chapter 7 - Contractor MSP Recovery Rules

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60 - Medicare Secondary Payer (MSP) Debt Collection and Referral Activities

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Contractors shall comply with all debt collection requirements and processes more specifically defined in Section 10 Group Health Plan (GHP), Section 40 (workers' compensation) and Section 50 (liability, no fault). Upon MSP debts becoming eligible for referral to Treasury for cross-servicing, contractors shall implement the Debt Collection and Improvement Act of 1996 (DCIA) actions for all types of MSP debts and their associated debtor(s).

The CMS has attempted to identify sections specific to HIGLAS users or sections revised to incorporate HIGLAS functionality with the operationally defined processes.

60.1 - Background

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

The DCIA requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center (DCC) for cross servicing and/or *Treasury* offset *program (TOP).* The CMS is mandated to refer all eligible *delinquent* debt, over 180 days' delinquent, *to Treasury* for cross-servicing. The CMS has the option of referring debt before it *becomes* 181 days' delinquent *but only after the contractor has notified the debtor of CMS' intent to refer the debt to Treasury for cross-servicing. Delinquency status occurs when a debt is still owed (either in full or partially) and is at least one day after the repayment date given within the demand letter. For example, a GHP demand dated 12/1/05 gives the debtor 60 days to respond, or interest will be accrued and assessed from the date of the demand. If the debt is still unresolved as of 2/2/06 (63 days after the date of demand) the debt is considered 3 days' delinquent. (See section 60.3 for further clarification of delinquency).*

60.2 – Debt and Debtor Definitions

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Debt:

- *For GHP-based debt where the demand was issued to the employer, insurer, third party administrator, GHP, or other plan sponsor, the debt includes all of the claims in a demand letter to a debtor for a particular beneficiary, even if a single cover letter has been issued to the debtor for multiple beneficiaries' claims. (For HIGLAS users, one debt will contain claims for multiple beneficiaries having the same debtor or debtor combination specific to a jointly and severally liable situation.)*
- *For duplicate primary payment (DPP) recovery demands to a provider or supplier (including physicians), the debt includes all claims in the recovery demand letter regardless of the number of beneficiaries involved.*
- *For GHP-based DPP recovery demands to a beneficiary, the debt includes all claims in the recovery demand letter. Medicare may only make such recoveries*

*when Medicare made and the beneficiary received the primary payment directly **AND** the insurer also paid the beneficiary.*

- *For liability, no-fault, and workers' compensation, the debt includes all claims in the recovery demand letter, minus Medicare's pro-rata share of procurement and attorney costs/fees.*

Debtor:

The debtor is an individual to whom or an entity to which the last recovery demand was issued. Where the demand was issued to an individual in his/her capacity as legal counsel or representative of any type, the debtor is the beneficiary, provider/supplier (including physician), or other individual or entity being represented. Where recovery is being pursued from the attorney or other representative in his/her own right, the debtor is the attorney or other representative.

***"Current debtor"** is a way of referring to the debtor for the most recently issued demand letter. It does not change the fact that other individuals/entities may have legal obligations with respect to the debt, including any other individual or entity that may have previously received a demand letter. Where an individual, such as an attorney, received the last demand letter in his/her capacity as a representative, the individual/entity being represented is the current debtor.*

***"Jointly and Severally Liable Debtors"** is a reference to multiple entities having equal responsibility for repayment of a debt. HIGLAS users will initiate this type of GHP recovery upon receipt of a "joint and several" debtor combination interfaced from ReMAS. Non-HIGLAS users will not initiate demands to this type of debtor.*

60.3 - Debt Selection and Verification

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Medicare contractors *shall* select *delinquent* debts from their existing debt *(open Accounts Receivable [AR]) balances* for *issuance of a DCIA intent to refer (ITR) to Treasury letter. The ITR will advise the debtor of CMS' intention to refer the debt to Treasury for further collection, if left unresolved.* The referral process for MSP debts involves selecting debts based on specific criteria, in order to certify these debts as valid.

For purpose of DCIA debt selection/referral criteria, a debt becomes "delinquent" (1) If it has not been paid in full by the payment date specified in the agency's initial written notification (i.e., the agency's first demand letter), unless other payment arrangements have been made, or (2) If at any time thereafter the debtor defaults on a repayment agreement. Specific to MSP, "delinquent" is defined as an outstanding debt for which any of the following apply: (a) full payment has not been made, (b) no response from the debtor regarding the debt, or (c) no valid documented defense to the debt. All validated debt for which no valid defense has been presented to the contractor with full supporting documentation is considered to be legally enforceable.

For purposes of debt selection and referral, any dollar threshold includes both outstanding principal and outstanding interest. Also, because some Medicare contractors record their AR at the claim level (Example: 5 claims in a demand = 5 ARs) and others record at the

demand level (Example: all claims for a particular beneficiary = 1 AR) contractor shall select for referrals based on the total demand amount.

60.3.1. - Debt Selection Criteria

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

All outstanding/open delinquent MSP debts shall be reviewed. Debts may be for Part A and/or Part B services *and specific to data match, non-data match GHP, Liability, no-fault, and workers' compensation cases. Liability debts may include Federal Tort Claim Act debts or other debts established by Central Office (CO) and transferred to the contractor for collection and DCIA activities.*

NOTE: Contractors shall not refer debts of those debtors that have entered into an approved extended repayment schedule (ERS) unless they default on the agreement. Debts under an ERS are considered current unless or until the debtor defaults. (See Pub. 100-6 Part 3 for definition of "default".)

*I*n addition to the above selection criteria, once a single debt for a particular debtor has been selected, all debt for a particular debtor that does not fall under a specific exclusion may be selected and referred. The **CO encourages Medicare contractors to select all of the debt for a particular debtor that was included in a particular demand letter regardless of the dollar amount involved.** (For example, if a single demand letter was issued for 5 DM Report IDs, the contractor should select all 5 debts.) This will be less confusing to the debtor and decrease the number of "intent to refer" packages which are issued to the same debtor. Medicare contractors shall group GHP-based debts; however, it is less likely an option for liability, no-fault or workers' compensation-based debts. *Contractors shall only group individual debts that meet the $25 threshold. Debts less than $25 (principal/interest) are excluded from referral and shall not be grouped.*

60.3.1.1 - Debts Excluded from Referral

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

(See Medicare Financial Management Manual, chapter 5, Financial Reporting):

- Debts in appeal (pending at any level);
- Debts where the debtor is in bankruptcy or, in the case of an insurance company, in "State Order" liquidation proceedings [Information on current bankruptcy exclusions will be updated through your RO MSP Coordinator]; (See section 80.)
- Debts under a fraud and abuse investigation, if the contractor has received specific instructions from the investigating unit (i.e., Office of Inspector General or Office of General Counsel) not to attempt collection;
- Debts in litigation [Information on current litigation exclusions will be updated through your RO MSP Coordinator. Additionally, contractors shall notify their RO MSP Coordinator of any litigation involving an MSP debt which is brought to their attention. For purposes of excluding a debt from referral, the term "litigation" is limited to legal

actions involving the United States (on behalf of CMS) and another entity. "Litigation" does **not** include litigation between the beneficiary and the insurer];

- Debts where the *identified debtor* received the last demand letter is the employer and the employer is a Federal agency;
- Debts where the debtor is deceased;
- Debts where CMS has identified a specific debt or group of debtors as excluded from DCIA referral [Information on current "CMS Identified Exclusion" will be updated through your RO MSP Coordinator];
- Debts where there is a pending *written* request for a waiver or compromise;

Note: In the event the waiver or compromise decision is unfavorable to the debtor, the contractor shall continue the debts on to debt referral.

