CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12438	**Date: January 4, 2024**
	Change Request 13483

NOTE: This Transmittal is no longer sensitive and is being re-communicated February 23, 2024. The Transmittal Number, date of Transmittal and all other information remains the same. This instruction may now be posted to the Internet.

SUBJECT: Updating the Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 7 with Current Terminology and Acronyms, Removing Outdated Policy and Procedures and Replacing with Current MSP Instruction

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Pub. 100-05, Chapter 7 with current terminology, acronyms and to remove outdated policy, procedures and replace with current MSP instruction.

EFFECTIVE DATE: February 6, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 6, 2024

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.*

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R	7/10/10.5/Handling Freedom of Information Act (FOIA) and Subpoena Duces Tecum Received by the MSP Contractors
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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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. 100-05	Transmittal: 12438	Date: January 4, 2024	Change Request: 13483

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SUBJECT: Updating the Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 7 with Current Terminology and Acronyms, Removing Outdated Policy and Procedures and Replacing with Current MSP Instruction

EFFECTIVE DATE: February 6, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: February 6, 2024

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to alert the A/B and DME MACs of changes being made to Chapter 7 of the MSP manual. Under the Medicare law, as enacted in 1965, Medicare was the primary payer for services except those covered by Workers' Compensation (WC). In 1980, Congress enacted the first of a series of provisions that made Medicare the secondary payer to certain additional primary plans. The purpose was to shift costs from the Medicare program to private sources of payment. These provisions are known as the Medicare Secondary Payer (MSP) provisions and are found at section 1862(b) of the Social Security Act (the Act). These provisions prohibit Medicare from making payment, if payment has been made or can reasonably be expected to be made by the following primary plans when certain conditions are satisfied: group health plans, workers' compensation plans, liability insurance, or no-fault insurance.

B. Policy: When Medicare is the secondary payer, the provider, physician, or other supplier, or beneficiary must first submit the claim to the primary payer. The primary payer is required to process and make primary payment on the claim in accordance with the coverage provisions of its contract. Although Chapter 7 explains MSP policy and operational procedures, there are no MSP policy or operational changes being made to this chapter.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13483.1	The A/B Medicare Administrative Contractors (MACs) and Durable Medical Equipment (DME) MACs shall review and provide comments, in the echimp forums, for the attached updated Pub. 100-05 Medicare Secondary Payer Manual, Chapters 7.	X	X	X	X					BCRC, CMS, CRC, ECRS, MSPIC

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13483.2	The A/B MACs and DME MACs shall not take the IOM update found in this change request as final and should not be used by the A/B MACs, DME MACs and down stream systems until CMS issues the IOM updates as final.	X	X	X	X					BCRC, CMS, CRC, ECRS, MSPIC

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

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

VI. 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 Secondary Payer (MSP) Manual

Chapter 7 – MSP Recovery

Table of Contents

(Rev. 12438; Issued: 01-04-24)

10.1 – General

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Section 1862(b) of the Social Security Act (the Act) gives Medicare the right to recover payments it has made on behalf of private insurers that are the primary (or "first") payers for Medicare beneficiaries. In situations where Medicare is a "secondary" payer, the primary payer must reimburse Medicare for any benefits that Medicare has *conditionally or* mistakenly paid as primary on behalf of a beneficiary.

The Medicare Secondary Payer (MSP) program ensures that Medicare is aware of situations where it should not be the primary (the first) payer of claims. If a beneficiary has Medicare and other health insurance, Medicare Coordination of Benefits (COB) rules decide which entity pays first. Medicare may make *conditional* payments on behalf of beneficiaries during COB activities, so that beneficiaries can maintain continual Medicare coverage throughout the COB period. Any such payments are conditioned on reimbursement to the appropriate Medicare trust fund.

10.*2 –Medicare and Medicaid Duplicate Payment*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Medicare and a State Medicaid agency may both conditionally or erroneously pay for items and/or services, and the amount recoverable for these items and/or services may be insufficient to reimburse both Medicare and Medicaid. In these situations, while both Medicare and Medicaid might have a recovery claim, Medicare's right to recovery has priority over Medicaid's recovery claim pursuant to 42 CFR § 405.908.

Medicare's priority right of recovery over Medicaid does not violate the concept of Medicaid being a payer of last resort. Under § 1862(b) of the Act, Medicare's ultimate statutory authority is not to pay at all where payment can reasonably be expected *to be made* by a third party that is primary to Medicare; and Medicare has a concomitant right to recover any conditional benefits it has paid.

The right of Medicaid agencies to recover benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party reimbursement. Since the beneficiary can assign to the State a right no higher than the beneficiary's own, and since Medicare's statutory right is higher than the beneficiary's, Medicare's right is superior to that assigned to the State.

Where both Medicare and Medicaid seek reimbursement from a primary payer, the MSP *C*ontractor informs the other parties to the claim that it must reimburse Medicare before it can pay any other entity, including a State Medicaid agency. Where a beneficiary, attorney, provider, physician, or other supplier receives payment from a primary plan, and the amount paid is less than the combined amounts paid by Medicare and Medicaid, the MSP *C*ontractor informs the payee that it is obligated to refund the Medicare payment up to the full amount of Medicare's claim before paying the State Medicaid agency. Only after Medicare has recovered the full amount of its claim does the beneficiary, attorney, provider, physician, or supplier have the right to reimburse Medicaid or another entity.

If a State Medicaid agency receives reimbursement from a primary payer before Medicare, the MSP *C*ontractor asks the State Medicaid Agency or the beneficiary to reimburse Medicare from any primary payment funds remaining. If the remainder of the primary payment is insufficient to reimburse Medicare in full, the MSP *C*ontractor asks the State Agency to reimburse Medicare up to the full amount the Agency received. The MSP *C*ontractor explains the legal basis for Medicare's right to recover. If the State Medicaid Agency refuses to reimburse in full, the MSP *C*ontractor refers the case to the CMS Regional Office (RO). The RO's recovery actions may include offset of Medicare's claim against any Federal Financial Participation funds otherwise due

the State. The MSP *C*ontractor will inform the primary payer that in future cases involving claims by Medicare and Medicaid, it must reimburse Medicare first.

10.*3 – Determination of Primary Payers among Non-Medicare Payers*
(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Medicare determines if it is a primary payer pursuant to 42 CFR § 411.26; however, as to other payers, Medicare does not make determinations as to which of these payers might be primary. Medicare may recover its mistaken and conditional payments from any party determined to have primary payment responsibility.

a) More Than One Primary Insurer

There may be instances where Medicare is secondary payer to more than one primary insurer (e.g., an individual who is covered under his/her own Group Health Plan (GHP) and under the GHP of an employed spouse or under no-fault insurance). In such cases, the other, primary payers will customarily coordinate benefits. If a portion of the charges remains unpaid after the other insurers have paid primary benefits, a Medicare payment may be made.

Coordination of benefits arrangements between *or among* private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to certain GHPs for individuals and spouses age 65 or over. Therefore, where the individual has GHP coverage based on current employment status in addition to GHP coverage as a retiree, Medicare is secondary to the GHP coverage based on current employment status and primary to the GHP coverage based on retirement regardless of the coordination of benefits arrangements between the plans.

b) Coordination of Benefits Rules Conflict with MSP Rules

Coordination of benefits arrangements between *or among* private plans, whether based on State law or private agreements, cannot supersede Federal law that makes Medicare secondary payer to GHPs and Large Group Health Plans (LGHPs) in certain situations. There are two scenarios to consider:

i. The first scenario is where an individual has dependent GHP coverage that is primary to Medicare (e.g., coverage based on the employment of the individual's spouse) in addition to nondependent coverage that is secondary to Medicare (e.g., coverage based on the individual's retirement), Medicare is secondary to the dependent coverage and primary to the nondependent coverage. In other words, the dependent coverage pays first, and the nondependent coverage pays second even though under private coordination of benefits agreements, the nondependent coverage would be expected to pay before the dependent coverage. For example:

Chris Thomas, age 67, is a Medicare beneficiary with coverage under Part A and Part B. He has been employed continuously by XYZ Bolt Company since 2002 and has GHP coverage through his employer. His wife, Ann, age 62, has been retired from the local police department since 2000 and received retirement health insurance coverage for herself and her husband*, which coverage is* secondary to Medicare *for her husband*. The order of payment for Chris's medical expenses is as follows:

A) Chris's GHP, based on current employment status is primary payer.

B) Medicare is secondary payer.

C) The spouse's retirement plan is the tertiary (third) payer.

ii. The second scenario is where a plan's payment would normally be secondary to Medicare but, under coordination of benefit provisions, the payment is primary to a primary payer under Section 1862(b) of the Act, the combined payment of both plans constitutes the primary payment to which Medicare is a secondary payer. In other words, both plans pay first. For example:

John Jones, age 75, is a Medicare beneficiary with coverage under Part A and Part B. He retired from the Acme Tool Company in 2003 and received retirement health insurance coverage that is secondary to Medicare. His wife, Mary, age 64, has been employed continuously with the local police department since 1977 and since that time has received coverage for herself and her husband under the department's GHP. The priority of payment for John's medical expenses is as follows:

A) The GHP of the spouse who has current employment status is primary payer. However, the retirement plan must coordinate benefits with the employed spouse's GHP (i.e., the spouse's GHP will not pay until after the retirement plan pays). Under these circumstances, the combined benefit of the two plans is primary to Medicare.

B) Medicare is secondary payer.

NOTE: *When* the retirement plan *pays* after the GHP under the private coordination of benefits, the order of payment will be as follows:

A) The GHP will be primary,

B) Medicare will be secondary, and

C) The retirement plan will be tertiary (third) payer.

10.*4 – MSP Contractor Correspondence*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors shall acknowledge and respond to all correspondence within 45 calendar days from the date of receipt in their corporate mailroom, or in any other mail center location, absent CMS instructions to the contrary for a particular activity.

10.*5 – Handling Freedom of Information Act (FOIA) and Subpoena Duces Tecum Received by the MSP Contractors*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If MSP *C*ontractors directly receive any kind of Freedom of Information Act (FOIA) request, a subpoena duces tecum (i.e., subpoenas for records), or any other kind of a subpoena from a third party, it shall immediately refer the request and all associated documentation to CMS for review.

MSP *C*ontractors shall address all CMS-sourced FOIA requests and subpoenas immediately.

10.*6 – Referral of Cases to Regional Office for Possible Government Intervention and/or Legal Action*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The MSP *C*ontractor shall refer the following situations to CMS and/or the appropriate RO:

a) Any notice from a court that CMS has been made a party to a lawsuit; or

b) Any case involving a lawsuit in which CMS's claim is at issue.

The MSP *C*ontractor shall include pertinent Medicare claims information in its referral, if not previously provided to the RO. It also shall immediately refer a case to the RO if the MSP *C*ontractor is named in any legal proceeding seeking to define or limit Medicare's right to recovery. It does not make referrals simply because a lawsuit has been filed between the beneficiary and the liable third party. However, it monitors such lawsuits so that timely referrals can be made to the RO if CMS's claim becomes an issue in the lawsuit.

CMS may notify a State Insurance Commissioner, or other official having jurisdiction over a GHP or employer/ other plan sponsor, that evidence suggests that Federal law was violated. CMS may request that the GHP's or employer/ other plan sponsor's actions be investigated, and that it be ordered to comply with Federal law and to make the appropriate refund to Medicare.

CMS may also advise the State Insurance Commissioner, or other responsible official, that the Medicare beneficiary is placed at risk by the GHP's actions and that Medicare will not make future primary payments for items and services covered by the GHP for this individual. The RO advises these officials that Medicare may recover from any parties to whom it has made improper payments. CMS may also consider possible legal action against the GHP or employer/other plan sponsor and/or referral of the case to the Equal Employment Opportunity Commission (EEOC). The ROs may consult with Central Office (CO), the HHS Office of the General Counsel (HHS OGC), the EEOC, and other appropriate entities regarding referral determinations.

10.*7 – Recovery from Estate of Deceased Beneficiary*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

A beneficiary's death does not materially change Medicare's interest in recovering its payments made on behalf of the beneficiary while alive. Upon death, the estate of the beneficiary comes into existence by operation of law. State and local laws govern the formation and execution of estates. An executor or administrator whose sole purpose is to conclude all business and financial matters that still remained at death manages it. Medicare's interest in the outcome of a third-party liability claim is one of these matters. Therefore, Medicare's claim is properly asserted against the estate, and the MSP *C*ontractor should request a copy of the letter of administration.

If a beneficiary is deceased before resolution of a Medicare secondary payer recovery claim associated with a liability insurance (including self-insurance), no-fault insurance, or workers' compensation settlement, judgment, award, or other payment, new proof of representation on behalf of the beneficiary's estate must be submitted. If there is no will or formal estate, the document or documents must be signed by an individual who is entitled under state law to pursue the applicable claim. Where state law requires court documentation to establish such status, that documentation should be provided. Where such a state requirement exists, and a will is available, the initial page of the will, the page(s) showing the executor, and the notarized signature page(s) should be provided. The method and process for properly filing claims against an estate is, again, an operation of state and local laws and not within the control of Medicare or its *C*ontractors.

Ordinarily, the estate should not have possession of any settlement proceeds that are due Medicare, since Medicare's claim should have been satisfied before distribution to the estate (i.e., while the attorney was still in possession of the proceeds). However, if the proceeds have been distributed to the estate, the MSP *C*ontractor must act quickly to resolve the outstanding claim, taking the following steps:

a) When the MSP *C*ontractor learns that the beneficiary has died, it identifies and contacts the executor or administrator, or whoever is acting in that capacity. It finds out if they are in possession of all Medicare correspondence that had been sent to the beneficiary while alive. If the information was not available, it sends the executor or administrator dated copies of all such notices;

b) If a settlement is reached, a letter containing an initial determination should be sent to the executor or administrator, or whoever is acting in that capacity. The rights to request waiver and/or appeal that are expressed in this letter apply equally to the estate if there is a surviving spouse or dependent that is entitled under Title II or XVIII of the Act. Where neither of these parties exists, waiver under Section 1870(c) of the Act may not be granted. However, relief may still be available under Section 1862(b) of the Act or the Federal Claims Collection Act (FCCA), and the MSP *C*ontractor will ensure that the executor or administrator understands Medicare's priority right to satisfaction of its claim by re-emphasizing that fact in conversations.

The MSP *C*ontractor should also attempt to end each conversation with a specific action that the administrator should take within a specific time period. If this time limit passes and the action has not occurred, the MSP *C*ontractor contacts the administrator again. The most important thing is the prevention of settlement of the estate prior to satisfaction of Medicare's claim.

10.*8 – Wrongful Death Claims*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Wrongful death statutes (including survival statutes) are state laws that permit an entity (such as a decedent's estate, personal representative or survivors) to assert the claims and rights that the decedent had at the time of death and/or to recover damages arising from that death itself. These laws may include recovery for the deceased's medical expenses. Medicare's right of recovery in relation to these statutes is governed by 42 CFR § 411.24 and is as follows (note that the analysis of wrongful death statutes described below would be similar to an analysis of wrongful death actions at common law):

a) When a liability insurance payment is made under a wrongful death statute, Medicare may recover on account of that payment if the wrongful death statute permits recovery of the deceased's medical expenses. If a state wrongful death statute does not permit recovery of the deceased's medical expenses, Medicare has no claim against recovery obtained solely under that wrongful death statute;

b) If the wrongful death statute permits recovery of the deceased's medical expenses, Medicare will pursue MSP claims arising from a primary payment obtained under that statute. Medicare will pursue its MSP claims even if the claimant who asserts the cause of action under the wrongful death statute:

- i) fails to explicitly request recovery for the decedent's medical expenses, and/or
- ii) only requests recovery for damages/losses incurred by the decedent's relatives and/or heirs;

c) When a wrongful death statue permits full recovery of medical expenses but limits the amount that creditors may obtain from that recovery of past medical expenses, Medicare may recover up to the full amount of its conditional payments from the entire recovery obtained under the wrongful death statute. However, if the wrongful death statute limits the amount of medical expenses that may be recovered from the tortfeasor and/or responsible insurer, Medicare may recover only up to that limited amount of the recovery (or up to the amount of the settlement, judgment, award, or other payment if that amount is less than or equal to Medicare's claim).

When a settlement, judgment, award, or other payment was obtained under a wrongful death theory of liability, documentation of that claim should be retained by the beneficiary's estate, personal representative, or other claimant. In the event of a dispute, submission of supporting documentation may be required in the form and manner specified by the Secretary. The documentation should be maintained regardless of whether other claims were also asserted, or whether the wrongful death statute was not the sole claim related to the settlement, judgment, award, or other payment. In cases where a lawsuit is actually filed based on a wrongful death theory of liability, such documentation should include the court pleadings (including both the original pleadings and any amendments thereto).

There may be cases where:

- a) a wrongful death lawsuit was filed, but subsequently withdrawn and resolved with a general release; or
- b) no lawsuit specifically seeking wrongful death recovery was ever filed. In *both of these* cases, examples of supporting documentation may include:
  - i) a fully executed settlement agreement or release;
  - ii) documents exchanged between the parties during settlement negotiations; and other documents the parties exchanged in anticipation of litigation.

Notwithstanding the above scenarios, the settlement documentation must unambiguously indicate that the settlement, judgment, award, or other payment was obtained under the wrongful death theory of liability and must support that position in order for CMS to acknowledge that recovery may be limited accordingly.

10.*9 – MSP Contractor Recovery Files*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors shall maintain an electronic recovery case file for all cases in which recovery has been attempted. Upon Medicare's request, MSP *C*ontractors shall recreate or retrieve requested cases files within two (2) business days of a request. Documentation contained in the recovery case file should include, but is not limited to, full copies of all demands and recovery correspondence issued on the case, notes on all telephone communications, as well as any other information documenting an MSP debt and all associated communications.

10.1*0 – Healthcare Integrated General Ledger and Accounting System (HIGLAS) Error Reports*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Error reports are created by the HIGLAS when there are errors or edits that resulted in a case not having an accounts receivable or demand letter generated. MSP *C*ontractors shall review and resolve all such errors within 45 calendar days of identification.

10.1*1 – Undeliverable Correspondence*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If any recovery correspondence, especially a demand or ITR letter, is returned to the MSP *C*ontractor as "Undeliverable Mail" (mail that cannot be delivered to the addressee) the MSP *C*ontractor will review these returned items. Unless otherwise directed, the MSP *C*ontractor will look for the correct address and, if possible, re-mail the undeliverable correspondence within 30 calendar days.

10.12 *–Time Limitation to Sue for Recovery of NGHP Debt*

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Under the Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART Act), the United States may not file suit under Medicare's direct right of action (§ 1862(b)(2)(B)(iii)) with respect to payment owed unless the complaint is filed not later than three years after the date of CMS's receipt of notice of the settlement, judgment, award, or other primary payment in accordance with § 1862(b)(8) that relates to such payment owed. This three-year limitation relates only to the filing of suit under Medicare's direct right of action and does not apply, or in any way limit, administrative or non-judicial recovery of conditional payments pursuant to § 1862(b)(8).

10.12.1– Federal Government's Right to Sue and Collect Double Damages

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Separate from its subrogation rights, the Federal Government has an independent right to take legal action to recover Medicare primary payments from primary payers that fail to meet the requirement or the responsibility. The Federal Government may recover double damages in this type of lawsuit pursuant to §1862(b)(2)(B)(ii) of the Act. Primary payers include:

- *Insurers and third party administrators of group health plans and large group health plans and employers/employee organizations that sponsor or contribute to such plans;*

- *No-fault insurers;*
- *Any liability insurers or entities having plans of self-insurance; and*
- *WC insurers or plans.*

The Government's right to collect double damages is effective for items and services furnished on or after December 20, 1989, under all MSP provisions except the MSP for the disabled provision. The Government's right to sue and collect double damages in a lawsuit under the MSP for the disabled provision is effective for items and services furnished on or after January 1, 1987.

20 – Overpayment Due to GHP Coverage

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Updates to the overpayment due to GHP coverage are identified below.

20.1 – Amount of GHP Primary Payments

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The GHP (as defined in 42 C.F.R. § 411.101) or other entity representing the GHP sponsor, might request that Medicare pay the GHP, or other entity representing the GHP, the amount that Medicare would have paid if a proper Medicare claim had been filed (or some other amount). Upon presentation of such a claim (even if it is for Medicare covered services which satisfy all of Medicare's claim filing requirements), the MSP *C*ontractor shall advise the GHP, or other entity representing the GHP, that Medicare law does not authorize payment to an entity other than the beneficiary, provider, physician, or other supplier. Pursuant to 42 CFR §§ 424.70-80, Medicare does not recognize so called "assignments of right to payment" by providers, physicians, other suppliers, and individuals to GHPs. The GHP, employer/ other plan sponsor, or other entity representing the GHP or the employer/ other plan sponsor, may request the MSP *C*ontractor's assistance in recouping its alleged mistaken primary payment, and in having the provider, physician, or other supplier bill Medicare.

The MSP *C*ontractor shall advise the GHP, or other entity representing the GHP, that Medicare may not provide the requested assistance. The MSP *C*ontractor shall further explain that Medicare does not waive its timely filing requirement for initial claims from providers, physicians, or other suppliers and beneficiaries when a GHP recoups its mistaken primary payment. This is because there has been no Governmental error. In addition, Medicare does not re-open claims previously adjudicated and either denied or paid as a secondary payer beyond one year of the date of initial determination on the original claim. This is because Medicare's regulations establish that good cause for Medicare to re-open a claim after one year does not exist in this situation.

20.2 – GHP Demand Process

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Cases will only be created if valid employer/ other plan sponsor and insurer/ TPA information is available for the MSP *C*ontractor. The MSP *C*ontractor shall follow debt collection and referral procedures as defined in § 70 of this Chapter and *Pub. 100-06,* Medicare Financial Management Manual*, Chapter 5*. All activities associated to the collection, adjustment, write-off, referral or closure of this debt shall be documented within the HIGLAS. The employer within the demand letter is the prime debtor and shall be referred for cross-servicing, if appropriate. For federal employers, the demand letter will be addressed to the associated insurer/ TPA. MSP *C*ontractors shall follow § 20.6 of this Chapter, specific to insurer/TPA employer defenses.

HIGLAS will generate the demand letter specific to the debtor and type of case identified. Two copies of the demand letter will be printed; one for the employer and one for the insurer/TPA. The employer is the primary debtor, therefore any actions specific to non-response or delinquency shall be initiated against the employer.

20.3 – GHP Demand Letters

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The MSP *C*ontractor shall provide the identified debtor (usually the employer/ other plan sponsor, or the employer is a federal employer, the insurer/ TPA) with sufficient materials to document a debt owed Medicare. *An* MSP recovery package should be sent for each demand made to an employer/other plan sponsor. The MSP recovery package has three main components:

a) Demand letter addressed to the identified debtor;

b) Summary of claims included in calculating the demand; and

c) Claim facsimiles or claim detail for each claim mistakenly paid primary. The facsimiles or claim detail must contain the name of the provider, physician, or other supplier, the type or description of services, date of services, place, of service, charged amount and Medicare paid amount. The claims facsimiles are available to the employer/other plan sponsor upon request, but are only routinely sent to the insurer/claims processing TPA as a part of its courtesy copy.

The recovery package must summarize and total the amount due Medicare. The total must equal the claim facsimiles or claim/detail.

The MSP *C*ontractor shall issue demand letters for all debts it believes are valid following the MSP *C*ontractor's required pre-demand validation, as specified in the *MSP C*ontractor's SOW. These demand letters shall include specific information regarding: the amount of the debt and how it arose; Medicare's priority right of recovery; how to dispute the debt if the debtor feels it is not valid; and interest provisions. Information regarding the potential for referral to Treasury if the debt remains unresolved shall also be included. The MSP *C*ontractor shall establish Accounts Receivable (AR) at the time the demand letter is issued. The AR date shall match the date printed on the demand letter. The MSP *C*ontractor shall use HIGLAS to track all ARs with claims-level detail.

20.4 – GHP Demand Activities

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The MSP *Contractor*s shall take the following actions:

a) MSP *C*ontractors shall initiate paid claims history searches within the time parameter specified in the *MSP Contractor*'s Statement of Work (SOW). This information will be used to determine if Medicare mistaken primary payments have been made that meet or exceed recovery tolerances.

b) *MSP C*ontractors shall aggregate demand letters with respect to a single employer/ other plan sponsor and insurer/ TPA combination into one package. MSP *C*ontractors shall issue a demand package to the identified debtor (usually the employer or other plan sponsor). The demand package shall include the demand letter as well as a listing of the claims for which Medicare seeks payment, and any other identified enclosures to the letter.

c) MSP *C*ontractors shall issue a courtesy copy of the entire employer/ other plan sponsor demand package to the insurer/TPA, with the exception of federal employers, as noted above. In a federal employer situation, the only copy of the demand package shall be the copy issued to the insurer/ TPA. The courtesy copy issued to the insurer/TPA shall include individual claims facsimiles for all claims included in the demand package as well

as an explanatory cover letter. Unless directed otherwise, MSP *C*ontractors shall issue all recovery correspondence via first class U.S. Mail.

i. In the event the insurer/TPA copy is returned to the *MSP C*ontractor as undeliverable, do not attempt to find a better address.

ii. In the event a particular insurer/TPA consistently returns/refuses their courtesy copies of an employer/ other plan sponsor's demand packages, the *MSP C*ontractor should cease mailing courtesy copies to that insurer/TPA for that employer/ other plan sponsor.

d) The employer/ other plan sponsor or other entity acting on the employer/ other plan sponsor's behalf may respond with a full payment. If the employer/ other plan sponsor or other entity repays Medicare in full (including any applicable interest), the MSP *C*ontractor shall close the recovery case. MSP *C*ontractors shall send an acknowledgment or response to the full payment to the employer/ other plan sponsor with a copy to the insurer/TPA.

e) If the employer/ other plan sponsor or other entity provides a full payment for certain services and provides a valid documented defense for all other services, MSP *C*ontractors shall close the case. A valid documented defense consists of evidentiary material demonstrating that the GHP was not obligated to repay Medicare pursuant to the MSP provision (an assertion of a defense without supporting evidence is not a valid documented defense). MSP *C*ontractors shall send an acknowledgment or response for the full payment and acceptance of the valid documented defense offered by notifying the employer/ other plan sponsor if the insurer/TPA had sent in full payment without having an employer/ other plan sponsor authorization to act as its agent.

f) If the employer/ other plan sponsor or other entity makes less than a full payment or provides less than a valid documented defense, MSP *C*ontractors shall adjust the debt as appropriate and continue collection activities. MSP *C*ontractors shall send an acknowledgment or response to the partial payment or invalid defense by notifying the employer/ other plan sponsor with a copy to the insurer/TPA.

g) To the extent that an employer/ other plan sponsor or the other entity responds with a valid documented defense to any portion of a recovery claim, MSP *C*ontractors shall adjust the debt accordingly. If the valid documented defense is that the GHP made primary payment to a provider, physician, or other supplier, the *MSP Contractor* shall forward the information about the claim and defenses to the appropriate *A/B Medicare Administrative Contractors (MACs) (Part A), A/B MACs (Part B), or A/B MACs (Part HHH) (collectively referred to as A/B MACs) and Durable Medical Equipment MACs (DME MACs)* to initiate recovery from the provider, physician, or other supplier. If the valid documented defense is that the GHP made primary payment to the beneficiary, MSP *C*ontractors shall consider this resolution of the claim. MSP *Contractor*s shall adjust the portion of the employer/ other plan sponsor debt, which had been paid directly to the provider, physician, other supplier, or beneficiary.

h) If an employer/other plan sponsor requests specific information or asks a specific question about the recovery claim, MSP *C*ontractors shall provide the information or answer the questions.

20.5 – GHP Recovery Instructions to *A/B* MACs *and DME* MACs

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

When a provider, physician, or other supplier receives primary payment from a GHP where Medicare has also paid primary, the provider, physician, or other supplier submits an adjustment bill showing the primary payment amount. The *A/B MACs and DME MACs* instructs the provider, physician, or other supplier to return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. The provider, physician, or other supplier may retain any excess GHP payment over the gross amount payable by Medicare.

*Prior to the activation of the automated Duplicate Primary Payment process, as described in §20.5.1, i*f duplicate payment was made to the provider, physician, or other supplier *(i.e.,* the provider, physician, or other supplier received or expects to receive both primary GHP payments and primary Medicare benefits*)*, the *A/B MACs and DME MACs* collect*ed* the Medicare overpayment from the provider physician, or other supplier. The *A/B MACs and DME MACs then* reprocess*ed* or adjust*ed* the claim to determine Medicare's corrected payment amount. If Medicare paid the provider, physician, or other supplier *but* the GHP paid the beneficiary, the provider, physician, or other supplier *was determined to be* liable. (See *Pub. 100-06,* Medicare Financial Management Manual, Chapter 3, § 90). The *A/B MACs and DME MACs* recoup*ed the payment* from the provider, physician, or other supplier in accordance with the Medicare Financial Management Manual, Chapter 3, § 90. The recoupment *was* completed by the provider, physician, or other supplier. *As part of this process, t*he *A/B MACs and DME MACs* obtain*ed* a copy of the plan's Explanation of Benefits (EOB) from the GHP or employer/ other plan sponsor in order to determine the excess Medicare payment.

If an adjustment bill *was* not received from the provider, physician, or other supplier within 120 calendar days of notifying the provider, physician, or other supplier to file a claim with the GHP, or the provider, physician, or other supplier refund*ed* the incorrect payment to the *A/B MACs and DME MACs* using the quarterly Credit Balance Report, the *A/B MACs and DME MACs* follow*ed* up to determine the status of the claim. If a credit balance report has not been utilized, the account receivable should be initiated to the provider. If the GHP has denied the claim for an acceptable reason, the recovery action may be canceled. If the GHP has denied the claim for another reason, or has not responded to the provider, physician, or other supplier's claim, the MSP *C*ontractor advise*d* the provider, physician, or other supplier that Medicare will attempt to recover from the employer/ other plan sponsor. *Additionally, t*he MSP *C*ontractor advise*d* the provider, physician, or other supplier to notify it immediately upon receipt of payment from the GHP.

20.5.1—Automation of the Duplicate Primary Payer (DPP) Process

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

As described in Section 20.5, *prior to the automation of the DPP process,* the A/B MACs and DME MACs handle*d* DPPs manually. Through this process, one or both of the Medicare Secondary Payer (MSP) *Contractor*s mail*ed* a package of information that demonstrate*d* a DPP situation. If the A/B MAC or DME MAC receive*d* enough detailed information about the primary payer's action taken on various claims, the A/B MAC or DME MAC initiate*d* DPP adjustments to recover the Medicare primary payment from the provider. To realize greater efficiencies in this process, CMS decided to automate the DPP process.