- Debts less than $25.00 (principal and interest); and
- Debts of $100.00 or less (principal and interest) where **NO** Tax Identification Number **(TIN)** is available. Cross-Servicing Technical Bulletin dated February 13, 2004 (Number 04-03) states: "Treasury will only accept debts of $100.00 or less (principal and interest) if the TIN is provided."

NOTE: For debts of $100.00 or less (principal and interest) and having **NO TIN**, contractors shall access and search their database to identify if there is a TIN for a debtor of the same name and address. If the TIN can be matched to the debtor, follow the DCIA referral process. If the contractor is NOT able to identify the TIN of the debtor by searching its database, document efforts taken to find the TIN *and follow instructions regarding write off in sections 70.3 and 70.4.* Contractors are reminded that the term TIN includes either the Employer Identification Number (EIN) of an entity or a Social Security Number (SSN) (for example, for a beneficiary debtor).

60.3.1.2 - Monitoring Debts Excluded From the DCIA Referral Process

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Medicare contractors *shall* monitor and report on debts that were selected for potential referral but met one of the exclusions to the DCIA referral process. Contractors *shall* monitor and determine any change in the status of such debts which would lift the exclusion and make the debt subject to referral (for example, if a debtor loses an appeal and still refuses to make payment or if CMS eliminates a litigation exclusion or a CMS-identified exclusion). *Contractors shall refer a previously excluded debt to Treasury within 15 calendar days after the date of a status change, unless there are instructions to the contrary (applicable to HIGLAS users, also).*

NOTE: Information on current litigation exclusions and on current "CMS Identified Exclusion" will be updated through your RO MSP Coordinator.

60.3.2 – Validation of Possible Eligible Debts for Referral

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

***For GHP debts**;* Medicare contractors *shall access and confirm the MSP issue specific to the GHP debt (only) is valid (e.g., a Common Working File [CWF] record exists and is applicable to the dates of services within the debt). Contractors shall include* a screen print of the *CWF information within the case file*. This review is to enable contractors to close debt, where appropriate, if the MSP record has been updated or terminated. *(ReMAS/HIGLAS GHP users are not required to validate MSP issues.)*

Note: Contractors are reminded that MSP periods for beneficiaries enrolled in "union plans" are not routinely placed on CWF. If the GHP on the original demand has a "union plan," the lack of CWF information for the debt would not be sufficient to invalidate the debt.

Contractors are also reminded that if one or more of the claims in a specific debt were covered by a MSP GHP settlement (such as the Blue Cross Blue Shield Association settlement, Aetna/Cigna settlement, etc.), those claims released in the settlement may not be included in the ITR letter and must be handled appropriately.

Note: Contractors shall follow all CMS communications specific to litigation or negotiation activities as conveyed by CMS and ensure compliance with all instructions.

***For Non-GHP debts**; Lead contractors shall confirm notice of settlement, judgment, award or other payment had been received on a liability, no fault or workers' compensation case and a recovery demand letter was issued.*

***For DPP debts**;* Where a provider, physician, or other supplier overpayment is the result of a *GHP* duplicate primary payment, it is not necessary to check CWF. The demand *shall not have been issued* unless insurer information had already confirmed the existence of a duplicate payment.

***For ALL Debt types**; Contractors shall bring closure (e.g., apply or respond) to all checks related to an established debts, posed defenses, waiver requests or compromise requests to a debt prior to the sending of an ITR to Treasury letter or the eventual referral to Treasury for cross-servicing, including TOP.*

***For Jointly and Severally Created Debts in HIGLAS:** Contractors shall follow instructions within the AR To-Be Process Flows and Narratives Section 3.3.1.2 Apply Receipts and Section 3.4.3.6 Process Other Receivable Adjustment, specifically those adjustments related to valid documented defenses for joint and several cases and debtors.*

If a debt has been referred to the Social Security Administration (SSA) for collection, the Medicare contractor must recall the debt from SSA and make adjustments for any amounts collected by SSA before issuing the ITR letter.

Contractors using the ReMAS/HIGLAS systems shall document all actions taken on a debt after the demand (e.g., posting check, adjusting for a defense, etc.,) within the HIGLAS system. Contractors shall maintain all incoming correspondence and copies of outgoing correspondence within a case file. Contractors that maintain case files and correspondence electronically shall ensure case retrieval or recreation take place within 2 business days of a request.

Additionally, contractors, *not on HIGLAS, shall* check their internal systems for an updated debtor address before sending the DCIA ITR letter. Contractors shall review this information and update the case file before an ITR letter can be issued.

Contractors shall update any changes to status codes within **all** associated systems, *including HIGLAS,* and shall update interest accruals while performing the debt validation process. This includes updates to internal systems and/or spreadsheets so that Medicare contractors can easily ascertain from their systems and/or spreadsheets what stage of the DCIA referral process a particular debt is in.

60.4 – Issuance of the "Intent to Refer" (ITR) Letter and Inquiries/Replies Related to DCIA Activities

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

The DCIA requires agencies to inform the debtor in writing of the agency's ITR the debt to Treasury for further collection activities, including TOP, and to provide the debtor information concerning the rebuttal and referral process.

60.4.1 – Issuance of the "Intent to Refer" to Treasury Letter

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Once contractors have identified and validated all eligible delinquent debts having a balance remaining they shall send an ITR to Treasury letter with all appropriate attachments to the current debtor or joint and several debtor combination (See section 60.2 for current debtor definition.) Contractors shall send ITR letters (See section 60.9.1) via certified mail, return receipt requested, to the "current debtor" or "joint and several debtor combination." (See section 60.2)

Use of the ITR letter is mandatory (including a copy of the last demand letter and all attachments to the demand letter). Contractors shall generate the ITR letter without standard system changes. For most contractors, this would be a PC-based generated document.

In the case of a GHP debt the contractor shall:

- *Send the "intent to refer" letter to the employer;*
- *Provide a courtesy copy to the employer's insurer/TPA. (See section 10.9);*
- *Enclose a copy of the original demand package;*
- *Provide an accounting of all services/portion of the debt still owed Medicare; and*
- *Enclose a copy of attachment 1E, which contains the most commonly posed defenses and how the debtor may support the defense. (This listing is not inclusive of all defenses that may be raised.)*

In the case of a Jointly and Severally Liable Debt within HIGLAS, the contractor shall:

- *Send the "intent to refer" letter, inclusive of required attachments, to both joint and several debtors, if funds are still owing by both entities;*

- *Enclose a copy of the original joint and several demand package;*
- *Provide an accounting of all services/portion of the debt still owed Medicare by each of the joint and several debtors;*

***HIGLAS NOTE**: All contractors using HIGLAS system will have the ITR letter generated via the HIGLAS.*

On Data Match debts recorded on the Mistaken Payment Recovery Tracking System (MPaRTS), Medicare contractors shall update the debts status code with an "IL" no later than one business day after the ITR letter is sent. Contractors on ReMAS and HIGLAS for GHP debts shall not update MPaRTS on newly identified ReMAS GHP cases or actions. Contractors having had active Data Match ARs converted into HIGLAS shall still be responsible for updating MPaRTS with all required status codes until closure of the case.

NOTE: When the ITR letter is issued and the amount of the debt has been previously reduced from the original demand letter, contractors shall appropriately annotate the demand packet and explain the difference. The debtor must be able to understand the figures referenced in the ITR letter. Consequently, screen prints or other annotations to the case file are insufficient.

***For liability, no-fault, and worker's compensation cases, contractor shall**:*

- *Send an ITR to the current debtor. Address the ITR letter to the beneficiary when the beneficiary is the debtor, with a copy to the beneficiary's attorney or other representative (if applicable). (See section 60.2 for debtor definition);*
- *Enclose a copy of the original demand package;*
- *Provide an accounting of all services/portion of the debt still owed Medicare;*
- *Send the ITR letter directly to the no fault insurer with a copy to the beneficiary, when the no fault insurer is the actual debtor; and*
- *Send the ITR letter directly to the workers' compensation carrier and a copy to the beneficiary, when the workers' compensation carrier is the debtor.*

*Regardless of the identity of the debtor, contractors shall attach to each ITR letter a copy of the original demand package, attached as stated in section 60.3.1; once a single debt for a particular debtor is selected, all debt for that debtor that do not fall under a specific exclusion may be selected and referred. Contractors shall issue a separate ITR letter for each debt, as well as an instructional cover sheet **for each package** of ITR letters when multiple ITR letters are sent to the same debtor at the same time. (See section 60.9.1.1 for the instructional cover sheet). Contractors shall generate this sheet without shared system changes. For most Medicare contractors, this would mean a PC-based generated document. Multiple debts may **not** be aggregated or otherwise combined in a single ITR letter. The ITR letters shall be debt specific. Input into the DCS shall also be debt specific.*

NOTE: Contractors shall issue an ITR letter to allow the debtor to respond in the required timeframe contained in the letter and still, if necessary, refer the debt prior to or by the time it reaches 180 days delinquency.

60.4.2 – Responding to Correspondence as a Result of the Issuance of the ITR Letter

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Contractors that receive a response to the ITR letter which challenges the amount of the debt, *shall* reply using the appropriate letters (*see section 60.9.1.2. 60.9.1.3 and 60.9.1.4* (Exhibit 1B, 1C, or 1D)). Contractors shall generate these letters without shared systems changes. For most Medicare contractors, this would mean PC-based generated letters. *For those contractors on the HIGLAS system, these letters will be part of a future release. Until that time, rebuttal letters for HIGLAS users shall be issued via PC. All replies to one of the jointly and severally liable debtors shall also be copied and sent to the non-responding joint and several debtor. The contractor shall inform the debtor or debtors of the amount that remains subject to referral* where a debtor establishes that the debt or part of the debt should not be referred to *Treasury* due to one of the exclusions. (The response should indicate what amount will be excluded from referral at this time and what amount continues to be subject to referral.)

Contractors shall respond to ITR responses (i.e., posed defenses) within 30 calendar days *of receipt and update all applicable internal and shared system financial/debt tracking systems including HIGLAS, if appropriate.*

In the event the response from the debtor or debtors is an actual repayment (either in part or in full), the contractor shall apply the check to the debt within 20 calendar days of its receipt and update all applicable internal and shared system financial/debt tracking systems (e.g., MPaRTS, HIGLAS, MARTI, RTS, Casework, etc.,).

For non-HIGLAS GHP Users: *if* an ITR letter is returned and stamped "Undeliverable Mail," contractors *shall* make one *attempt* to locate a better address (for example, by calling directory assistance to obtain a phone number for the debtor and calling the debtor). If a better/new address is obtained, contractors shall re-issue the ITR letter with a new issuance date and *shall* ensure that CWF is updated, via an ECRS CWF *A*ssistance *R*equest. If this limited development effort does not result in a new address, contractors *shall* document *its* development *attempt*, staple the envelope to the returned ITR letter, and file it in the case. The debt *shall* be referred *immediately* to the PSC/Treasury for further collection activity.

If the certified mail delivery to the debtor is "refused," the contractor *shall* re-mail the original ITR letter, by regular mail, within 7 calendar days of receiving the refusal. *The contractor shall re-mail the existing letter (re-issuing the letter with the current date) by regular mail and proceed with the referral process based upon the date in the original letter.* Contractors *shall* retain documentation of the refusal and annotate the file to show the date the letter was re-mailed.

If the certified mail delivery to the debtor is returned as "unclaimed," contractors *shall* follow the same procedures as they would for "refused" mail.

Medicare contractors shall answer all inquiries resulting from the DCIA ITR letter. *Contractors shall bring closure (e.g., post or address) to all checks or posed defenses to a debt prior to the actual referral to Treasury for cross-servicing via the DCS system.*

For HIGLAS Users Addressing a Non-GHP Debt or a Single GHP Debtor Situation: *if* an ITR letter is returned and stamped "Undeliverable Mail," contractors *shall* refer the *debt immediately* to the PSC/Treasury for further collection activity.

For HIGLAS Users Addressing a GHP Joint and Several Debt : *If an ITR letter is returned from* ***one*** *of the joint and several debtors, contractors shall continue collection efforts with the remaining debtor. This action does not mean the "undeliverable" ITR entity is no longer responsible for repayment of the delinquent debt.*

REMINDER: Contractors shall bring closure (e.g., post or address) to all checks related to established debts, posed defenses, waiver requests or compromise requests to a debt prior to the actual referral of the debt(s) to Treasury for cross-servicing.

NOTE: For debtors that have administrative appeal rights and/or the right to request a waiver of recovery under section 1870 of the Social Security Act, the contractor *shall* evaluate whether any *written* reply constitutes an implied appeal (if the time period for an appeal has not expired) or a request for a waiver has not previously been requested.

60.5. – Debt Collection System (DCS) and DCS Entry

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Contractors shall use the DCS to refer MSP debts to the PSC, as the PSC is still responsible for completing the referral process to Treasury cross-servicing and TOP.

60.5.1 – DCS

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

The DCS is used to refer debts to the PSC/Treasury for cross-servicing of individual debts, including TOP. It is also used to track debts pending action at the PSC/Treasury. Input into the DCS certifies the debt as valid, legally enforceable, and ready for referral to the PSC/Treasury. *(See Pub. 100-6 Chapter 4 for the DCS User Guide.)*

HIGLAS users will no longer manually update the DCS with initial referrals to Treasury for cross-servicing, or downward adjustments and collections received at the contractor subsequent to the initial referral. HIGLAS will systematically send these transactions to DCS.

60.5.2 – DCS Entry of Delinquent Debt

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Contractors shall individually enter debts eligible for referral to Treasury for cross-servicing for which correspondence has been received and responded into the DCS, if appropriate. Contractors shall complete DCS entry and other system updates within 10 calendar days after correspondence is worked and/or checks posted (this includes

MPaRTS, HIGLAS, etc.). The status code on MPaRTS when the debt is referred to the PSC is "PS."

Generally, contractors have 45 calendar days to respond to ITR-generated correspondence barring instructions to the contrary. Some examples of instructions to the contrary are: 1) Contractors shall apply checks to a debt within 20 calendar days of receipt and 2) See Section 60.6.1 for timeframes specific to a contractor's response to a Treasury Action Form (TAF).

NOTE: Contractors shall manage workloads in such a way to afford the debtor(s) appropriate time to respond and refer eligible delinquent debt to Treasury for cross-servicing on or before it becomes 180 days' delinquent.