Through the automated DPP process, *which CMS implemented on March 13, 2023,* two of the MSP *C*ontractors within the Coordination of Benefits & Recovery (COB&R) program enter information from the primary payer's explanation of benefits or remittance advices or other payment remittances into the Benefits Coordination and Recovery System (BCRS). The information (i.e., required data elements) that the *C*ontractors enter into BCRS will normally result in one of two types of Health Utilization Duplicate Primary Payment (HUDP) transactions that the COB&R systems *C*ontractor will create: one that contains a Claims Processing Indicator value of "F" (primarily for a non-group health plan (NGHP)transaction) or one that contains a Claims Processing Indicator value of "S" (for a Group Health Plan (GHP) transaction). If, for example, the information for an NGHP transaction that one of the COB&R *C*ontractors enters is very limited, such as the beneficiary name (surname and first name), MSP Insurance Type Code, date of incident, and diagnosis code, the COB&R systems *C*ontractor will build a HUDP transaction with the Claims Processing Indicator set to "F." By contrast, the information for a GHP transaction that one of the COB&R *C*ontractors enters may be very comprehensive, providing enough of the required claims data to enable the shared system maintainer representing an A/B MAC or DME MAC to create and complete a DPP secondary claim adjustment. Under this scenario, the COB&R systems *C*ontractor will build a HUDP transaction with the Claims Processing Indicator set to "S."

Initiation of the Automated DPP Process

Following the creation of the HUDP file containing various DPP records for multiple beneficiaries and case types, the COB&R systems *C*ontractor shall transmit the file to the Common Working File (CWF). This action could occur on a daily basis. CWF shall review the incoming HUDP to determine if the Health Insurance Claim Number (HICN), *A/B MAC or DME MAC* Number, MSP Type Code, Claims Processing Indicator, and Claim-From Date and Claim-Through Date (also known as Dates of Service (DOS)) are present and valid. CWF shall also attempt to find a matching MSP auxiliary record (MSPA) when the incoming HUDP transaction Claims Processing Indicator is set to "S" or "F."

If CWF determines there are issues with the incoming HUDP transaction, the system shall return the applicable disposition code or error condition code to the COB&R systems *C*ontractor for resolution.

If CWF determines that a portion of the incoming HUDP DPP records contains errors while other segments of the DPP records do not, CWF shall allow the DPP records without detected issues to be transmitted to the shared system representing a given MAC. And CWF shall return the DPP records that failed validation to the COB&R systems *C*ontracto*r*. CWF shall transmit the HUDP DPP records that passed validation to the shared system representing a given MAC via the current daily Unsolicited Response (UR) file or daily CWF reply file, as applicable to the shared system.

CWF shall return a disposition code 01, denoting acceptable of the record, to the COB&R systems *C*ontractor. CWF shall also transmit a disposition code 01 to the shared systems and associated A/B MACs and DME MACs as part of the HUDP file.

A/B MAC and DME MAC Shared Systems Actions

Upon receipt of the HUDP DPP records, the shared system shall determine whether it can create either a full claim denial adjustment (or full claim adjustment, as applicable) when the HUDP DPP record Claims Processing Indicator is set to "F" or attempt to create a DPP secondary claim adjustment when the Claims Processing Indicator is set to "S."

To the greatest extent possible, the shared system shall auto-adjudicate the identified DPP claims where Medicare inappropriately paid as primary.

For HUDP DPP records where the Claims Processing Indicator is set to "F," the shared system, or, as applicable, the A/B MAC or DME MAC, shall:

Fully deny the claim as a full claim denial adjustment. (Note: No matter how the shared systems or A/B MACs or DME MACs achieve the adjustment result or what terminology is used to describe the adjustment (i.e., a full claim denial, full claim adjustment, full replacement), CMS's intention is that the shared systems or A/B MACs or DME MACs shall reverse the claim(s) to take back Medicare's full payment from the provider.)

Capture the MSP Type Code (Part B)/MSP Insurance Type Code (Part A) from the HUDP DPP record and associate it with the full claim denial adjustment.

Ensure that MSP savings are appropriately captured under the reported MSP Type Code (Part B)/MSP Insurance Type Code (Part A).

Initiate a full recovery from the provider.

For HUDP DPP records where the Claims Processing Indicator is set to "S," the shared system shall review the HUDP DPP record to ensure all required information is present. Additionally, the shared system shall review the A/B MAC or DME MAC's on-line DPP claim to extract other required data elements needed to create a Health Insurance Portability and Accountability Act (HIPAA) 837 compliant outbound claim as well as a compliant outbound Electronic Remittance Advice (ERA).

When the shared system cannot create and/or complete a DPP adjustment due to problems with the HUDP DPP record's content (e.g., missing required data elements or information that conflicts with the online DPP claim),

the shared system shall include the information from the DPP record on to a report for A/B MAC or DME MAC review/intervention.

As part of the automated DPP process, the shared system shall create DPP reporting on a daily and monthly basis and make the reports available to the associated A/B MAC or DME MAC.
All A/B MACs and DME MACs, with the assistance of their Virtual Data Centers (VDCs), as necessary, shall store/retain all HUDP DPP records received from CWF and the various reports created and display them on-line for twelve (12) months.

A/B MAC and DME MAC Requirements

When adjudicating DPP adjustments, the shared system shall always set the claim header Mass Adjustment Indicator field value to "O" before transmitting the claims to CWF for normal processing. Additionally, the shared systems shall always set the Beginning of the Hierarchical Transaction Reference Identification (BHT03) file value position 23 to "S" before creating outbound 837 coordination of benefits (COB) claims that result from DPP adjustments. The DME MAC shared system shall also include the value "S" in the 23rd byte 504-F04 (Message) field indicator when creating outbound National Council for Prescription Drug Programs (NCPDP) batch COB claims that result from DPP adjustments.

All A/B MACs and DME MACs shall always process DPP adjustments as "935 adjustments." An exception to this rule is provider-initiated or requested adjustments, which are not handled as 935 adjustments. (See Pub.100-06, Chapter 3, § 200 for more information.)

For DPP adjustments, A/B MACs and DME MACs shall use the same reason/discovery codes as they have done under the manual DPP process.

When incoming claims have dates of service that are five (5) or more years old, the shared system shall not create an automated DPP adjustment claim. The shared systems shall instead include the DPP records on a report for A/B MAC or DME MAC review/intervention.

When the shared systems do not auto-adjudicate a DPP claim whose Claim Processing Indicator= S and, instead, include the claim on a report for A/B MAC or DME MAC review and intervention due to missing required elements, the A/B MAC or DME MAC shall contact the BCRC or CRC, as applicable, by phone or via fax to attempt a resolution to the issue.

If the appropriate MSP Contractor is able to obtain the missing required information and enter it into BCRS, the COB&R systems Contractor shall transmit the claim, with missing elements, added to CWF to re-initiate the DPP process.

When there is conflicting information between the data on the DPP record and the claim within the A/B MAC or DME MAC's claims history (e.g., the procedure codes and modifiers do not match), the A/B MAC or DME MAC shall:

1) Cancel the DPP claim if created by the shared system; and
2) Contact the BCRC or CRC, as applicable, by phone or via fax to attempt a resolution to the issue.

As with the missing required data scenario, if the appropriate MSP Contractor is able to resolve the conflicting DPP information and make the needed correction in BCRS, the COB&R systems Contractor shall transmit the corrected claim to CWF to re-initiate the DPP process.

During the interval between CWF validating the incoming HUDP transaction and the time that the shared system receives an HUDP DPP record via the CWF UR daily response or daily CWF reply, it is possible that the primary payer may have deleted the MSP auxiliary record. When this occurs, it is important that all

stakeholders involved take certain steps to address the deleted MSP auxiliary record. In this situation, the A/B MAC or DME MAC shall:

Not attempt to create an MSP Investigational ("I") record on CWF;
Contact the appropriate MSP *C*ontractor to request that the primary payer be notified regarding the discrepancy between the evidence it has submitted to confirm its primacy status and the action taken to

1. Delete the MSP auxiliary record; and
2. Cancel the DPP adjustment.

Important: For the automated DPP process, all shared systems shall bypass their normal logic that requires the creation of an MSP "I" record when it has been determined that CWF does not contain an associated MSP auxiliary record.

Once the appropriate MSP *C*ontractor has re-established the MSP auxiliary file, the COB&R systems *C*ontractor shall reinitiate the HUDP transaction, thereby restarting the DPP process.

20.6 – GHP Communications Received in Response to Recovery Actions

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Section 1862(b) (2) (B) of the Act, as amended by § 2344(b) of the Deficit Reduction Act of 1984 (Pub. L. 98-369), gives the Government the right to recover mistaken Medicare payments. Medicare must be reimbursed conditional primary benefits paid. The definition of primary payer, primary payment, and primary plan is found in 42 CFR § 411.21. If the GHP still refuses to reimburse Medicare or does not respond to requests, the MSP *C*ontractor refers the case to Treasury in accordance with the Debt Collection Improvement Act (DCIA).

If a GHP that is primary to Medicare refuses to reimburse Medicare for mistaken payments Medicare has made, the GHP must explain its reason. If the explanation is that plan benefits are not payable, and no valid defenses to non-payment are applicable, the MSP *C*ontractor shall not accept the explanation without supporting evidence from the GHP and/or the employer/ other plan sponsor. Valid defenses may include: coverage status; non-covered services; physician, provider, or other supplier duplicate primary payment (DPP); capitation; timely filing; employer size (working aged and disabled); long-term disability. If no valid defense is given, the MSP *C*ontractor shall inform the employer/ other plan sponsor that it is obligated to refund such payments to Medicare under applicable Medicare authority. Explanations that may not be accepted could include: the plan has not received a claim from the beneficiary; the insurance policy does not provide for payments to third parties; the plan maintains it is secondary payer for individuals who are in a 30-month End Stage Renal Disease (ESRD) coordination period; the plan provides benefits secondary to Medicare regardless of the employment status of the individual or the individual's spouse; or the plan does not respond.

If a GHP states that a primary payment was made, the *MSP C*ontractor shall request an explanation of the benefits paid. In this situation, the information regarding the DPPs shall be forwarded to the appropriate *A/B* MAC*s and DME* MAC*s*. The *A/B* MAC*s and DME* MAC*s* shall recover any provider, physician, or other supplier, DPP. If payment was made to the beneficiary, the MSP *C*ontractor shall obtain a copy of the EOB from the employer/ other plan sponsor/GHP or the party that received the payment to confirm whether a true DPP situation exists with the beneficiary. It requests the party that received the GHP payment to refund the excess Medicare payment. The excess Medicare payment is the difference between the proper (as determined under the applicable regulations at 42 C.F.R. 411, Subpart E) Medicare conditional primary payment and the amount Medicare is obligated to pay as secondary payer.

MSP *C*ontractors shall use extra care when evaluating defenses submitted by the insurer/TPA when the debtor is the employer/ other plan sponsor. A defense raised by the insurer/TPA might be valid if the insurer/TPA were

being pursued with respect to the debt, but invalid as a defense for the employer/ other plan sponsor. For example, the insurer might respond that it did not provide coverage during the period in question, or the TPA might respond that its contract was not in effect during the period in question. While proper documentation could establish these as defenses for the insurer and/or TPA, they are not defenses for the employer/ other plan sponsor. The employer/ other plan sponsor could have provided coverage through another insurer or had a different TPA contract in effect. Where the offered defense is an issue involving the specific coverage or payment limits of the policy, this should not be an issue. For example, a defense of exhaustion of the payment limits of the policy applies equally to the employer/ other plan sponsor and the Insurer/TPA.

20.7 – Recovery Where GHP Acknowledges Specific Debt (42 C.F.R. § 411.25)

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If a GHP voluntarily and unsolicited by Medicare acknowledges that Medicare made a mistaken primary payment for a specific service and acknowledges that it should have or did make primary payment, the GHP must refund the Medicare primary payment. When *an* MSP *C*ontractor receives notice from a GHP along with identification of the specific claims for which Medicare mistaken primary payments were made, the MSP *C*ontractor shall:

a) Confirm whether a Common Working File record of the MSP situation has been established. If a record has not yet been established, the MSP Contractor shall ensure the MSP occurrence is documented (via the Electronic Correspondence Referral System (ECRS) request, if necessary) no later than 30 calendar days following identification of the new MSP occurrence.

b) In the event of identified duplicate primary payments to physicians, providers, or other suppliers, the MSP *C*ontractor should refer those claims to the appropriate *A/B MACs and DME MACs* for recovery. The *A/B* MAC*s and DME* MAC*s* shall initiate the recovery process from the provider, physician, or other supplier for the identified duplicate primary payments. The MAC shall follow the instructions listed in *Pub. 100-06,* Medicare Financial Management Manual, Chapter 3, § 200.1.6.

c) In the event of an unsolicited voluntary refund, the MSP *C*ontractor sends notice and a refund check (classified as a voluntary/unsolicited refund) along with identification of the specific claims for which Medicare mistaken primary payments were made. The MSP *C*ontractor shall first:

i. Confirm that the payment was intended for GHP debt. Look for any indication that the GHP has advised the *MSP C*ontractor responsible for coordination of benefits of its primary payment responsibility. (e.g., there may be a cc at the bottom of the letter, etc.);

ii. If there is no indication that the GHP has advised of its primary payment responsibility, forward the notice information (usually via ECRS). If there is an indication that the GHP has advised CMS of its primary payment responsibility, do not send an ECRS request;

iii. Process the refund check as described in *Pub. 100-06,* Medicare Financial Management Manual, Chapter 5, § 410.4.

20.8 – Recovery from the Provider, Physician, or Other Supplier

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If both Medicare and the GHP made primary payment to the provider, physician, or other supplier, the *A/B* MAC*s and DME* MAC*s* shall recover from the provider, physician, or other supplier pursuant to 42 CFR § 411.24(g). Interest charges shall be assessed if repayment of the debt does not occur within the identified timeframe.

When a provider, physician, or other supplier receives payment from a GHP where Medicare has also paid, the provider, physician, or other supplier submits an adjustment bill showing the primary payment amount. The fact that the provider, physician, or other supplier received two primary payments establishes the repayment obligation. The *A/B* MAC*s and DME* MAC*s* shall instruct the provider, physician, or other supplier to return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. The provider, physician, or other supplier may retain any excess GHP payment over the gross amount payable by Medicare.

If duplicate payment was or will be made to the provider, physician, or other supplier, i.e., the provider, physician, or other supplier received both primary GHP payments and primary Medicare benefits, the *A/B* MAC*s and DME* MAC*s* shall collect the duplicate primary payment from the provider, physician, or other supplier. The amount to be recovered is the lesser of the amount paid by Medicare and the amount that the GHP paid as its full primary payment. If the GHP paid the provider, physician or other supplier on a capitation basis, the appropriate amount to recover is the amount that Medicare paid.

20.9 – Recovery from a Beneficiary Who Has Received Primary Payment from Both Medicare and a GHP

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If both Medicare and the GHP made primary payment to the beneficiary, the *A/B* MAC*s and DME* MAC*s* recover the appropriate amount from the beneficiary based on the provisions of 42 CFR § 411.24(g). The appropriate amount to be recovered is the lesser of the amount that Medicare paid and the amount that the GHP paid as its full primary payment. Interest charges shall not be accessed to the beneficiary for this type of recovery situation.

If Medicare paid the provider, physician, or other supplier and the GHP paid the beneficiary, Medicare does not recover from either entity. Likewise, Medicare does not recover from any entity if the GHP paid the provider, physician, or other supplier and Medicare paid the beneficiary. Medicare has recovery rights against providers, physicians, and other suppliers, and beneficiaries only if both Medicare and the GHP paid the same entity.

20.10 – Courtesy Copy of All MSP GHP-Based Recovery Correspondence to the Insurer/Third Party Administrator (TPA)

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors currently initiate GHP-based recoveries of mistaken payments to the employer/ other plan sponsor (considered the debtor if it received the original demand), with the exception of federal employers. In order to facilitate employer/ other plan sponsor's efforts in responding to demand packages, MSP *C*ontractors shall send a copy of these demand packages and all other recovery correspondence to the employer/ other plan sponsor's insurer/TPA.