Contractors on HIGLAS shall no longer be required to update DCS with the initial referral information. HIGLAS will provide a listing of all debts eligible for referral to Treasury for cross-servicing. HIGLAS users shall update the case status to allow HIGLAS to send all appropriate debts to the DCS system for transmission to the PSC systematically. Some fields in DCS will require manual entry. For example: Contractors shall change SA code from COR to IND if a debtor is an individual. Contractors shall review the DCS report before transmitting to DCS. Debts less than $100 with no TIN shall be excluded, at the time of review, from referral. Contractors shall follow instructions in section 60 regarding debts less than $100 with no TIN.

Once the debt has been *entered into the DCS or successfully transmitted to the PSC, all* contractors shall forward a copy of the ITR letter with all attachments and/or enclosures, to the Treasury in Homewood, Alabama within 7 calendar days from the date of *DCS entry*.

If a Medicare contractor receives a partial collection (through offset or check) and/or a valid documented defense for part of the debt prior to referral to Treasury, it reduces the debt (both principal and interest) accordingly **before** entering the remaining debt into the DCS. On the Comments Screen of the DCS, the Medicare contractor shall enter that a collection occurred and/or a valid documented defense was received; from whom; how much the debt balance was at the time of the ITR letter; the amount of any collection; and the resulting balance being referred. The contractor shall annotate the balance to show principal amount, interest amount, and total amount.

60.6 – Contractor Actions Subsequent to DCS Entry

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

All contractors, RO and CO shall cease recovery efforts once a debt is referred to Treasury. However, *contractors shall maintain and track debts referred to Treasury* in their *financial* systems (such as *HIGLAS, RTS, SMART, MARTI, etc.)*. *Interest shall continue to accrue on all debts referred to Treasury for cross-servicing.* The CO, via the RO, furnishes Medicare contractors with routine reports of debts transmitted to Treasury *as of a certain date.*

If Treasury or an entity on its behalf *(Private Collection Agencies (PCAs))* recovers on an MSP debt, *notification of the recovery will be sent to the contractors from CMS CO. (Posting of a Treasury collection in DCS does not equal "contractor notification.")*

*Contractors shall **not** take any action on a debt that has been referred to Treasury, unless notified by CMS to do so.*

In the event contractors receive a check or a valid documented defense directly from the debtor after the debt had been referred to Treasury, the contractor shall update all applicable financial systems and show any collection or adjustment due to the valid defense within the collection screen in the DCS system. HIGLAS users shall not update DCS collection screens in this situation. HIGLAS users will update the applicable HIGLAS collection screens. Once updated on HIGLAS, the update information will be transmitted to DCS systematically. Contractors may receive telephone inquiries/questions on debts that have already been referred to Treasury. Medicare contractors *shall attempt to* identify *the creator of the letter the inquirer is in receipt of* (PSC, PSC contractor, Treasury, Treasury contractor, or Medicare contractor*) and direct the caller to send any correspondence, defenses or repayments to the creator of the letter.*

All contractors shall copy and send to Treasury all waiver or compromise requests received directly from the debtor after the debt has been referred to Treasury.

60.6.1 – Steps Contractors Shall Take Upon Knowledge or Receipt of Certain Information

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

A. Contractors shall update their internal financial systems of a collection made by Treasury when notified by CMS CO. In the situation of Treasury collections, CMS CO will update the DCS with the collection information.

Contractors shall update their financial systems and DCS (manual DCS updates are not applicable to HIGLAS users) when acknowledging a valid documented defense, either submitted directly to the contractor by the debtor or via a TAF from Treasury/PCA.

B. Contractors may receive correspondence stating the insurer or employer has paid the provider/physician or other supplier. In this situation, the contractor shall ask for proof of payment. The insurer or employer still owes any interest that accrued up until the date it paid the provider, physician, or other supplier. If it paid the provider, physician, or other supplier before Medicare issued its demand, then proof of such payment is a valid documented defense for the entire debt. However, if the insurer or employer paid the provider, physician, or other supplier after Medicare issued its demand letter, the employer or insurer still owes any interest which had accrued and was due at the time of the payment to the provider, physician, or other supplier. (Proof of payment may include a remittance advice, an EOB (explanation of benefits), cancelled checks and/or spreadsheets/computer print-outs on the insurer's letterhead that establish that the insurer in fact paid the provider, physician, or other supplier.) On the Data Entry Screen within DCS the contractor shall enter in the Principal Referred Amount field, one dollar with a penny ($1.01) and in the Interest Referred amount field the amount of interest still due and owed by the debtor. The contractor shall enter a comment on the Comments Screen explaining that the debtor has paid the provider all the principal due, but still owes interest on this debt to the Medicare Program.

NOTE: HIGLAS users shall manually enter into the DCS the $1.01 for interest only debts, ONLY after having received the notice of DCS acceptance from the CO via an NDM file or an email notice.

C. If a cross-servicing entity receives partial or full collections for debts that have been referred, *Treasury* will notify CO via an Intergovernmental Payment and Collection (IPAC) report. (The IPAC report was previously known as the OPAC report.) The notification when furnished to the Medicare contractor will *describe* how the collection *shall be applied. Contractors shall not update DCS with a Treasury collection. The DCS update will be done by CMS CO.*

D. If a PCA discovers an error, receives information that establishes a valid documented defense, or receives information that would exclude all or part of a debt from DCIA referral, the Medicare contractor shall receive a TAF from the PCA via the CO/RO. The TAF is not an OMB-approved form. Therefore, contractors may see different formats used by the PCAs. The TAF, along with supporting documentation, is sent to CMS by Treasury for contractor decision. The TAF is not a resolution of a debt by Treasury; it is a request for the Medicare contractor to review the documentation and provide a decision. Therefore, it is the Medicare contractor's responsibility, after review of the TAF and supporting documentation, to initiate all required actions including total debt recalls or adjustments due to valid documented defenses. Medicare contractors shall update all systems, including DCS, HIGLAS and other CFO tracking systems, if the decision so warrants within 30 calendar days. Medicare contractors shall notify Treasury of their decision either via fax or mail (Treasury needs the decision and its rationale; contractors shall ***not*** *send back the case documentation). This notification of the contractors' decision shall include the applicable Debt Management Service Center Number in their response (the number is located at the top left of the TAF).*

NOTE: HIGLAS users shall manually update DCS ONLY when changing and "X" code back to a "UJ" code. For example: A posed defense is sent via a TAF to the contractor and the contractor determines the defense to be invalid; the contractor shall change the DCS code back to the "UJ" code; collection efforts will continue.

E. If the Medicare contractor discovers an error, receives a *direct* repayment (by check or internal offset), *directly* receives information *from the debtor* establishing a valid documented defense, or receives information that would exclude all or part of a debt from DCIA referral, the *contractor* shall update the DCS Data Entry Screen *with status updates and changes to the dollar amount prior to the transmission to Treasury and the Collection Screen for all other scenarios listed above.*

HIGLAS users shall update the HIGLAS system with all appropriate downward adjustments (includes collections) and status codes prior to the debt being released for a systematic DCS interface.

Contractors *shall* no longer send the recall reports to the *Treasury.* *Recalls will* be transmitted automatically to *Treasury* by CO. If a collection is received *by the contractor, the contractor shall update the collection screen within the DCS (not applicable to HIGLAS users).* For further instructions about the DCS system, see the DCS *User Guide*.

F. If a debt has been referred to Treasury and falls under the $100 or less, no TIN category, due to an adjustment or collection at the contractor's site, these debts shall not be recalled *by the contractors. Contractors will be notified by CMS CO as to the action to take (applicable to HIGLAS users, also).*

H. Contractors *may receive* a request for a "waiver of interest." This issue is not within Medicare contractor jurisdiction. Any such request must be in writing, and must explain why the debtor believes that the interest should be waived. Such requests must be forwarded to the RO with a copy of the case file. The ROs must review any such requests and make a recommendation to CO. Once CO makes a decision, it will communicate the decision in writing to the debtor, with a copy to the RO and to the Medicare contractor**.** The contractor shall take all actions necessary to implement the decision and update all appropriate records and systems.

NOTE: Contractors shall not refer requests for waiver of interest on cases in which the debtor has supplied to the contractor proof of actual receipt date of settlement proceeds. (For example, a copy of the settlement check, front and back.) If repayment to Medicare is not made by the due date in the recovery demand letter or within 60 calendar days from the date the beneficiary receives the settlement proceeds, whichever is later, then interest accrues from the date of the demand letter or the date of the receipt of the settlement proceeds, whichever is later. (See section 50 of the MSP manual)

NOTE: If a debt is recalled/returned from Treasury due to a bankruptcy notification, the Medicare contractor shall follow bankruptcy procedures in Section 80.

60.7 - DCIA Treasury Collection (Placeholder)

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Medicare contractors *shall* monitor and report on debts that were selected for potential referral but met one of the exclusions to the DCIA referral process. Contractors *shall* monitor and determine any change in the status of such debts which would lift the exclusion and make the debt subject to referral (for example, if a debtor loses an appeal and still refuses to make payment or if CMS eliminates a litigation exclusion or a CMS-identified exclusion). *Contractors shall refer a previously excluded debt to Treasury within 15 calendar days after the date of a status change, unless there are instructions to the contrary (applicable to HIGLAS users, also).*

NOTE: Information on current litigation exclusions and on current "CMS Identified Exclusion" will be updated through your RO MSP Coordinator.

60.8 - Financial Reporting

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Contractors shall document all accounting actions taken on any debt, whether the debt is actively being collected by the contractor or by Treasury/PCA/TOP. Contractors shall follow all applicable financial reporting requirements defined in Pub. 100-6 Chapter 4 and 5 and in Pub. 100-5 Chapter 7 Section 70. Further instructions will be published to address contractor requirements in documenting, updating and reporting debts collected

by Treasury/PCAs or through TOP. Until instructions are issued, contractors shall ***TAKE NO ACTION*** *to update their financial systems to reflect collections by Treasury/PCAs or through TOP.*

60.9 - Exhibits

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

NOTE: Medicare contractors shall note that interest *accrues* from the date of the original demand letter to the debtor(s). The additional information about interest accrual is included in the letter so that the debtor(s) will know how much it must repay if it does not make repayment immediately upon receipt of the ITR letter.

Contractors using HIGLAS shall use the reply exhibits 1B-D in this section when appropriate. When replying to a rebuttal from a jointly and severally liable debtor, contractors shall send a copy of the response to the other non-responding joint and several debtors.

60.9.1 - Exhibit 1 - DCIA "Intent to Refer" (ITR) to Treasury Letter

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

NOTE: DCIA Joint and Several ITR letters will be generated out of HIGLAS. The language below is very similar to the HIGLAS-generated language with a few modifications on the text to identify both debtors as addressees and both entities having joint and several liability for the repayment of the outstanding debt.

[Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

Past-due debt owed CMS as of **[insert:date of "intent to refer" letter/this letter] :** $**[insert: total principal and interest]**

Date debt became past-due: **[insert:the 61st day after demand letter date]**

Date of Demand Letter previously sent: **[insert: date; Contractors, remember that this is the date of the demand to the debtor receiving this "intent to refer" letter.]**

Debt identification numbers: **[insert: Contractor number plus contractor case ID number for all MSP other than DM; contractor number plus MPaRTS Report ID number for DM]**

Taxpayer Identification Number (TIN): **[insert: EIN (or SSN for beneficiary debtors or other non-corporate debtors]**

Beneficiary's Name: **[insert]**

Beneficiary's HIC#: **[insert]**

[insert for liability, no-fault, workers' compensation "intent to refer" - Date of Accident/Incident: (insert date)]

NOTICE OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY OR A DEPARTMENT OF TREASURY DESIGNATED DEBT COLLECTION CENTER FOR CROSS-SERVICING AND OFFSET OF FEDERAL PAYMENTS

(Note that it is possible that this letter is being sent to you by a Medicare contractor other than the one who issued the request(s) for repayment that is(are) attached to this letter. This situation would occur whenever one contractor has assumed responsibility for a particular workload from another contractor (usually because the initial contractor is leaving or has left the Medicare program).)

The Centers for Medicare & Medicaid Services (CMS) has determined that you are indebted to the Medicare program for the amount shown above and that this amount is delinquent. The amount shown includes principal and interest. This debt arose under the Medicare Secondary Payer (MSP) provisions of the Social Security Act. The CMS has the right to collect this debt through offset of any payments due to the debtor. In addition, the Debt Collection Improvement Act (DCIA) of 1996 requires federal agencies to refer delinquent debts to the Department of Treasury and/or a designated Debt Collection Center (DCC) for collection through cross-servicing, including the Treasury Offset Program (TOP). Under TOP, delinquent federal debts are collected through offset from other Federal agency payments you may be entitled to, including the offset of your income tax refund through the referral of this debt to the Internal Revenue Service (IRS), and Federal benefit payments such as Social Security retirement or disability benefits. Treasury or a designated DCC uses various collection tools to collect the debts, including offset, demand letters, phone calls, referral to a private collection agency and/or referral to the Department of Justice or agency counsel for litigation.

The purpose of this notice is to inform you *that your* debt *may be referred* to a Treasury/designated DCC, under the provisions of the DCIA, Title 31 United States Code, Section 3711 to collect this debt. This referral will permit the Department of Treasury and/or a designated DCC to use the aforementioned means of collection as well as to permit administrative offset of payments you may be receiving from other federal agencies. During this collection process, interest will continue to accrue on the debt and you will remain legally responsible for any amount not satisfied through the collection efforts.

Please read the following instructions carefully as they may assist you in resolving this matter prior to referral. Add: **[insert - Contractors, insert the following sentence for "intent to refer" letters to insurers, employers, third party administrators, GHPs, or other plan sponsors: Please note that in addition to the information set forth below, we are enclosing more detailed information on how to review this debt, and proper documentation requirements for asserting that the debt is not past due or legally enforceable.]**

Challenging the Indebtedness:

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing to the address listed below. Additionally, you have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise this right, this office must receive a copy of the evidence to support your position. Please include a copy of this notice when corresponding with the agency regarding this matter. You must submit any evidence that the debt is not owed or legally enforceable within 60 days of the date of this letter. We will notify you within 30 days of receipt of the information of our determination as to whether the debt is still past due and legally enforceable. Failure to present any evidence will result in the automatic referral of the debt to the Department of Treasury/a designated DCC for cross-servicing/offset actions.

Your debt will not be referred for further collection action if you make payment in full. Please be advised that payment of principal only is not considered payment in full and will not satisfy this debt. By law, partial payments are applied to interest first and then to principal.