The courtesy copy sent to the employer/ other plan sponsor's insurer/TPA does not change the employer/ other plan sponsor's status as the debtor. The insurer/TPA is not considered a debtor because the insurer/TPA was not the addressee on the original demand letter. For Federal employer/ other plan sponsors, the insurer is considered the debtor and the demand letter is addressed to the insurer. MSP *C*ontractors shall comply with the sending of the courtesy copy of the demand package(s) to the employer/ other plan sponsor's insurer/TPA. The demand letter will be addressed to the employer/ other plan sponsor, and the employer/ other plan sponsor is considered to be the debtor.

MSP *C*ontractors shall follow debt referral procedures in § 70 of this chapter. The fact that the insurer/TPA receives a copy of the demand package or that the insurer/TPA may be given authority to resolve a debt on behalf of its client (the employer/ other plan sponsor) does not change the status of the employer/ other plan sponsor as the debtor and as the entity to be referred to Treasury.

30 – Overpayment Due to Workers' Compensation Coverage

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Updates to the overpayment due to workers' compensation coverage are identified below.

30.1 – General

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The provision of 42 CFR § 411.40(b) provide*s* that no Medicare payment may be made for items and services to the extent that payment has been made or can reasonably be expected to be made for such items or services under a workers' compensation (WC) law or plan of the United States or any state.

Further, no Medicare payment may be made if a WC plan has paid an amount:

a) Which equals or exceeds the Medicare reasonable charge;

b) Which equals or exceeds the provider's charges for Medicare covered services; or

c) Which the provider, physician, or other supplier accepts or is required under the WC law to accept as payment in full.

30.2 – *A/B* MAC*s and DME* MAC*s* Actions for Workers' Compensation Recovery

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The *A/B* MAC*s and DME* MAC*s* may pay for items or services, and subsequently learn that those services were work-related. The information indicating that a particular injury or illness occurred on the job does not necessarily mean that Medicare payments made for that injury were incorrect. In those circumstances, the *A/B* MAC*s and DME* MAC*s* will review the information it received to determine if an MSP occurrence needs to be added.

If the information included an EOB showing that payment was made to the provider by the WC carrier, the *A/B* MAC*s and DME* MAC*s* initiates recovery according to their DPP process or accepts the funds sent with the Voluntary Refund or Credit Balance Report payment. Otherwise, recovery is made by the MSP *C*ontractor.

30.3 – Time Limit for Filing WC Claims

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Beneficiaries are obligated to apply for WC benefits *for* which they are entitled, and to abide by the terms under which those benefits are offered. See 42 CFR § 411.43. Most WC plans have time limits within which the employee must notify the employer/ other plan sponsor that a work-related injury or illness occurred and file a claim. If a claim was not timely filed to the WC carrier, Medicare would deny the claim if submitted for payment.

30.4 – Duplicate Payment Received by Provider, Physician, or Other Supplier

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If a Medicare payment duplicates a WC payment, the MSP contactor recovers the Medicare payment from the provider, physician, or other supplier*s* in accordance with the Medicare Secondary Payer Manual, Chapter 3, § 10.4.

In any case, in which a primary payment is received from Medicare and from a third party payer, Medicare must be reimbursed within sixty (60) calendar days of receipt of the duplicate payment pursuant to the provisions of 42 CFR § 489.20(h)

Recovery of conditional payments is not subject to the reopening rules nor to the limitation on recovering incorrect Medicare payments discovered later than three years after the WC plan has become the primary payer. (See SSA § 1862(b) (2) (B) (iii)).

30.5 – Medicare Paid for Services Which Should Have Been Paid for by WC

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

In any case in which it is clear that Medicare paid for services that should have been paid for by the WC carrier, the MSP *C*ontractor shall request that the Medicare program be reimbursed for the amounts conditionally paid by Medicare.

The MSP *C*ontractor includes in the request the amount that Medicare paid but should not have. In addition, it explains that the Medicare law excludes payments for services covered under WC, and requires WC carriers to refund the Government where Medicare has paid for services that are reimbursable under WC. If the beneficiary requests a waiver or an appeal of the overpayment determination, the beneficiary will be held responsible for the interest on the debt if the agency prevails and a refund is later collected. See 42 C.F.R. § 411.24(m). If the beneficiary is represented by an attorney, the MSP *C*ontractor should copy the attorney on any correspondence. The MSP *C*ontracto*r* sends copies of all correspondence to the WC carrier when the WC carrier is the identified debtor, and issues courtesy copies to the WC state agency.

42 C.F.R. § 411.24(h) requires that a beneficiary or other entity repay CMS within 60 calendar days of receiving a primary payment. See 42 C.F.R. § 411.24(h). Medicare assesses interest on MSP debts by exercising common law authority that is consistent with the FCCA and implementing regulations. See 42 C.F.R. § 411.24(m). If CMS does not receive a full refund, or adequate proof that no overpayment exists, within 60 calendar days of notifying the beneficiary of CMS's demand, the MSP *C*ontractor begins assessing interest as of the date of the mailing of the demand letter.

42 C.F.R. § 411.24(h) and 42 C.F.R. § 411.24(m) provide express authority to assess interest on MSP debts. Interest is calculated on MSP debts using the method applicable to Non-MSP Medicare overpayments and underpayments as stated in 42 C.F.R. § 405.378. For Medicare overpayments and underpayments and MSP debts, interest is calculated in full 30-day periods. Interest instructions for Medicare overpayments and underpayments are found in Pub. 100-06, Medicare Financial Management Manual, Chapter 4.

30.6 – Medicare Made Party to WC Hearing

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If a WC agency has suggested that Medicare be represented at a WC hearing or has named Medicare as a party to a WC claim, the MSP *C*ontractor will contact CMS for guidance.

30.7 – Effect of Settlement

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If the beneficiary agrees to a settlement, and the settlement has given reasonable recognition to the income replacement objectives of the WC law, the settlement may be accepted as a basis for applying the WC award amount agreed to in the compromise lump sum settlement.

The MSP *C*ontractor recovers, from the beneficiary, any Medicare payments made for items or services that have also been paid for by the WC settlement. (See the Medicare Secondary Payer Manual, Chapter 2, § 50 and 42 CFR § 411.45).

Pursuant to 42 CFR § 411.47(b), where the award does not identify the items of medical or hospital expense covered, the MSP *C*ontractor allocates the amount of the award for medical and hospital expenses incurred up to the date of the award, in the following manner:

a) First to any beneficiary payments for services payable under WC but not covered under Medicare;

b) Second to any beneficiary payments for services payable under WC and also under Medicare Part B. (These include deductible and coinsurance amounts and, in unassigned cases, the charge in excess of the reasonable charge); and

c) Third to any beneficiary payments for services payable under WC and also covered under Medicare Part A. (These include. Part A deductible and coinsurance amounts and charges for services furnished after benefits are exhausted).

The difference between the amount of the WC payment for medical expenses and any beneficiary payments constitutes the Medicare overpayment. The beneficiary is liable for that amount.

The following examples illustrate the above concepts:

a) A WC settlement paid for $6,000 of the total medical expenses. The $18,000 in medical expenses included $1,500 in charges for services not covered under Medicare, $7,500 in charges for services covered under Medicare Part B, and $9,000 in hospital charges for services covered under Medicare Part A. All charges were at the workers' compensation payment rate, that is, in amounts the provider, physician, or other supplier must accept as payment in full.

The Medicare allowed charge for physicians' services was $7,000 and Medicare paid $5,600 (80 percent of the reasonable charge). The Part B deductible had been met. The Medicare payment rate for the hospital services was $8,000. Medicare paid the hospital $7,480 ($8,000 minus the Part A deductible of $520)

In this situation, the beneficiary's payments totaled $3,920 as follows:

Services not covered under Medicare totaled $1,500.

Excess of physicians' charges over reasonable charges totaled $500.

Medicare Part B coinsurance was $1,400.

Part A deductible was $520.

Total: $3,920

The Medicare overpayment, for which the beneficiary is liable, would be $2,080 ($6,000 -$3,920).

If it appears that a settlement represents an attempt to shift to Medicare the responsibility for the payment of medical expenses for the treatment of a work-related condition, it will not be recognized. Settlements of this type may occur, for example, when the parties attempt to maximize the amount of disability benefits paid an injured employee under WC by releasing the WC carrier from liability for a particular course of treatment, despite facts showing a relationship between the work injury and the condition that necessitated the treatment.

b) A Medicare beneficiary had surgery for a hip fracture received in the course of employment. Following surgery, the individual went into postoperative shock and suffered a cerebrovascular accident that required hospitalization for an additional three (3) months. The total hospital bill was $12,000. Despite the fact that, under these circumstances, the State WC plan would have covered the individual's entire hospital bill, the beneficiary 's attorney instructed the hospital to bill the WC carrier only for the expenses incurred through the date of the hip surgery, pending the outcome of the disability settlement that was being negotiated.

The State WC agency subsequently approved a compromise settlement, under the terms of which the WC carrier admitted liability for the hip fracture but not for the stroke. The settlement provided payment to the beneficiary of $18,000 plus payment to the hospital of $1,200 for his stay through the date of the surgery.

Following the settlement, the beneficiary requested the MSP Contractor to pay for the three months of hospitalization following the surgery, since the settlement did not stipulate that treatment of the stroke was work-related. The MSP Contractor determined that payment under WC for treatment of the stroke could reasonably have been expected if the beneficiary had not agreed to give up his right to such compensation. It, therefore denied the claim. The provider, physician, or other supplier has the right to bill the beneficiary, since these services would have been covered by WC and, therefore, are not payable by Medicare.

c) A Medicare beneficiary settled a WC claim which stipulated, among other things, that the WC carrier would:

i. Pay the individual a lump sum of $50,000 as compensation for permanent and total disability;

ii. Pay all of the individual 's medical expenses related to his work injury until he became entitled to benefits under Medicare or any other Government medical benefit program; and

iii. Continue to pay, without any time limitation, any portion of his medical expenses for the work injury that was not reimbursable under a Government program.

It further stipulated that the employee would seek payment for the medical care related to the work injury from State and Federal Government programs to reduce the obligation of the employer/ other plan sponsor and carrier as much as possible.

Although the compensation order was designed to reduce the obligation of the employer/ other plan sponsor and carrier to pay for medical care by shifting medical expenses to Medicare and other Government programs where possible, the agreement recognized the WC carrier's continuing responsibility for the individual's medical care. Since Medicare is not bound by such covenants, benefits were denied for all expenses subsequently incurred for treatment of the work injury. The Medicare beneficiary may be billed for these services.

d) In July, 1998, Mr. Y, age 30, was involved in an accident at work sustaining injury to his neck, back, right arm and legs. Beginning with the date of the accident, the WC carrier paid Mr. Y weekly benefits of $207 for temporary disability and also paid all of his medical expenses.

In 2000, Mr. Y became entitled to Medicare based on disability. In July 2002, the WC insurer decided to terminate Mr. Y 's medical and disability payments based on medical advice that his continuing impairments were not attributable to the work injury. By this time, the insurer has paid a total of $90,000 for Mr. Y 's medical care.

Mr. Y contested the termination of his WC benefits, and the case was settled by compromise. A lump sum of $46,000 ($6,000 of which was designated as attorneys' fees) was paid to Mr. Y. As part of the settlement agreement, Mr. Y signed a final release that stipulated that future medical expenses were in dispute and that they were to be assumed by Mr. Y as his sole responsibility.

The fact that Mr. Y accepted, and the State WC agency approved, a relatively small lump sum payment, compared with what Mr. Y would have received had his WC claim been approved in full, indicates that there was doubt as to the compensability of the injury. There was no indication that the lump sum was intended to be payment for future medical expenses, nor do these facts indicate that the settlement represented an attempt to shift the responsibility for future medical expenses from WC to Medicare.

Therefore, Mr. Y's signing of the final release of all rights under WC makes it possible for medical expenses incurred after the date of settlement to be reimbursed under Medicare.

40 – Overpayment Recoveries from Liability Insurance Including No-Fault Insurance, Uninsured, or Under-Insured Motorist Insurance

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Updates to the overpayment recoveries are identified below.

40.1 – General

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Section 1862(b) of the Act grants Medicare a priority right of recovery. Section 1862(b) also gives the Medicare program the right of subrogation for any amounts payable to the Medicare under Section 1862 of the Act. To recover any conditional payments it has made, Medicare may bring a direct cause of action in its own right against the entity responsible or required to pay Medicare for the items and/or services Medicare conditionally paid, or against any other entity that has received payment. In addition, Medicare has, under subrogation law, a right to recover its payment from an individual or other entity that received payment from a third-party payer.

Medicare has a priority right of recovery regarding its benefits, which takes precedence over the claims of any other party, including Medicaid. MSP *C*ontractors should focus on Medicare's priority right of recovery when corresponding with the beneficiary and/or the beneficiary's attorney.

Medicare may employ various statutory authorities to waive, compromise, terminate, or suspend its right of recovery. Section 1862(b)(2)(B)(v) of the Act provides for waiver of an MSP overpayment when it is in the best interests of the Medicare program. Section 1870(c) of the Act also permits Medicare to waive its right to recovery when the beneficiary meets certain criteria. See 42 C.F.R. § 411.28. The Federal Claims Collection Act (FCCA) of 1966 (31 U.S.C. § 3711) gives Medicare the right to compromise claims for less than the full amount on behalf of the Government of the United States, or to suspend or terminate collection action. MSP *C*ontractors have authority to resolve claims under Section 1870(c) of the Act, but not under the FCCA nor Section 1862(b) of the Act.

It is common for insurance companies to settle claims without admitting liability. Therefore, any payment by a liability insurer, except payments under a no-fault clause in a non-automobile policy, constitutes a liability insurance payment whether there has been a determination of liability. In addition, regardless of how amounts may be designated in a liability award or settlement, e.g., loss of consortium, special damages or pain and suffering, Medicare is entitled to be reimbursed for its payments from the proceeds of the award or settlement.

If a negligent party who carries liability insurance decides to pay a liability claim with his/her own funds rather than submit the claim to the liability insurer, Medicare recovers its benefits for such a payment because it is deemed to be a liability insurance payment (which includes self-insured entities). See 42 C.F.R. § 411.50.

40.2 – Provider, Physician, Other Supplier, and Beneficiary's Responsibility with Respect to No-Fault Insurance

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The provider, physician, other supplier*s*, and beneficiary (or the beneficiary's representative) are responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under no- fault insurance. See 42 CFR §§ 411.50(c) and 489.20. Therefore, unless conditional payments can be made under § 40.7 of this Chapter, Medicare shall not make any Medicare payments until the provider, physician, other supplier, or the beneficiary has exhausted the entire claims process under no-fault insurance (unless the claim is disputed by the no-fault insurer, in which case Medicare is obligated to pay the claim, if properly submitted to Medicare). Conditional benefits are not payable if payment cannot be made under no-fault insurance because the provider, physician, other supplier, or the beneficiary failed to file a proper claim. (See Chapter 1, § 20 of the Medicare Secondary Payer Manual for definitions).

40.3 – Conditional Primary Medicare Benefits

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Conditional Medicare payments may be made in liability cases under the following circumstances:

a) The beneficiary has filed a claim with the liability insurer, and the MSP *C*ontractor determines that the insurer will not pay or will not pay promptly (i.e., within 120 calendar days of receipt of the claim) for any reason except when the liability insurer claims that its benefits are only secondary to Medicare; or

b) The beneficiary, because of physical or mental incapacity, failed to meet a claim filing requirement of the liability insurer.

When such conditional Medicare payments are made, they are made on condition that the beneficiary will reimburse the program to the extent that the liability/no-fault insurer subsequently makes payment. When making such payments, the MSP *C*ontractor notifies the beneficiary and the insurer of the requirement for repayment. (However, failure to do so does not relieve the beneficiary or insurer of the obligation to refund the payments.)

The MSP *C*ontractor flags all cases for possible follow-up action to recover the conditional payments.

An individual's refusal to file a claim with a liability or no-fault insurer or to cooperate with a provider, physician, or other supplier in filing such a claim is not a basis for making a conditional Medicare payment.

40.4 – Services Covered Under No-Fault Insurance Where Liability Claim Also Filed

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If injuries are covered under automobile, medical, or no-fault insurance, and the individual also files a claim against a third party for injuries suffered in the same accident, a claims determination must first be made by the automobile, medical, or no-fault insurer before a claim for Medicare benefits can be paid. *A* Conditional Medicare payment may be made to the extent that payment is not made under the automobile, medical, or no-fault insurance. The payment is subject to recovery if the individual later receives payment from a liability insurer. For example, an individual incurs $20,000 in covered medical expenses due to an automobile accident. The individual receives $5,000 in no-fault insurance benefits toward covered medical expenses and also has a liability claim pending against the driver of the other car. Medicare does not pay benefits for the $5,000 in expenses paid for by the no-fault insurer but pays conditional benefits based on the additional $15,000 in expenses. The Medicare payment is subject to recovery when the liability claim is paid (in other words, a settlement, judgment, award, or other payment has been received/made).

40.5 – Action if a Liability Insurance Payment Has Been Made to the Provider, Physician, or Other Supplier Who Accepted Medicare Assignment

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If a *A/B* MAC*s and DME* MAC*s* discovers that Medicare paid primary benefits and payment was also made by a liability/no-fault insurer, it recovers the excess Medicare benefits in accordance with Chapter 3 of the Medicare Financial Management Manual. Section 90 of that manual states when a provider, physician, or other supplier is liable for refunding the primary Medicare payments. The beneficiary is liable in all other situations.

Upon receipt of information that a liability/no-fault insurer paid a provider, physician, or other supplier for services previously paid for by Medicare, the *A/B* MAC*s and DME* MAC*s* determines the amount of Medicare secondary benefits payable on the claim. It recoups from the provider, physician, or other supplier any portion of the amount Medicare paid in excess of the amount of Medicare secondary benefits payable, subject to the overpayment recovery threshold (currently $25) in *Pub. 100-06,* Medicare Financial Management Manual, Chapter 4, § 10. Where no Medicare secondary benefits are payable, the *A/B* MACs *and DME* MACs recover

the amount of the Medicare payment. The provider, physician, or other supplier may keep the full liability/no-fault insurance payment, but may not charge the beneficiary any amount for the services and must return any deductible and coinsurance amounts paid by or on behalf of the beneficiary. (See Pub. 100-06, Medicare Financial Management Manual, Chapter 3, § 70, where the provider, physician, or other supplier did not file a proper claim).

40.6 – No-Fault Insurance Pays and Medicare Makes No Secondary Payment

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Under 42 C.F.R. § 411.32(b), Medicare does not make a secondary payment if the provider, physician, or other suppliers are either obligated to accept, or voluntarily accepts as full payment, a third party payment that is less than its charges.

For example, if the amount of payment for particular services under no-fault insurance is less than the provider, physician, or other supplier's charges but is deemed payment in full under State law, Medicare benefits are not payable. The insurance payment constitutes a service benefit; i.e., the payment constitutes full discharge of the patient's liability to the provider, physician, or other supplier.

40.7 – No-Fault Insurance Does Not Pay All Charges Because of Deductible or Coinsurance Provision in Policy

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

In a number of States, no-fault insurers may reduce no-fault insurance benefits by deductible or coinsurance amounts or may offer the option for such a reduction. If such contract provisions apply to all policyholders, Medicare pays benefits with respect to otherwise Medicare-covered expenses that are not reimbursable under such a no-fault contract. Therefore, if a no-fault insurer has been billed and has made no payment because of a deductible or coinsurance, or only a partial payment (e.g., the insurance deductible has been bridged), the claimant may bill Medicare following the procedures set forth in the Medicare Claims Processing Manual for billing for secondary Medicare benefits. If no payment was made under no-fault, the MSP Contractor applies the usual Medicare deductibles and coinsurance in calculating the Medicare secondary payment. See 42 CFR §§ 411.50-411.53.

For example, the beneficiary receives outpatient hospital services covered by no-fault insurance. The total charges are $200. The no-fault insurer is billed for $200, but makes no payment because of a $1000 deductible in policy. The hospital then bills Medicare for $200.

40.8 – Other Situations

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

In other cases, no-fault insurance may not pay the provider, physician, or other supplier's charges because the beneficiary's total medical expenses exceed the dollar limit of the coverage, or because of some other coverage limit, deductible, or coinsurance applicable to all policyholders. (See § 40.7 of this Chapter).

A provider, physician, other supplier of services, or any other facility, may not charge a beneficiary or any other party for Medicare covered services, if the provider, physician, other supplier, or facility has been paid by a no-fault insurer an amount that equals or exceeds the gross amount payable by Medicare. This prohibition is based on the terms of their Medicare participation agreements, under which a provider, physician, or other supplier may bill a Medicare beneficiary only for deductible and coinsurance amounts and for non-covered services.

If an MSP Contractor has reason to question the correctness of the amount shown on the Medicare claim as having been paid by no-fault insurance, it confirms the amount with the insurer or beneficiary. A copy of a no-fault insurer's explanation of benefits is the best evidence.

40.9 – Medicare's Recovery from a Primary Payer

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

There is no Medicare overpayment until the beneficiary receives a settlement, judgment, award, or other payment. Medicare's claim comes into existence by operation of law (Section 1862(b)(2)(B)(ii) of the Act) when payment for medical expenses that Medicare conditionally paid for has been made by a third party payer. Consequently, while Medicare may alert beneficiaries and their attorneys of Medicare's right to recover settlement proceeds in pre-settlement correspondence, no demand for recovery may be made until a settlement has been reached. However, the MSP *C*ontractor should send a letter to the beneficiary and attorney giving notice of possible recovery by Medicare.

40.10 – Pre-Settlement Communications

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

In many instances, liability settlements are reached without resorting to litigation, or before a trial commences. If the beneficiary is pursuing the claim, the MSP *C*ontractor advises the beneficiary of Medicare's interest in the matter.

If the beneficiary has engaged counsel, that counsel should file a proof of representation with Medicare. Without the proof of representation, Medicare cannot communicate with the beneficiary's representative. If the MSP *C*ontractor receives proof of representation, it will retain copies for the file. Note that if the beneficiary has not engaged counsel, there may not be beneficiary procurement costs to subtract from Medicare's claim. MSP *C*ontractors are not permitted to conduct negotiations with liability insurers.

If the beneficiary wishes for any other party to receive information regarding his/her MSP recovery case, or if any other party wishes to receive such information, the party much have an executed Consent to Release before the MSP *C*ontractor can share the information.

40.11 – Designations in Settlements

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

In general, Medicare policy requires recovering payments from liability settlements, judgments, awards, or other payments, whether the settlement arises from a personal injury action or a survivor action, and without regard to how the settlement agreement may stipulate disbursement of any proceeds. This includes situations in which a settlement, judgment, award, or other payment does not expressly include damages for medical expenses or in situations where multiple settlements have been received related to the same incident.

Because liability payments are usually based on the injured or deceased individual's medical expenses, liability payments are considered to have been made with respect to medical services related to the injury even when the settlement does not expressly include an amount for medical expenses. To the extent that Medicare has paid for such services, the MSP provisions of the Act require Medicare to seek recovery of its payments. See 42 CFR § 411.37.

Medicare may, at *its* discretion, recognize allocations of liability payments to nonmedical losses when:

a) The allocation is based on a court order;

b) Issued by a court of competent jurisdiction (a court that has jurisdiction over both the dispute regarding the medical items/services at issue and the parties to the case or controversy at issue);

c) That considered the merits of the case, including the medical items/services at issue in the case; and

d) That considered Medicare's interests in the liability recovery at issue.

If such an order specifically designates amounts that are not related to medical items/services, Medicare may, at is discretion, accept the court's designation.

Medicare generally does not seek recovery from portions of court awards that are designated as payment for losses other than medical items/services.

40.12 – Allegation of Pre-existing Conditions

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

In some cases, the amount of the overpayment is questioned on the grounds that services included in the calculation were for pre-existing conditions and should be omitted from the overpayment calculation.

When a beneficiary has filed suit for accident-related services, including services relating to exacerbation of an underlying condition as the basis for the complaint, the total amount of Medicare's payments should be used to calculate the amount of Medicare's recovery. The fact that the settlement, or other documentation provides that all parties considered such services to be unrelated to the accident or injuries, does not justify omitting them from Medicare's recovery.

40.13 – MSP Contractor Action if a Liability Claim Is Pending and Medicare Benefits Were Paid

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If the MSP *Contractor* has specific information from a third party payer, beneficiary, or attorney that an insurer had primary payment responsibility for a particular MSP situation, the MSP *C*ontractor must search all applicable claims history, identify primary payments related to the MSP situation, and recover any conditional payments Medicare has made.

The MSP *C*ontractor develops all cases where there is no specific information that *an* MSP situation does exist but there is evidence that *an* MSP situation may exist to determine if *an* MSP situation does exist. If the MSP *C*ontractor development establishes that *an* MSP situation does exist and that there are primary payments to be recovered, the MSP *C*ontractor must recover the conditional payments identified.

If a Medicare claim has been paid and there is indication that a liability claim is pending, the MSP *C*ontractor takes steps to assure that, in the event a liability insurance payment is made, any conditional primary Medicare payments are refunded for services related to the injury. If the services were not related to the accident, but were used to procure the settlement, the MSP *C*ontractor recovers Medicare's payments. If the services were unrelated to the accident, the MSP *C*ontractor will not recover Medicare's payments.

However, the entire amount of a settlement is subject to recovery, whether the liability payment is made at the time of settlement, or over a period of time agreed to by the parties in a structured settlement. The MSP *C*ontractor notifies the beneficiary of Medicare's right to reimbursement. If the beneficiary has an attorney, the MSP *C*ontractor also notifies the attorney and retains a copy of the notification in its files.

If disbursement has not yet been made to the beneficiary (e.g., beneficiary's attorney is holding monies in an escrow account, or a multiple party check is yet unsigned), the MSP *C*ontractor attempts to recover Medicare's portion of the settlement. It is very important that the file reflect that Medicare's right to reimbursement was asserted before the beneficiary had an opportunity to dispose of the funds. This information is especially important if a future request for waiver or compromise is submitted.

When a liability claim is pending, and Medicare made conditional payments for services rendered before settlement, and Medicare is billed after the settlement has been reached, the MSP *C*ontractor may recover

Medicare's payment for the additional claims if Medicare did not have knowledge of them at the time of settlement. See 42 C.F.R. § 411.50-54.

40.14 – Recovery from Liability Insurers

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The fact that a settlement has been made between the beneficiary and the liable party does not, necessarily, bind Medicare to that settlement. If the liability insurer was aware of Medicare's interest, but Medicare was not consulted in the settlement, Medicare may pursue the balance of its claim, over and above any amount granted to it in the settlement, against the liability insurer. (See 42 C.F.R. § 411.24(i)).

Section 1862(b) of the Act, as amended in 1984, gives the Government the right to recover Medicare payments from liability insurers without regard to whether the insurer has already made a liability insurance payment. If the liability insurer does not properly pay Medicare, Medicare has the right to take legal action against the insurer and to collect double damages.

NOTE: When a liability insurer is obligated to make payment to an injured plaintiff who is age 65 or older, the insurer has reason to know of Medicare's probable interest and to act to ascertain Medicare's involvement.

When CMS seeks to recover Medicare conditional payments from an insurance company paying a settlement amount owed to the beneficiary, the MSP *C*ontractor must send a copy of the letter to the beneficiary. Likewise, it must notify the insurer of the fact that the beneficiary was sent a copy of the letter. If it knows that the beneficiary has an attorney, it forwards a copy of the letter to the attorney. It retains copies for the file.

40.15 – Recovery of Liability or No-Fault Payments from the Beneficiary

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Pursuant to 42 C.F.R. § 411.24, if a liability or no-fault insurance payment was made to the beneficiary, the MSP *C*ontractor recovers the amount of primary benefits Medicare paid in excess of any secondary Medicare benefits payable. Regulations permit reducing that amount to allow for the beneficiary's costs in procuring liability or no-fault benefits only in cases where the claim was in dispute (i.e., the no-fault insurer at first would not pay and only after an attorney intervened was payment made). If the beneficiary claims procurement costs to obtain liability insurance payments, the MSP *C*ontractor secures a breakdown between the two; however, the MSP *C*ontractor will not seek this additional information if the beneficiary is deceased.

If a beneficiary is paid by a liability insurer, MSP *C*ontractors recover from the beneficiary, Medicare's primary payment, reduced by a proportionate share of the beneficiary's procurement costs, if any. The MSP *C*ontractor uses the formula in § 40.18 of this Chapter to determine the amount of Medicare's claim when there are beneficiary procurement costs.

If a negligent party who carries liability insurance decides to pay a liability claim with their own funds rather than submit the claim to the liability insurer, Medicare recovers its benefits from such a payment because it is deemed to be a liability insurance payment. Medicare benefits are also subject to recovery from payments by a self-insured party. (See Chapter 1, § 10 of the Medicare Secondary Payer Manual).

40.16 – Calculating Medicare's Share of Beneficiary Procurement Costs

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Pursuant to 42 C.F.R. § 411.37, the Medicare recovery is reduced when procurement costs are incurred by a beneficiary to obtain a third party payment as a result of a settlement, judgment, award, or other payment.

If the reimbursement is not made, Medicare:

a) May bring legal action against any entity required to make or responsible for payment and collect double damages;

b) May take legal action to recover its benefits from any entity that has received primary payment from the NGHP for items and services furnished to an individual for whom Medicare is the secondary payer;

c) May join or intervene in any legal action against the NGHP related to the events that gave rise to the need for the items or services; and

d) Is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from a NGHP.

Under 42 C.F.R. § 411.37, Medicare will recognize a proportionate share of the necessary procurement costs incurred by a beneficiary in obtaining a settlement, judgment, award, or other payment. Procurement costs are those costs incurred by the beneficiary in obtaining a settlement, judgment, award, or other payment (e.g., court costs, attorney fees). If a liability insurer pays a beneficiary, the MSP *C*ontractor recovers Medicare's payment from the beneficiary, reduced by a proportionate share of the beneficiary's procurement costs, if any.

If, under the Prospective Payment System (PPS), Medicare pays a provider, physician, or other supplier more than its charges, the MSP *C*ontractor does not recover more than the charges from a beneficiary's liability settlement. See P.L. 98-21 (97 Stat. 65, April 20, 1983). (Under Medicare regulations, a beneficiary who must refund a Medicare payment made to a provider, physician, or other supplier is liable only to the extent that the beneficiary benefited from the payment. Since the beneficiary would have had to pay only the provider, physician, or other supplier's charges in the absence of Medicare, the beneficiary is not liable for refunding more than the charges). The provider, physician, or other supplier is not required to refund the excess of the Medicare payment rate over the provider, physician, or other supplier's charges. See Medicare Financial Manual, Chapter 3 (Overpayments), Section 110.1.

To determine beneficiary procurement costs, the MSP *C*ontractor asks the attorney to furnish (in writing) the costs, including attorney fees, incurred by the beneficiary to procure the settlement, judgment, award, or other payment. If these costs appear in excess of the prevailing costs in the area for similar claims, it asks for an itemized statement of costs or copy of a contingency agreement, if applicable, or other appropriate documentation. If the beneficiary's procurement costs are documented, the MSP *C*ontractor allows them. Should *an* MSP *C*ontractor need advice on what constitutes beneficiary procurement costs in a particular case, it should consult CMS.

The MSP *C*ontractor uses the following formula to determine the amount of Medicare's claim when there are beneficiary procurement costs:

a) Determine the ratio of the beneficiary procurement costs to the total amount of the liability insurance settlement, judgment, award, or other payment;

b) Apply this ratio to the Medicare payment. The product is the Medicare share of the beneficiary procurement costs; and

c) Subtract the Medicare share of beneficiary procurement costs determined in step 2 from the lesser of the total conditional payments or the provider, physician, or other suppliers' charges. The remainder is the amount to be refunded to the Medicare program. (This amount may be rounded to the nearest dollar).