The past-due debt owed to CMS as of **[insert: date of "intent to refer"/this letter]**, including interest accrued through **[insert: date of last day of the current interest period]**, is **[$]**. ***[Insert: use (A) for debts established before 10/01/04; use (B) for debts established on or after 10/01/04; (A)*** By regulation, interest is due and payable for each 30-day period as of the **first day** of that 30-day period; ***(B) By regulation, interest is due and payable for each full 30-day period that the debt is not fully liquidated.]***. Be advised that interest is accrued monthly and is added to the balance of the debt. If the debt remains outstanding after **[insert specific date: date of last day of the current interest period]**, the amount of the debt, including interest, will be **[insert dollar amount]**. If no payment is received by **[insert date: date of last day of the next interest period (30 days from date of the last day of the current interest period)]**, the amount of the debt including interest will be **[insert: dollar amount, including interest]**; and if no payment is received by **[insert date: date of the last day of the third interest period (60 days from the date of the last day of the current interest period)]**, the amount of the debt including interest will be **[insert: dollar amount, including interest]**. Please make your check or money order payable to *Medicare*, include a copy of this notice and forward both to the address below.

[insert & instructions: "interest only debt" – If the outstanding debt is interest only, that debt does not accrue additional interest. "Interest only" debts generally happen when the employer or insurer paid the provider/supplier after the date of the demand. In these situations, contractors must delete the preceding paragraph (that is, starting with "The past due debt owed….") and insert the following paragraph in its place: Please be aware that if you paid the provider, physician, or other supplier for the claims at issue after Medicare issued its demand letter, you still owe any interest which accrued and was due at the time of the payment to the provider, physician, or other supplier. The past due debt of [insert: amount] owed to CMS is comprised entirely of interest. Please make your check or money order payable to *Medicare*, include a copy of this notice and forward both to the address below.]

[insert & instructions: beneficiary GHP-based debt - If the debtor is the beneficiary and the debt is GHP-based debt, CMS does not charge interest to the beneficiary. In

these situations, the contractor must delete the standard paragraph which includes information about interest (that is starting with "The past due debt owed....") and insert the following paragraph in its place: The past-due debt owed to CMS is [insert: amount of outstanding debt]. Please make your check or money order payable to *Medicare,* include a copy of this notice and forward both to the address below.

[insert: Name of Medicare Contractor - MSP Unit

Attention: Manager's Name

Address of Medicare Contractor]

Your check should also include the "debt identification numbers" as shown at the beginning of this letter in order to ensure that you receive proper credit for your payment.

If you cannot make the payment in full, you may be allowed to enter into an extended repayment agreement.

Bankruptcy Related Information: If you have filed for bankruptcy **and** an automatic stay of bankruptcy is in effect, you are not subject to offset while the automatic stay is in effect. Documentation supporting your bankruptcy status, along with a copy of this notice, must be forwarded to this office at the above address in order to avoid referral.

Information for Individual Debtors Filing a Joint Federal Income Tax Return: TOP automatically refers debts to the IRS for offset. Your federal income tax return is subject to offset under this program. If you file a joint income tax return, you should contact the IRS before filing your tax return to determine the steps to be taken to protect the share of the refund which may be payable to the non-debtor spouse.

If you have questions concerning this debt, extended repayment plans, and/or relating to the submission of evidence, you may contact:

[insert: Name of Contractor's Contact Person

Telephone Number of Contact Person]

If you call, please be sure that you have this letter available so that you can readily provide us with the identification information provided at the beginning of the letter.

Sincerely,

[insert: Name

Title

Contractor's Name - MSP Unit]

Enclosures:

Demand Letter

Claims Summary/*Payment Record Summary*

[insert for GHP insurer, employer, third party administrator, GHP, or other plan sponsor debts only: Enclosure with supplemental information on resolving debts *or 1E attachment*]

[insert where the beneficiary is the debtor and is represented - cc: attorney or other representative]

60.9.1.1 - Exhibit 1A - Cover Instruction Sheet When Contractor Sends Multiple "Intent to Refer" Letters to the Same Debtor in One Package

(Rev)

Date: [Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

MULTIPLE NOTICES OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY OR A DEPARTMENT OF TREASURY DESIGNATED DEBT COLLECTION CENTER FOR CROSS-SERVICING AND OFFSET OF FEDERAL PAYMENTS

The Centers for Medicare & Medicaid Services (CMS) has determined that you are indebted to the Medicare program and that the amounts due are delinquent.

Enclosed are multiple "Notice of Intent to Refer" letters regarding referral of debt to the Department of Treasury or a designated Debt Collection Center for cross-servicing and offset of Federal payments. **Each notice is for a separate debt, provides specific information concerning the debt, and includes documentation supporting that debt**.

When you send payment or contact us about these debts, it is important that you identify a particular debt by the debt identification numbers provided at the beginning of each Notice of Intent. This is necessary so that you receive proper credit for any payment and/or so that we may properly assist you with any questions you may have. Each Notice of Intent to Refer letter contains contact information if you have any questions, as well as directions for making payment on the debt.

60.9.1.2 - Exhibit 1B - Valid Documented Defense for All Claims Included In the Intent to Refer Letter-- Reply

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Date: [Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

Debt Owed to Medicare: **[insert: dollar amount]**

Debt Identification numbers: **[insert: Contractor number plus contractor case ID # for all MSP other than DM, contractor number plus MPaRTS Report ID number for DM]**

Beneficiary's Name: **[insert]**

Beneficiary's HIC#: **[insert]**

[insert for liability, no-fault, workers' compensation - Date of Accident/Incident: (insert date)]

Re: Defense Offered to Intent to Refer Letter Dated **[insert: date]**

Dear **[insert: Debtor Name]**:

We have reviewed the rebuttal (defenses) you offered in your **[insert: date]** letter in response to our Intent to Refer Letter Dated **[insert: date]**.

The rebuttal (defense) offered constitutes a valid documented defense. Accordingly, we consider this matter resolved.

If you have any further questions concerning this matter you may contact:

[insert: Name of Medicare Contractor - MSP Unit

Attention: Contact Person's Name

Address of Medicare Contractor

Telephone Number of Contact Person]

Sincerely,

[insert: Name

Title

Contractor's Name - MSP Unit]

60.9.1.3 - Exhibit 1C - Unacceptable Defense for All Claims in the Intent to Refer Letter - Reply

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Date: [Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

Debt Owed to Medicare: **[insert: dollar amount]**

Debt Identification numbers: **[insert: Contractor number plus contractor case ID # for all MSP other than DM, contractor number plus MPaRTS Report ID number for DM]**

Beneficiary's Name: **[insert]**

Beneficiary' s HIC#: **[insert]**

[insert for liability, no-fault, workers' compensation - Date of Accident/Incident: (insert date)]

Re: Defense Offered to Intent to Refer Letter Dated **[insert: date]**

Dear **[insert: Debtor Name]**:

We have reviewed the rebuttal (defenses) you offered in your **[insert: date]** letter in response to our Intent to Refer Letter Dated **[insert: date]**.

The rebuttal (defense) you offered does not constitute a valid documented defense because **[insert: contractor must include rationale explaining why the offered defense is insufficient]**. The underlying debt is valid and must be repaid.

Please refer to the Demand Letter dated **[insert: date]** for a summary of your obligations and Medicare's rights regarding collection of this debt.