NOTE: If Medicare payments equal or exceed the amount of the liability insurance settlement, judgment, award, or other payment amount, the MSP *C*ontractor recovers the entire liability insurance settlement, judgment, award, or other payment, up to the amount of the provider, physician, or other suppliers' charges, minus the total beneficiary procurement costs.

40.17 – CMS Incurs Procurement Costs

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If CMS must bring suit against the party that received payment because that party opposes CMS' recovery, the recovery amount is the lower of the following:

a) The Medicare payment; or

b) The total settlement, judgment, award, or other payment amount, minus the party's total procurement costs.

40.18 – Medicare Liability Settlement Claim Reimbursement Summary

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The Medicare Liability Settlement Claim Reimbursement Summary provides a worksheet for use in calculating beneficiary procurement costs, Medicare's share of the beneficiary's procurement costs, and Medicare's claim to be recovered as follows:

MEDICARE LIABILITY SETTLEMENT CLAIM REIMBURSEMENT SUMMARY

Beneficiary:

HICN:

1. Amount of settlement $

2. Medicare payments (identified by MSP Contractor) $

3. Total Medicare payments $

4. Attorney fees (% of line 1, if applicable) $

5. Other procurement costs incurred by the beneficiary (per attorney) $

6. Total beneficiary procurement costs (lines 4 + 5) $

7. Ratio of beneficiary procurement costs to settlement (line 6 / line 1) %

8. Medicare's share of beneficiary procurement costs (line 3 x 7) $

9. Total Provider, Physician, or Other Suppliers' Charges $

10. Medicare's claim to be recovered (the lesser of line 3 or line 9 minus line 8) $

40.19 – Collecting Interest on Medicare's Claim

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Medicare assesses interest on MSP debts by exercising common law authority that is consistent with the FCCA and implementing regulations. (See 45 C.F.R. § 30.18). CMS requires that a beneficiary or other entity repay CMS within 60 calendar days of receiving insurance proceeds from a third-party payer. (See 42 C.F.R. § 411.24(h)).

If CMS does not receive a full refund, or adequate proof that no overpayment exists, within 60 calendar days of notifying the beneficiary of CMS's demand, the MSP Contractor begins assessing interest as of the date of the mailing of the demand letter.

Interest will continue to accrue on delinquent debts until the debt is either paid in full or there is a determination to terminate the collection action by CMS.

The following considerations apply in determining the amount of interest owed on an outstanding MSP debt:

a) Interest can be charged only after the responsible entity has been notified of the debt and a demand for payment has been made, and has had sixty calendar (60) days in which to make repayment. Interest due is calculated beginning from the date of the original demand letter;

b) Interest cannot be assessed on deductible and coinsurance amounts; and

c) Even though MSP *C*ontractors will be requesting repayment of the gross Medicare payment, interest can be charged only on the actual Medicare payment or the provider, physician, or other supplier's charges, if less. Therefore, these amounts must be separated to determine the amount on which interest will be charged.

40.20 – Installment Payments and Multiple-Party Settlement Checks

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If the beneficiary wishes to refund in installments, the MSP *C*ontractor follows the instructions found in the Medicare Financial Management Manual, Chapter 3, § 110.8.

If a liability insurer sends the MSP *C*ontractor a check intended to repay Medicare benefits paid on the beneficiary's behalf, but which is made out jointly to Medicare and to other parties (such as the beneficiary or representing attorney), the MSP *C*ontractor sends a note to the other payee(s) asking them to endorse the check and return it to the MSP *C*ontractor. It does not endorse the check before endorsement of the other payee(s) is received.

40.21 – Appeals Procedures for MSP Liability and Waiver Determinations

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

These instructions prescribe procedures to be used in processing appeals of: 1) MSP liability determinations (including Non-Group Health Plan (NGHP) debt, beneficiary debt, and insurer debts created after 4/28/2015 (following implementation of the *Strengthening* Medicare and Repaying Taxpayers Act of 2012); and 2) MSP waiver determinations. Since recovering MSP liability determinations involves procedures which vary somewhat from those used for general Medicare overpayments, the following recovery instructions are to be used in place of the general overpayment instructions found in the Medicare Claims Processing Manual (Chapter 29, Appeals of Claims Decisions), except where specific references to those sections are provided. These instructions supersede any conflicts in the procedures.

40.22 – Initial Determinations

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Initial determinations generate appeal rights. There are three types of initial determinations made within the context of the MSP program that generate appeal rights.

The beneficiary may appeal:

a) The existence of the overpayment;

b) The amount of the overpayment; and

c) A waiver request under 1870(c) of the Act that receives a less than fully favorable CMS decision.

Effective for recovery demand letters issued on or after April 28, 2015, the rules do not change for GHP-based recovery demand letters. The rules do change for recovery demand letters issued to "applicable plans", that is, to liability insurance (including self-insurance), no-fault insurance, or workers' compensation entities as the identified debtor. Recovery demand letters issued to these entities on or after April 28, 2015, are "initial determinations" and are subject to the regulations in 42 C.F.R. § 405.900 et seq. *Applicable plans may appeal*

only the existence of the overpayment and the amount of the overpayment identified in the initial determination. Applicable plans may not appeal their identity as a debtor or a responsible reporting entity. Furthermore, § 1870 waiver of recovery is not applicable to demands issued to applicable plans. Consequently, § 1870 waiver of recovery language shall not be included in demands issued to the applicable plan as the identified debtor.

Negotiation of a compromise or suspension or termination of collection action under FCCA by CMS is not an initial determination and, therefore, generates no appeal rights. (See 42 C.F.R. § 405.926(h)). A waiver granted under Section 1862(b) of the Act also generates no appeal rights.

40.23 – Notification of the Right to Appeal

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The beneficiary *or applicable plan* must be given notice of appeal rights within the document reflecting the initial determination. If the beneficiary continues to follow through with the appeal process, notice of the next sequential appeal right must be given with each new determination. (See also § 40.26).

40.24 – Appeals of MSP Liability Determinations

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP liability determinations that may be appealed are listed at § 40.24. MSP *C*ontractors are responsible for processing appeals of these determinations. When processing MSP determination appeals, the MSP *Contractor* generally follows the process set forth in the Medicare Claims Processing Manual (Chapter 29, Appeals of Claims Decisions).

a) Requests for Appeal

Any writing that the MSP *C*ontractor receives indicating dissatisfaction with the initial determination constitutes a request for an appeal. Any language about a review, reexamination, investigation or the like is deemed an implied request for an appeal. (See for example 42 C.F.R. § 405.944).

b) Combined Requests for Waiver and Appeal

If a beneficiary objects to recovery of Medicare's claim on the basis of hardship or inequity, the MSP *C*ontractor treats the objection as a request for waiver, even if it is filed on a document normally used to request an appeal.

If the beneficiary simultaneously requests an appeal of the overpayment (either the amount or its existence) AND requests waiver, the MSP *C*ontractor processes the appeal request before processing the request for waiver.

If the initial overpayment determination is affirmed, then the MSP *C*ontractor proceeds with evaluation of the waiver request in accordance with the instructions found in § 50 of this Chapter. It issues the waiver determination.

Where simultaneous waiver and appeal requests have been made, the MSP *C*ontractor sends a brief letter acknowledging receipt of the requests. The acknowledgment letter informs the beneficiary that both requests will be processed together, although the correctness of the overpayment determination will be determined first. After a determination regarding both the overpayment and the waiver request have been made, the MSP *C*ontractor sends one letter notifying the beneficiary of the determination(s).

c) NGHP Insurer Appeal

Effective for recovery demand letters issued on or after April 28, 2015, for demands issued to the applicable plan as the identified debtor, only the applicable plan is a party with reopening or appeal rights. If the applicable

plan files an appeal, the *MSP C*ontractor is required by regulation to provide notice to the beneficiary, but the beneficiary has no further involvement with the appeal. See 42 C.F.R. § 405.947.

d) Steps in Deciding an Appeal

A person other than the one who made the initial determination must decide an appeal. The objective is to make a determination as to whether the initial determination was correct.

As part of the appeal determination, staff may need to conduct medical review of the services in question. Therefore, it is important to obtain all related documentation (i.e., emergency room reports, admission history, physician orders, nursing notes, and discharge summary) in order to make an informed evaluation.

e) Other steps that should be followed:

i. Check all mathematical computations for accuracy;

ii. Determine whether any new evidence has been produced since the time the initial determination was made; if so, that information must be considered;

iii. If the beneficiary is appealing a denial of a waiver request, use the criteria found in § 50 of this Chapter to determine whether the initial determination is correct;

iv. Once the determination has been made, send the debtor and authorized parties the letter. The MSP *C*ontractor's letter must include a clear rationale for its determination; and

v. The determination contains notification of the second appeal right. This appeal right automatically comes into effect when the debtor is dissatisfied with the reconsideration, or review determination and makes a written request for such an appeal. See the Medicare Claims Processing Manual (Chapter 29, Appeals of Claims Decisions), for the next level of appeal and the time limits for filing for the various levels of appeal.

40.25 – Role of MSP Contractors in MSP Liability Appeals Process

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The MSP *C*ontractors conduct liability appeals. There are statutory appeal processing timeliness requirements which require prompt action on the part of CMS. See 42 C.F.R. 405.950. For processing timeliness, the MSP *C*ontractor uses the date of receipt in the mailroom as the date of receipt. The date the beneficiary *or applicable plan* filed the request with the MSP *C*ontractor is used to determine if the beneficiary*, or applicable plan,* filed timely.

50.3 – Compromise of Claim, or Suspension or Termination of Collection, Under the Federal Claims Collection Act (31 U.S.C. § 3711)

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

CMS may agree to compromise a claim for reimbursement under the FCCA, if:

a) The individual does not have the present or prospective ability to pay the full amount of the claim within a reasonable period;

b) It is determined that it would be difficult to prevail in this case before a court of law; or

c) The cost of collecting the claim is likely to be more than the amount collected.

Under the FCCA, CMS has delegated authority to compromise claims up to $100,000. The Department of Justice (DOJ) has the authority to compromise claims over $100,000. CMS works with DOJ, through HHS OGC, regarding compromise matters where the debt, exclusive of interest, is over $100,000. Legal clearance must be obtained from HHS OGC for proposed compromises if the amount of the debt is $100,000 or less

(exclusive of interest, penalties, and administrative costs, and after all partial payments and collections have been deducted, and the difference between the amount offered by the debtor and the amount owed the Government is more than $25,000).

Under the FCCA, agencies have the authority to compromise claims where:

a) The cost of collection does not justify the enforced collection of the full amount of the claim;

b) There is an inability to pay within a reasonable time on the part of the individual against whom the claim is made; or

c) The chances of successful litigation are questionable, making it advisable to seek a compromise settlement.

These criteria are provided here for MSP *C*ontractor information, since only CMS staff, not MSP *C*ontractors, are permitted to compromise Medicare claims.

When a beneficiary agrees to a compromise settlement under the FCCA, the beneficiary also agrees not to appeal the matter further.

50.4 – Compromise Exercised Only by CMS

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If a beneficiary, attorney, or beneficiary's representative offers to pay Medicare less than the full amount of its claim, the MSP *C*ontractor informs the inquiring party of their rights to request waiver, appeal, or compromise of the claim. It advises them that while MSP *C*ontractors may assist them in securing a waiver or appeal, MSP *C*ontractors are not permitted to compromise claims on behalf of the Government. Then, the MSP *C*ontractor follows the instructions at § 70.3 of this Chapter, which provide that a resolution through the FCCA is available through CMS at any time after the MSP *C*ontractor is aware that Medicare has made conditional payments in a liability situation.

The FCCA grants Medicare the right to compromise its claims, or to suspend or terminate its recovery action. However, only CMS may take this action. Consequently, MSP *C*ontractors may not, under any circumstances, enter into negotiations (either pre- or post-settlement) with beneficiaries, or their attorneys or representatives, to compromise Medicare's claim. If beneficiaries, or their attorneys or representatives, wish to discuss arrangements by which Medicare's claim might be reduced (outside of a formal request for Medicare to waive its claim), the MSP *C*ontractor either: 1) instructs the party to either make its request for compromise in writing, in which case the MSP *C*ontractor forwards the request to CMS, or 2) refers the party directly to the appropriate staff person at CMS to handle the negotiation. MSP *C*ontractors may advise an attorney or beneficiary that Medicare's conditional payment must be considered during settlement negotiations with any third party.

50.5 – Documentation Necessary for Cases Where Compromise is Requested

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If *an* MSP *C*ontractor receives a written request for a compromise of a Medicare overpayment that meets the specified criteria above, the request and the case file must be forwarded to CMS. No action can be taken on telephone requests, even for pre-settlement compromise.

50.6 – Waivers under Section 1870(c) of the Act

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors have authority to consider beneficiary requests for waivers under Section 1870(c) of the Act. However, the authority to waive Medicare claims under Section 1862(b) of the Act, and to compromise claims or to suspend or terminate recovery action under the FCCA, is reserved exclusively to CMS staff.

Distinctions between waiver, partial waiver, and compromise are important, and are found at *Pub. 100-05,* Chapter 1 where each term is defined.

A beneficiary may offer to refund to the MSP *C*ontractor less than the full amount of Medicare's claim. Medicare may accept such an offer either as a compromise under the FCCA, or as a waiver under Section 1870(c) of the Act.

Medicare claims (see *Pub. 100-05,* Chapter 1 for definition) that do not involve the FCCA could be considered for waiver based on "economic hardship" or "equity and good conscience." The MSP *C*ontractor handles waiver requests. Waivers granted under this authority may not be appealed because they are granted at CMS's discretion. See 42 C.F.R. § 405.926(h).

50.7 – Beneficiary Right to Request Waiver of Medicare's Claim

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The MSP *C*ontractor must inform the beneficiary that he or she has the right to request waiver of adjustment or recovery of the overpayment, and/or to appeal the existence of an overpayment, the amount of the mistaken payment, or the denial of waiver of conditional payment. This notice (right to request appeal and/or waiver of recovery) must be given at the time repayment is requested from the beneficiary.

50.8 – Beneficiary Must Submit Waiver Request in Writing

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The beneficiary must request a waiver in writing. Once the waiver request has been received, the *MSP C*ontractor sends the beneficiary and attorney a letter: 1) acknowledging that the waiver request has been received by CMS; and 2) informing that CMS will send a letter advising of the request's outcome once a determination has been reached.

50.9 – Timely Processing of Waiver Determinations

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Waiver determinations should be completed within 120 calendar days from the date a waiver request is received (and date stamped) in the MSP *C*ontractor mailroom or entered into the MSP portal.

50.10 – Steps for Waiver Determination under Section 1870(c) of the Act

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

a) Collect All Pertinent Data

The MSP *C*ontractor will collect all supporting documentation necessary for the waiver determination, including:

i. Beneficiary procurement costs;

ii. Accident-related out-of-pocket medical expenses incurred; and

iii. Expenses and income information that demonstrate financial hardship (if the beneficiary is alleging financial hardship).

b) Apply Waiver Criteria

The MSP *Contractor* determines whether the beneficiary meets the criteria for waiver determinations under Section 1870(c) of the Act (see also 42 C.F.R. § 405.355 and 20 C.F.R. §§ 404.506-512).

Section 1870(c) of the Act provides that CMS may waive all or part of its recovery in any case where an overpayment under Title XVIII of the Act has been made with respect to a beneficiary:

i. Who is without fault, and/

ii. When adjustment or recovery would either:

A. Defeat the purpose of title II or title XVIII of the Act, or

B. Be against equity and good conscience.

iii Based on the CMS application of the SSA definition of fault, found at 20 C.F.R. § 404.507, CMS deems that beneficiaries are without fault.

c) Determine if a full or partial waiver is warranted.

50.11 – Allowing Out-of-Pocket Expenses in Waiver Determinations

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Out-of-pocket expenses should be considered in determining if a full or partial waiver is warranted. Out-of-pocket expenses are defined as those medical expenses for which a beneficiary has paid or is responsible to pay incurred for injuries directly related to the accident and that are not covered by insurance (including Medicare), settlement proceeds, or court- awarded damages.

A waiver of all or part of the out-of-pocket expenses may be granted only if the following criteria have been met. In determining the amount of out-of-pocket expenses to be waived, each case must be considered on its own merits. The MSP Contractor must not automatically assume that out of pocket expenses should be waived.

The following documentation should be considered proper proof of the expenses paid:

a) Notarized/sworn statement which attests to the validity of the expenses;

b) Canceled checks (which correlate to bills received);

c) Receipts for services furnished; and

d) Copies of bills demonstrating services furnished.

The following are types of out-of-pocket expenses that may support granting a waiver:

a) Housing renovation – beneficiary's residence had to be modified to accommodate beneficiary because of an accident-related injury e.g., addition of a ramp to accommodate a wheelchair;

b) Adult diapers - where the accident caused loss of bladder use;

c) Prescriptions for medication needed as a result of an accident-related injury;

d) Private duty nursing or custodial care not covered by Medicare;

e) Coinsurance and deductibles not covered by supplemental insurance; and

f) Expenses for dental work caused by the accident.

MSP Contractors should not consider:

a) Funeral expenses; or

b) Travel for relatives (even if accident-related).

50.12 – Factual Data in Determining Whether a Full or Partial Waiver is Warranted

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Other factual data that MSP Contractors should use in determining if a full or partial waiver is warranted are:

a) Age of beneficiary;

b) Beneficiary's assets;

c) Beneficiary's monthly income and expenses; and

d) Physical or mental impairments.

50.13 – When Recovery Would Defeat the Purpose of Title II or Title XVIII

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

This means recovery would defeat the purpose of benefits under these titles, i.e., would cause financial hardship by depriving a beneficiary of income required for ordinary and necessary living expenses. This depends upon whether the beneficiary has an income or financial resources sufficient for more than ordinary and necessary expenses, or is dependent upon all of their current benefits for such needs.

A beneficiary's ordinary and necessary expenses includes:

a) Fixed living expenses, such as food, clothing, rent, mortgage payments, utilities, maintenance, insurance (e.g., life, accident, and health insurance, including premiums for supplementary medical insurance benefits under Title XVIII), taxes, installment payments, etc.;

b) Medical, hospitalization, and other similar expenses not covered by Medicare or any other insurer;

c) Expenses for the support of others for whom the beneficiary is legally responsible; and

d) Other miscellaneous expenses which may reasonably be considered necessary to maintain the beneficiary's current standard of living.

50.14 – Examples of Financial Hardship in Waiver Determinations

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Following are examples of determining financial hardship on a Medicare beneficiary:

a) The beneficiary has spent the settlement proceeds and the only remaining income from which the beneficiary could attempt to satisfy Medicare's claim would be from the money that is needed for the beneficiary's monthly living expenses. Waiver may be appropriate under this aspect of the waiver criteria. If documented and appropriate monthly expenses consume the entire amount of money available, a full waiver may be warranted. A partial waiver may be appropriate if the beneficiary retains at least some (for example $25.00) discretionary income each month;

b) The demonstrated beneficiary income and resources are at a poverty level standard, such as being in an SSI pay status. A beneficiary may demonstrate proof of SSI pay status by requesting the Form SSA-2458, Benefit Verification, from a SSA office. If Medicare's claim would have to be satisfied from income and resources that meet an established level of poverty, waiver may be appropriate. However, preexisting financial hardship alone may be an insufficient basis for granting a waiver. All factors, not just the existence of poverty, must be weighed before a waiver decision can be made; or

c) An unforeseen severe financial circumstance existing at the time Medicare's claim comes into existence can also constitute financial hardship. If a beneficiary has become legally financially responsible for an unforeseen obligation, has acted in good faith at all times with respect to Medicare's claim, and has no other

financial resources to meet this legal obligation, waiver may be warranted. For example, waiver would be appropriate if a beneficiary's grandchildren became the legal responsibility under a will or trust that came into existence upon the sudden death of the beneficiary's child (the parent of the grandchildren).

NOTE: The MSP *C*ontractor should assume in all waiver examples that the attorney has already taken attorney fees from the settlement proceeds, and the beneficiary does not have to pay the attorney from the settlement figure shown. Also, it should assume that the settlement proceeds are being retained in an escrow account by the attorney and have not been spent. In cases where the funds have already been spent by the beneficiary, the beneficiary*'*s monthly financial situation and the likelihood of recouping the monies will be significant factors.

In the following situations, Medicare's full recovery would create the kind of financial hardship in which granting waiver would be appropriate.

a) Facts: The beneficiary was injured in a slip and fall accident. A liability suit awarded a settlement of $4,500 to the beneficiary. The attorney's fees were $1,500. The beneficiary incurred $1,700 in allowable, properly documented out-of-pocket medical expenses. The beneficiary is left with $1,300, but there will be future medical expenses that are not likely to be covered by Medicare. The beneficiary submitted documentation indicating Social Security benefits are received and there is still a monthly shortfall of $200. Medicare's recovery after reducing for Medicare's share of the beneficiary's procurement costs is $537.

Analysis: While Medicare's claim is very small, so is the settlement. The money the beneficiary would use to repay Medicare could be used to pay the additional medical expenses and pay the beneficiary for out-of-pocket expenses. The beneficiary is already experiencing financial hardship. Medicare*'*s recovery would produce additional financial hardship.

Action: Grant full waiver.

b) Facts: The beneficiary sustained serious injuries from a fall on a bus. The beneficiary sued the bus company and received a settlement of $5,000. Medicare made conditional payments of $6,369. Attorney's fees total $1,667. After reducing its claim to share in the beneficiary's procurement costs, Medicare's net conditional payments total $3,333. (When Medicare's payments exceed the amount of the settlement, Medicare's recovery becomes the amount of the settlement, less total beneficiary procurement costs). The beneficiary's monthly income and expenses are equal. The beneficiary incurred non-covered out-of-pocket medical expenses of $3,000, of which $1500 is properly documented.

Analysis: After reducing for beneficiary procurement costs, Medicare is entitled to recover $3,333.33, the remainder of the settlement funds. If the beneficiary repaid Medicare the total amount owed after reduction for beneficiary procurement costs, there would be no funds left with which to pay out-of-pocket medical expenses. Repayment to Medicare would create a financial hardship with respect to the out-of-pocket costs. Therefore, Medicare may further reduce its claim to avoid causing a financial hardship for the beneficiary.

Action: Grant a partial waiver of the amount owed.

50.15 – Recovery Would Be Against Equity and Good Conscience

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

In addition to the factors and parameters of 42 C.F.R. § 405.376, equity and good conscience is applied to Medicare overpayment recoveries when required, based on the totality of the circumstances in a particular case. In applying the standard of equity and good conscience factors to consider include, but are not limited to, the following:

a) The degree to which the beneficiary contributed to causing the overpayment;

b) The degree to which Medicare and/or its MSP Contractors contributed to causing the overpayment;

c) The degree to which recovery or adjustment would cause undue hardship for the beneficiary;

d) Whether the beneficiary would be unjustly enriched by a waiver or adjustment of recovery; and

e) Whether the beneficiary changed their position to their material detriment as a result of receiving the overpayment or as a result of relying on erroneous information supplied to the beneficiary by Medicare.

Below are several Medicare overpayment situations when application of equity and good conscience is likely to result in a waiver of adjustment and recovery:

a) The beneficiary made a personal financial decision, based on written information from an official CMS source, that the overpayment was correct, and recovery would change the beneficiary's position for the worse.

b) Recovery of the full overpayment amount is contraindicated by especially compelling mitigating facts and circumstances of the beneficiary's case.

c) Facts: The beneficiary sustained injuries in an automobile accident. Medicare made conditional payments in the amount of $7,500 on the beneficiary's behalf. The beneficiary later filed suit for the injuries and damages suffered as a result of the accident and received a $5,000 settlement. There were no attorney's fees, thus Medicare's claim is $5,000. The beneficiary requested a waiver of the overpayment. The beneficiary submitted documentation demonstrating that the money received was used to replace the automobile that was totaled in the accident.

Analysis: If Medicare seeks full recovery, the beneficiary will likely have to sell the replacement vehicle to repay Medicare. The beneficiary's vehicle was the only means of transportation used for a part-time job to supplement income as well as transportation to doctors etc. Selling the vehicle to repay Medicare would cause the beneficiary to be placed in a worse position than before the accident, which would be against equity and good conscience.

Action: Either full or partial waiver may be granted. Obviously, Medicare may seek its entire recovery. However, since the beneficiary's documentation indicates that the entire $5,000 was needed to replace the car, full waiver would be more appropriate.

NOTE: Using the settlement money to replace the totaled car was considered appropriate only because loss of the beneficiary's car was complete. It would be inappropriate to grant waiver simply because the beneficiary chose to purchase a car from the proceeds.

d) Facts: The beneficiary sustained multiple injuries in an automobile accident, including a permanent injury that will preclude employment ever again. Monthly income equals monthly expenses. Medicare's conditional payments were $8,500. The beneficiary received a liability insurance payment of $5,000 (which was the limit of the policy). No attorney was retained. Therefore, Medicare's recovery becomes $5,000. The beneficiary incurred allowable, properly documented out-of-pocket medical expenses of $4500.

Analysis: Since the beneficiary is now unable to work, the ability to absorb the out-of-pocket medical expenses has greatly diminished. Since a valuable right, i.e., the right to be gainfully employed, is a change in one's position, it would be against equity and good conscience for Medicare to recoup its entire recovery. In accordance with § 40.15, since Medicare stands to recover 100 percent of the settlement amount, it may waive 100 percent of the out-of-pocket costs. It would not be feasible to pursue recovery of the remaining $500.
Action: Grant full waiver.

50.16 – When the Beneficiary Fails to Meet Either Waiver Criterion under Section 1870(c)

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

When the beneficiary requests a waiver, but does not meet either of the two stated criteria, the request for waiver should be denied. The following examples illustrate such circumstances:

a) Facts: The beneficiary broke a leg and is now unable to work. Medicare's conditional payments total $7,000. The beneficiary received a settlement of $20,000. After reducing Medicare's claim to allow for beneficiary procurement costs, Medicare should recover $4,667. The total beneficiary monthly income is $1,004 (interest income and social security benefits), with monthly expenses of $585. Out-of-pocket incurred expenses total $870 and the beneficiary has requested a full waiver.

Analysis: Wavier criteria is not met because the beneficiary has not shown that daily living expenses could not be met, nor that repayment would be unfair. This determination is based upon the information provided, which documents that the beneficiary is able to meet daily living expenses, and has excess funds ($285 excess per month), even without the settlement received. Moreover, the beneficiary received a large enough settlement to pay the non-covered out-of-pocket expenses and to repay Medicare without incurring a financial hardship. Repayment under these circumstances is equitable.

Action: Waiver request is denied.

b) Facts: The beneficiary was unemployed before injury that triggered Medicare conditional payments. However, the accident has reduced the probability that the beneficiary will ever be able to work again. Medicare's recovery is $11,000. No attorney was used in procuring the settlement, nor were there other beneficiary procurement costs. Therefore, no beneficiary procurement costs were subtracted from the amount of Medicare's recovery. The beneficiary received a $55,000 settlement. Documented out-of-pocket medical expenses equal $10,000. Monthly expenses are $2,068 and monthly income is $1150 ($771 social security benefits, $344 unemployment, and $35 interest income).

Analysis: The beneficiary has a monthly shortfall of $918, which appears to constitute a financial hardship. However, this financial hardship existed before the accident. Repaying Medicare must be the circumstance that causes financial hardship. Preexisting financial hardship alone is not a sufficient reason to grant waiver. Additionally, after repaying Medicare and paying for out-of-pocket expenses, the beneficiary retains $33,221 of the settlement proceeds. Repayment of Medicare's claim will not deprive the beneficiary of any valuable right or put the beneficiary in a worse position than before the accident. For this reason, repaying Medicare is not against equity and good conscience.

Action: Waiver request is denied.

60.2 – Collection of MSP Debts

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors have primary responsibility for collecting all MSP debts and are expected to pursue recovery of all accounts receivable (AR) to the fullest extent possible, regardless of the identity of the debtor. MSP *C*ontractors shall follow all financial reporting requirements contained in the Medicare Financial Management Manual (CMS Pub. 100-06), Chapter 5. However, when ARs cannot be collected, an appropriate write-off is required.

Debts that are over 180 calendar days delinquent (240 calendar days old for MSP debts) will be systematically classified as "Currently not Collectible" (CNC). The CNC debt will not be recognized as an active AR for financial statement reporting purposes, because to do so would overstate the true economic value of the assets on the financial statements. While CNC debts are not reported as an AR on the financial statements, *MSP*

Contractors must continue appropriate recovery efforts for these debts until they are recommended and approved by CMS for Write-Off/Closed.

60.3 – Identification of MSP Write-off/Closed Accounts

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Generally, MSP Contractors may recommend write-off for debts which are reported as part of their ending AR balance. ARs that have been referred (but not transferred) to another location remain the responsibility of the MSP Contractor.

NOTE: These instructions apply only to established ARs (i.e., MSP accounts receivable are not established until a settlement, judgment or award has been reached and a demand letter is issued.). They shall not be used to close MSP liability/no-fault/workers' compensation leads where no settlement, judgment, award or other payment exists and no recovery demand has been issued.

60.4 – Write-off/Closed Definition

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The definition of Write-off/Closed refers to an AR on which collection activity and servicing of the debt has been terminated. The MSP Contractor maintains records of the debts written off as "closed." However, the debts are not to be used for future offset or interest accruals.

60.5 – Documentation Required for Write-off/Closed

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

For a debt to be considered for write-off, the MSP Contractor must maintain, and be able to provide upon demand, all documentation related to the debt.

60.6 – Bases for Termination of Collection

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Title 42 C.F.R. § 401.621 sets forth several bases for the termination of collection action on debts. The criteria set forth in this instruction for Write-off/Closed are based upon CMS's consideration of a combination of the bases set forth in this regulation rather than any single basis. In some situations, an AR could be written off as closed as of three years from the original demand date solely based upon the statute of limitations for initiating litigation. In other situations, this would not be true because the statute may have been suspended for some period, or started a new due to a particular event, but CMS may have still determined that write-off as closed is appropriate because of the likelihood of recovery and/or the cost of recovery, age, or the application of some other factor. In other instances, CMS may determine that collection action beyond three years is appropriate, in part due to the Governments offset authority.

60.7 – Criteria for MSP Based Debts to Qualify for Write-off/Closed

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

In accordance with the Digital Accountability and Transparency Act of 2014 (DATA Act) which amended the DCIA of 1996, MSP AR which are 120 calendar days delinquent must be referred to Treasury for cross-servicing, which includes referral to the Treasury Offset Program. Where *an* MSP Contractor has issued a 60-day notice of CMS's intent to refer the AR to Treasury, the AR may not be recommended for Write-off/Closed until the AR has been referred to Treasury and after lengthy recovery attempts Treasury returns the debt to agency (to CMS).

a) Debt Close Out Reports

The *MSP C*ontractor shall submit two (2) separate quarterly debt close out reports. These reports shall be submitted to CMS no later than the first day of the second month of each quarter (i.e., November 1, February 1, May 1, and August 1). These reports shall not include debts with a combined principal and interest balance less than $25. CMS will determine which referred debts shall be written off as closed and shall notify the MSP *C*ontractor as appropriate.