If you have any further questions concerning this matter you may contact:

[insert: Name of Medicare Contractor - MSP Unit

Attention: Contact Person's Name

Address of Medicare Contractor

Telephone Number of Contact Person]

Sincerely,

[insert: Name

Title

Contractor's Name - MSP Unit]

60.9.1.4 - Exhibit 1D - Payment and/or Acceptable Defense for One or More But Not All Claims in the Intent to Refer Letter--Reply

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

Date: [Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

Debt Owed to Medicare: **[insert: dollar amount]**

Debt Identification numbers: **[insert: Contractor number plus contractor case ID # for all MSP other than DM, contractor number plus MPaRTS Report ID number for DM]**

Beneficiary's Name: **[insert]**

Beneficiary's HIC#: **[insert]**

[insert for liability, no-fault, workers' compensation - Date of Accident/Incident: (insert date)]

Re: Defense Offered to Intent to Refer Letter Dated **[insert: date]**

Dear **[insert: Debtor Name]**:

____ We have reviewed the rebuttal (defense) you offered in your **[insert: date]** letter in response to our Intent to Refer Letter dated **[insert: date]**.

The rebuttal (defense) you offered constitutes a valid documented defense for a portion of the debt (**[insert: dollar amount]**). It does not constitute a valid documented defense for the remainder of the debt because **[insert: contractor must include rationale explaining why the offered defense is insufficient]**. Accordingly, we have adjusted the debt by **[insert: dollar amount]**.

____ We received your check in the amount of **[insert: dollar amount]**. This amount has been applied to the outstanding overpayment, and both the principal and interest due have been reduced accordingly.

The remainder of the debt is valid and must be repaid. The outstanding debt as of the date of this letter is principal **[insert: dollar amount]**; interest **[insert: dollar amount]**.

Please refer to the Demand Letter dated **[insert: date]** for a summary of your obligation and Medicare's rights regarding collection of this debt. Additionally, we are enclosing an

updated copy of the summary of claims data sheet that was included with the Intent to Refer letter dated **[insert: date]**. This summary has been annotated to indicate the claims that have been subtracted from our demand because of the rebuttal and/or payment you submitted. The interest due has also been recalculated to take this reduction into consideration.

If you have any further questions concerning this matter you can contact:

[insert: Name of Medicare Contractor -MSP Unit

Attention: Contact Person's Name

Address of Medicare Contractor

Telephone Number of Contact Person]

Sincerely,

[insert: Name

Title

Contractor's Name - MSP Unit]

Enclosure

60.9.1.5 - Exhibit 1E - Enclosure for DCIA "Intent to Refer" Letter to Employer, Insurer, Third Party Administrator, Group Health Plan (GHP), or Other Plan Sponsor

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

The Centers for Medicare & Medicaid Services (CMS) anticipates that the employer or insurer may ask its health insurance contractors (i.e., the group health plan (GHP) or any entity responsible for payment under the plan (employer, insurer, third party administrator (TPA), or other plan sponsor) to assist in resolving these Medicare Secondary Payer (MSP) debts. This is certainly acceptable. However, the employer, the insurer, and other health insurance contractors must recognize that the date of Medicare's original demand letter is the date applicable to any defense that the employer, insurer, or health insurance contractors may have to any portion of this debt. The date that the employer, insurer (or other entity to the demand letter was issued) elected to share MSP claims information with a particular health insurance contractor is not relevant.

The numbered sections below show what you must take into consideration and what documentation you must provide if you wish to assert that the debt is not past due or legally enforceable. If you determine that you can resolve the debt based upon the information in a particular section, you do not need to proceed to the next numbered section.

The numbered sections will reference proper documentation. When copies of "individual claims," demand letters, and report identification numbers are requested, you may use the copies we are providing you but the information of most importance is documentation to support your defense.

Number 1

Many employers and entities that process claims for employer group health plans (EGHPs) organize their records by the name and unique identifier of the employee to whom individual or family health insurance coverage is afforded. We provide information on the individual (in most cases the employee) to whom the health insurance was afforded. This information is the primary insurance that usually covers the individual beneficiary that received the medical services. We have observed that some employers and claims processors neglect to check the MSP Summary Data Sheet and mistakenly assume that the beneficiary is an employee. Historically, the majority of MSP recovery claims have involved services provided to spouses of employed individuals. The employer and any health insurance contractors that assist the employer in this effort must utilize the individual claim and the associated MSP Summary Data sheet to determine coverage at the time services were provided.

Number 2

The health plan information that Medicare provided in the original demand letters was, in almost all cases provided by the employer in response to Internal Revenue Service (IRS)/Social Security Administration (SSA)/CMS Data Match questionnaires. In other cases, the health plan information was obtained from the beneficiary, the insurer, or the provider/physician/other supplier that furnished services to the beneficiary. Thus, the

information is presumed to be accurate as of the time it was provided. Many employers offer employees the opportunity periodically to choose among several available group health plans (GHPs). Because CMS was not advised of changes in employees' group health plan (GHP) choices, the group health plan Medicare identified as providing the health insurance may not be correct as of the date particular services were provided to an identified beneficiary.

The MSP debt is still valid as long as the Medicare beneficiary, entitled to Medicare on the basis of age or disability, had coverage under any employer plan based on their own or spouse's current employment status. (A disabled beneficiary may also have had coverage based on another family member's current employment status.) In the case of a beneficiary entitled to Medicare on the basis of ESRD (end stage renal disease), the debt is still valid if the beneficiary had coverage under any Employer plan on any basis. If you are unclear about your responsibility relative to ESRD, please call the Medicare contractor.

The original demand letters explain that interest is due on any debt that is not resolved timely (60 days from the date of the original demand letter) and advises the recipient of the applicable interest rate. Interest applies from the date of the demand letter for each full 30-day period that the debt is unresolved. Accordingly, to resolve any MSP claim for which payment is due, the responsible entity (GHP, employer, insurer, TPA), or other plan sponsor) must pay both the principal due and the applicable interest. To assist the responsible entity in determining the amount due on any individual unresolved MSP debt and CMS in verifying that the correct payment has been made, the responsible entity should provide the Medicare contractor with the following information:

- A copy of the individual claim;
- Date of the original demand letter containing the claim;

Associated claim identification number for that claim as provided in the demand letter;

- Explanation of how the principal payment was determined; and
- Explanation of how applicable interest was computed.

The responsible entity (employer, insurer, TPA, GHP, or other plan sponsor) should contact the Medicare contractor with any question on the exact amount the responsible entity owes.

Number 3

It is possible that a beneficiary, entitled to Medicare on the basis of age or disability, did not have coverage under any employer plan based on their own or a spouse's current employment status at the time the services were provided, because the individual or his/her spouse had retired or left employment. (A disabled beneficiary may also have had coverage based on another family member's current employment status.) If properly documented, the retirement or termination of the individual through whom the beneficiary had coverage is a valid defense to associated debts. Proper documentation would consist of the following:

- A copy of the individual claim;

- Date of original demand letter containing the claim;
- Associated claim identification numbers for that claim as provided in the demand letter;
- Identification of the individual through whom the beneficiary had coverage; and
- Certification of the date of retirement or termination of that individual.

We will consider all claims for which such a documented defense is provided and Medicare determines to be valid to be fully resolved.

Number 4

It is also possible that a beneficiary who has employer plan coverage that is obligated to be a primary payer may have had services not covered by the employer's plan. This would mean that the services are not the responsibility of the employer's plan. If properly documented, this would be a valid defense to the debt associated with those services. Proper documentation would consist of the following:

- A copy of the individual claim with the non-covered services annotated;
- Date of the original demand letter containing the claim;
- Associated claim identification number; and
- Copy of plan documents (e.g., Employee Services Handbook, Member Services Booklet, etc.) that establishes that the services are not covered under the plan with the applicable coverage terms annotated.

We will consider all claims for which such a documented defense is provided and Medicare determines to be valid to be fully resolved.

Number 5

It is possible that both Medicare and an employer plan made primary payment for the services identified on any unique MSP claim. If properly documented, an employer plan's full primary payment for the services on an MSP claim is a valid defense to the debt that had been associated with that claim. Proper documentation generally would consist of the following:

- A copy of the individual claim;
- Date of the original demand letter containing the claim;
- Associated claim identification number for that claim as provided in the demand letter;
- Explanation of how the prior primary payment was determined; and
- Proof of payment (e.g., copy of remittance advice).

If the employer plan is an HMO and the employer plan's full primary payment responsibility was resolved by a capitation payment to the provider, physician or other supplier that treated the Medicare beneficiary, proper documentation would consist of the following:

- A copy of the individual claim;
- Date of the original demand letter containing the claim;
- Associated claim identification number for that claim as provided in the original demand letter;
- Copy of the relevant portions of the HMO contract with the provider, physician or other supplier stipulating that the only payment obligation of the HMO was payment of a capitated amount;
- Proof that the capitated amount for the individual for the time period when the services were furnished was paid.

In these instances, Medicare will recover from the medical provider or supplier that received Medicare's payment.

Number 6

Most group health plans (GHPs) have established time limits during which claims must be submitted in order to qualify for payment. If a GHP or any entity responsible for payment under the plan (employer, insurer, third party administrator (TPA), or other plan sponsor ("responsible entities")) does not receive a claim within those time limits, the plan is not obligated to make payment (even if it would be obligated to make payment if the claim had been submitted prior to the expiration of the time limit). These time limits are typically called "timely filing" requirements. Applicable Federal law limits the ability of any responsible entity (including the employer/insurer/TPA/GHP/other plan sponsor) that received a demand letter to assert a timely filing defense to an MSP-based debt.

As a first point, the date of Medicare's original demand letter is the date applicable to any defense that the recipient of the demand letter, or any entity acting on its behalf may have to the debt or any portion of the debt. This is true regardless of which of these entities the original demand letter is issued to, and regardless of whether or not the demand is immediately shared among these entities. For example, the insurer may not establish a timely filing defense on behalf of an employer based upon the date the insurer received the demand letter from the employer. The insurer may only establish a timely filing defense for the employer based upon the date of the demand letter to the employer.

Additionally, two different rules are applicable to the MSP claims that comprise the Medicare debts. These rules are explained below.

The first rule applies to all services, regardless of the date those services were provided. The recipient of the demand letter (regardless of whether it is the employer/insurer/TPA or other responsible entity) does not have a valid timely filing defense if either the employer, the insurer, the TPA, or other responsible entity had knowledge within the plan's timely filing period that the services were provided. This knowledge could come from a variety of sources, but is often due to the receipt of a claim from a provider, physician or other supplier (or the plan member) which included the services at issue.

The second rule applies to services provided on or after August 5, 1997, and further restricts the use of a timely filing defense. The Balanced Budget Act of 1997 eliminated timely filing defenses for at least 3 years from the date of the service. For services on or after August 5, 1997, there is no timely filing defense if Medicare's original demand

letter is dated within 3 years of the date of the service. This rule applies even if the plan's timely filing period is less than 3 years. (If the services were on or after August 5, 1997, and Medicare's original demand letter is not dated within 3 years from the date of the service, then the first rule applies.)

Under the first rule, proper documentation of a timely filing defense would consist of the following:

- A copy of the individual Medicare claim supplied with the demand letter with the services for which the defense is offered annotated by the entity asserting the defense;
- The date of the original Medicare demand letter containing the claim (and the associated report identification number for Data Match recoveries);
- A copy of plan documents that establish the timely filing period with the applicable provisions annotated; and
- A written statement by or behalf of the recipient of the demand letter that claims records of all responsible entities exist for the time period when the services were provided, were searched, and no record of the services being provided to the beneficiary were found.

Medicare considers all claims for which such a documented defense is provided to be fully resolved, subject to Medicare's subrogated appeal rights described in Step *8*.

Remember that if a demand letter is sent to an employer and another responsible entity such as an insurer or TPA responds, the responding entity is assumed to be acting as the agent of the employer. In this situation, the date of the original demand letter to the employer is the date applicable to any asserted timely filing defense.

Number 7

When the entity that received the demand letter is a TPA, the TPA will not be required to repay Medicare or provide a claim specific defense for services provided prior to August 5, 1997, if the TPA provides the following documentation:

- Copies of individual claims;
- Dates of original demand letters containing the claims;
- Associated claim identification numbers for those claims as provided in the original demand letters;
- Copy of the relevant portion of the contract with the employer or other plan sponsor stipulating that the entity was a TPA only.

Number 8

As explained in the original demand letter, in addition to its statutory recovery rights, Medicare also has subrogation rights. Medicare utilizes its subrogated rights to appeal a denial of payment due to a timely filing defense and/or seek waiver of the timely filing requirements to the same extent that the patient could appeal and/or seek such a waiver. Where there is a denial of payment based upon a timely filing defense, Medicare's original demand letter must be treated as a request for appeal of that denial. Similarly, if the right to seek a waiver of the plan's requirement exists, Medicare's original demand

letter must be treated as a request for waiver. If such rights do not exist, a copy of the plan's documents that explain that such rights do not exist must be provided.

When a patient's rights to appeal a timely filing denial and/or to seek a waiver of the plan's timely filing requirements exist(s), the employer/insurer/TPA/GHP/other plan sponsor must apply the same criteria to Medicare's appeal and request for waiver as they would have had the appeal or waiver request been made by the patient. For example, if the timely filing requirement is always waived for the patient if the claim was not filed timely through no-fault of the patient, the employer/insurer/TPA/GHP/other plan sponsor must waive the timely filing requirements for Medicare. Accordingly, before a case can be closed with respect to a particular service (or services) due to presentation of a valid fully documented timely filing defense, the employer/insurer/TPA/GHP/other plan sponsor must furnish to the contractor a notification that the appeal and waiver requests have been denied and provide copies of any provision upon which the denial is based. (This documentation is in addition to the information previously described as necessary for a timely filing defense.)

60.9.2 - Exhibit 2 - Treasury Address

(Rev. 47, Issued: 03-10-06, Effective: 04-10-06, Implementation: 04-10-06)

The address for contractors to utilize when sending case files to Treasury and overnight deliveries is:

U.S. Department of Treasury

Attn: MSP Room

190 Vulcan Road

Homewood, AL 35209

The address for debtors to utilize when corresponding with Treasury is:

U.S. Department of Treasury

Financial Management Service

Debt Management Service Branch

P.O. Box 830794

Birmingham, AL 35283

Treasury's Phone Number: 1-888-826-3127

NOTE: The above address and telephone number are the only address and/or telephone number that contractors are to give to debtors.

Outsourcing Solutions, Inc. (OSI)'s Address:

OSI Collections Services, Inc.

P.O. Box 469

Owings Mills, Maryland 21117

Attn: Ms. Gemette Dorsey

OSI's Telephone Number: 1-800-234-3550 or (410) 602-6860

Fax Number: (410) 602-5375

Contact Person at OSI:

Ms. Gemette Dorsey