The first report shall include debts that are not eligible for Treasury referral (for example, beneficiary fraud, deceased provider), referred to as Non-Return to Agency (RTA), and RTA debts that are non-RU (uncollectable)/RN (not in business) debts (other than bankruptcy debts) with principal balances up to $100,000 and RU/RN debts with principal balances up to $500,000. The debts listed on this report will be reviewed and approved by CMS.

The second report shall include non-RTA and non-RU/RN debts (other than bankruptcy debts) with a principal balance greater than $100,000 and RU/RN debts with a principal balance greater than $500,000. HHS OGC will provide legal advice on the debts listed on this report.

b) Referral for Cross Servicing

No debt shall be recommended for Write-off/Closed without having first been referred for cross-servicing (see above in this section) and subsequently "returned to agency" (CMS) by Treasury, unless one of the exceptions set forth below exists. Regardless of the existence of an exception, an approval for Write-off/Closed will not be granted in all instances.

With the above limitations, debts which can be recommended for Write-off/Closed without having first been referred to Treasury for cross-servicing are:

i. Debt equaling $100 or less (principal and interest) in which there is no Tax Identification Number (TIN);

ii. Debt is less than $25 (principal and interest), where no adjustment/recovery has occurred in the past 60 days. Write-off of this type of debt is automated in HIGLAS and it does not require CMS approval.

iii. Debt in which the debtor is deceased (**Remember that the deceased beneficiary is not the debtor in a wrongful death action).

iv. MSP *C*ontractor cannot find a Tax Identification Number (TIN) and development for the TIN has been unsuccessful. (Write-off of this type of debt is automated in HIGLAS if the debt balance is $1,000 or less, and it does not require CMS approval).

v. Debts that are discharged/forgiven by the bankruptcy court are to be recommended for Write-off/Closed.

vi. Debts greater than 10 years old, regardless of amount, shall be recommended and submitted to CMS for termination of collection action and Write-off/Closed.

NOTE: Debts excluded from cross-servicing do not qualify for Write-off/Closed without having CMS approval.

c) Litigation, CMS Identified Exclusion and Pending Bankruptcy

Debtors currently excluded from consideration for Write-off/Closed due to litigation in which the Department of Health and Human Services/CMS is a party or debts excluded due to a CMS Identified Exclusion will be communicated to MSP *C*ontractors via a joint signature memorandum. (See § 70 of this Chapter).

Debts involved in a pending bankruptcy cannot be recommended or approved for Write-off/ Closed. If there are questions about the documentation regarding discharge, MSP *C*ontractors shall consult CMS.

All debts which are excluded from DCIA referral due to litigation or a CMS identified exclusion are also subject to exclusion from Write-off/Closed absent specific instructions.

d) MSP Beneficiary Debt

For MSP beneficiary debt, Medicare reserves its right to recoup from (1) future Medicare paid claims where the payment is issued directly to the beneficiary, or (2) the beneficiary's Social Security (SS) benefit payments. However, as a practical matter, this is generally an insufficient manner of recovery, particularly as the Social Security Administration does not generally accept the referral of debts less than $1,000. Additionally, beneficiaries often delay consideration of repayment until all appeals have been exhausted. Therefore, before recommending a beneficiary debt for Write-off/Closed, the MSP *C*ontractor shall follow appropriate debt referral procedures (see Section 70). In the event the debt is actively being appealed, respond to the appeal. After the appeal has been completed, if there remains a balance owing, refer the debt to Treasury for cross-servicing after issuance of a proper intent to refer letter.

e) Write-off/Closed of Less than Full Amount is Not Permitted

MSP *C*ontractors may not recommend Write-off/Closed of less than the full amount of an outstanding debt. See § 70.3 of this Chapter for definition of the term "debt."

60.8 – Data Requirements and Format for Recommendations for Write-off/Closed

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The request for Write-off/Closed requires the submission of a Debt Close-Out Report (a completed checklist) that entails detailed information regarding the debts that are being closed out. Some of the fields on the checklist to be completed by MSP *C*ontractor are as follows:

a) MSP *C*ontractor name and number;

b) Type of MSP Debt - GHP or NGHP (including liability, no-fault, and workers' compensation);

c) Beneficiary name;

d) Name of debtor;

e) Existing AR amount;

f) Basis for recommendation.

g) TIN for debtor, if available. There must always be a TIN for a provider, physician, other supplier, or beneficiary debt. (The TIN is the Employer Identification Number (EIN) or Social Security Number (SSN).

NOTE: The debtor is the individual or entity to whom/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, physician, other supplier, 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.

Where the TIN is unavailable, the MSP *C*ontractor's Write-off/Closed recommendation shall leave this field blank.

The MSP *C*ontractor's Chief Financial Officer (CFO) must sign debt close-out reports. The CFO's signature constitutes his/her certification to all information/statements contained in the recommendation.

The MSP *C*ontractor shall send the recommendations for the approval of Write-off/Closed no later than the first day of the second month of each quarter (November 1, February 1, May 1, and August 1). The recommendation

may be sent electronically via secured email but it shall still include the validation statement signed by the *MSP Contractor's* CFO.

60.9 – Write-off/Closed Debts Which Have Been Returned by Treasury or Recalled by CMS and CMS Has Determined that No Further Collection Attempts are Appropriate

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

During the collection process, Treasury either collects debts or makes a final determination as to the status of the debts. Certain types of returned debts that are considered uncollectable can be eligible for Write Off/Closed. The MSP Contractor shall submit write-off requests to CMS for approval.

Treasury returns debts to CMS for the following reasons:

a) In Bankruptcy

b) Uncollectible

c) Out of Business

d) Dispute Timer Expired

e) Miscellaneous Dispute

f) Manual Return to Agency

g) Recall Approved

h) Complaint

i) Paid in Full

k) Satisfied through Payment Agreement

l) Satisfied through Compromise

CMS will send monthly reports of these debts to the MSP Contractors for final resolution. The reports will state the reasons Treasury returned the debts.

There are status codes in HIGLAS for each of the reasons the debts were RTA. The RTA reports, prepared by CMS, will reflect the new status codes. If Treasury returns debts and HIGLAS already shows the debts in a recall status, the system will not update the status code. However, the RTA reports will include the debts showing the existing HIGLAS recall status codes and the reason for the Treasury RTA.

The RTA reports are sent out in Excel format so the *MSP Contractors* may sort them as appropriate. The *MSP Contractors* shall address all debts on the RTA reports and forward the completed report to CMS within 30 calendar days after receipt.

NOTE: There will be instances when debts will be returned to agency due to unresolved issues. RTA status is not a guarantee that the debt will be approved for Write-off/Closed.

Further information regarding this guidance is found in the Medicare Financial Manual, Chapter 4, Section 70.17, and provides a detailed description of current status codes for debts returned by Treasury.

60.10 – Debts Returned by Treasury as Uncollectable (RU) or Out of Business (RN)

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The MSP *C*ontractors shall use the RTA report to research the debts in order to determine the current status or final disposition. The debts already in a recalled status are included so that the MSP *C*ontractors will know that Treasury considers the debts uncollectible or out of business.

The MSP *C*ontractors shall determine whether collection by litigation is a viable option for debts showing a status code of RU (RTA – Uncollectible) or RN (RTA – Out of Business). If so, follow established procedures for referring the debts for litigation (See Chapter 4, § 70 of the Medicare Financial Management Manual (CMS Pub. 100-06)).

The MSP *C*ontractors shall also consider whether all other appropriate actions to collect debts have been taken before recommending debts for Write-off/Closed, including the procedures in Chapter 4, § 70 of the Medicare Financial Management Manual (CMS Pub. 100-06)).

60.11 – Write-off/Closed Approval Process

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

CMS is responsible for approval or denial of all recommendations for Write-off/Closed for MSP AR made based upon the criteria set forth in this Chapter.

When in receipt of a Write-off/Closed recommendation for a debt in which the debtor is deceased CMS will determine the category of the debt. For example, wrongful death, medical malpractice, etc. Prior to approval CMS will also determine if the estate is closed. Debts shall not be closed when the debtor is deceased and the estate is still open or for a wrongful death matter where the wrongful death settlement, judgment, or award is awarded to other than the beneficiary's estate.

For the debts that have been recommended for Write-off/Closed, the MSP *C*ontractor shall consider the following:

1. For such debts, changes shall not be made to the AR for Write-off/Closed until written approval by CMS is received.

2. For such debts, receipt of this approval authorizes the MSP *C*ontractor to write-off the AR as closed, and to update the AR and associated case in all appropriate systems. Where CMS does not approve a recommended Write-off/Closed for a particular debt, CMS will annotate this clearly on the returned form.

60.12 – Financial Reporting for MSP Write-off/Closed

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The following reporting is required for write-off debts closed by MSP *C*ontractors:

a) Associated interest for Write-off/Closed MSP *C*ontractors shall use the amount of interest currently carried in HIGLAS.

b) On Form CMS-M751 and MC751, the amount that CMS has approved for Write-off/Closed, including principal and interest, is recorded on line 6a (M751) and line 4d (MC751), bad debt. The CMS written approval for Write-off/Closed is sufficient support for the subsequent write-off, including any increase in the interest, as long as the principal remains the same.

c) The MSP *C*ontractor shall document in the remarks section of Form CMS-M751 and MC751 each quarter the amounts (principal and interest) that were written off as closed as a result of implementation of these instructions.

60.13 – Date for Establishment of MSP AR

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP ARs must be established as of the date of the recovery demand letter or the payment receipt date (see instructions for voluntary/unsolicited refunds within the Medicare Financial Management Manual (CMS Pub. 100-06), Chapter 4, § 10).

MSP *C*ontractors shall not delay establishment of the AR until payment is received.

70 – Medicare Secondary Payer (MSP) Debt Collection and Treasury Referral Activities

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Updates to the MSP debt collection and treasury referral activities are identified below.

70.1 – General

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Upon MSP debts becoming eligible for referral to Treasury for cross-servicing, MSP *Contractor*s shall implement the DCIA actions for all types of MSP debts and their associated debtor(s).

The *MSP C*ontractor shall review and refer all eligible debts to Treasury during the weekly HIGLAS debt referral cycle. CMS has attempted to identify sections specific to HIGLAS users or sections revised to incorporate HIGLAS functionality with the operationally defined processes.

70.2 – Background

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The DATA Act which amended 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 120 calendar days delinquent, to Treasury for cross-servicing. The CMS has the option of referring debt before it becomes 121 calendar days delinquent but only after the MSP *C*ontractor has notified the debtor of CMS's 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 calendar days to respond, or interest will accrue and *be* 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 § 70.4 of this Chapter for further clarification of delinquency).

70.3 – Debt and Debtor Definitions

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

For GHP-based debt where the demand was issued to the employer/ other plan sponsor, 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 DPP recovery demands to a provider, physician, or other supplier, the debt includes all claims in the recovery demand letter regardless of the number of beneficiaries involved.

For liability, no-fault, and workers' compensation, the debt includes all claims in the recovery demand letter, minus Medicare's pro-rata share of the beneficiary's procurement costs and attorney costs/fees when the beneficiary is the identified debtor. This pro rata reduction is only applicable to procurement costs incurred by

the beneficiary, and only applicable to recovery from the beneficiary. The pro rata reduction for attorney fees and other costs is not applicable to demands issued to applicable plans as the identified 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, physician, other supplier, 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.

"Identified debtor" is the debtor identified in 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 identified debtor.

"Jointly and Severally Liable Debtors" is a reference to multiple entities having equal responsibility for repayment of a debt.

70.4 – Debt Selection and Verification

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors shall select eligible delinquent debts from their existing debt (open AR balances) for issuance of a DCIA ITR to Treasury letter. The ITR will advise the debtor of CMS's intention to refer the debt to Treasury for further collection, if left unresolved.

The MSP *C*ontractors must review and update debt information as necessary. For purposes of DCIA debt selection/referral criteria, *an* MSP debt becomes delinquent: (1) If the debt 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 after such notification, the debtor defaults on a repayment agreement.

Specific to MSP, the term "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 MSP *Contractor* with full supporting documentation is considered to be legally enforceable. *A debt is not considered delinquent unless one of the above conditions are met within 60 days of the day of the agency's initial demand letter. For example, if a demand letter is issued on 1/1/2022, the debtor has 60 calendar days (3/4/2022) to respond to, pay, or otherwise dispute the debt. On 3/5/2022, the debt is delinquent for the first day. Therefore, any reference to a debt being a certain number of days delinquent refers to the number of days after the 60-day period, not the number of days from the initial demand letter.*

For purposes of debt selection and referral, any dollar threshold includes both outstanding principal and outstanding interest. See the Medicare Financial Management Manual (CMS Pub. 100-06), Chapter 4.

70.5 – Debt Selection Criteria

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

All outstanding/open delinquent MSP debts shall be reviewed. Debts may be for Part A and/or Part B services and specific to GHP, liability, no-fault, and WC cases. Debts that do not meet all the criteria set forth in Section 70.6 shall be excluded from referral.

NOTE: MSP *C*ontractors 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 the Medicare Financial Management Manual (CMS Pub. 100-06), Chapter 4.

70.6 – Debt Excluded from Referral

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Debts excluded from referral include:

a) Debts in appeal (pending at any level);

b) Debts where the debtor is in bankruptcy or, in the case of an insurance company, in State Ordered liquidation proceedings (See § 80 of this Chapter);

c) Debts under a fraud and abuse investigation, if the MSP *C*ontractor has received specific instructions from the investigating unit (i.e., Office of Inspector General or HHS Office of the General Counsel) not to attempt collection;

d) Debts where the identified debtor received the last demand letter is the employer/ other plan sponsor and the employer/ other plan sponsor is a Federal agency;

e) Debts where the debtor is deceased;

f) Debts where CMS has identified a specific debt or group of debtors as excluded from DCIA referral;

g) Debts where there is a pending written request for a waiver or compromise;

h) Debts less than $25.00 (principal and interest); and

i) 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: In the event the waiver or compromise decision is unfavorable to the debtor, the MSP *C*ontractor shall continue the debts on to debt referral.

NOTE: For debts of $100.00 or less (principal and interest) and having NO TIN, MSP *C*ontractors 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 MSP *C*ontractor 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. MSP *C*ontractors are reminded that the term TIN includes either the Employer Identification Number (EIN) of an entity or *an* SSN (for a beneficiary debtor).

70.7 – Monitoring Debts Excluded *from* the DCIA Referral Process

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors shall monitor and report on debts that were selected for potential referral but met one of the exclusions to the DCIA referral process. MSP *C*ontractors 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). MSP *C*ontractors shall refer a previously excluded debt to Treasury within fifteen (15) calendar days after the date of a status change unless there are instructions to the contrary.

70.8 – Validation of Possible Eligible Debts for Referral

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors are reminded that if one or more of the claims in a specific debt were covered by a MSP GHP settlement, those claims released in the settlement may not be included in the ITR letter and must be handled appropriately.

NOTE: MSP *C*ontractors 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; MSP *C*ontractors 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: The demand shall not have been issued unless insurer information had already confirmed the existence of a duplicate payment.

For ALL Debt types: MSP *C*ontractors shall bring closure (e.g., apply and/ or respond) to all checks related to 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 the TOP.

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

70.9 – Issuance of the ITR to Treasury Letter

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Once MSP *C*ontractors 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 identified debtor (See § 70.3 of this Chapter for identified debtor definition.) MSP *C*ontractors shall send ITR letters via first class mail, return receipt requested, to the identified debtor or joint and several debtor combination.

Use of the ITR letter is mandatory (including the payment summary form and/or claims detail from the original demand letter properly annotated showing payments and/or valid documented defenses).

In the case of a GHP debt the MSP *C*ontractor shall:

a) Send the ITR letter to the identified debtor;

b) Enclose a copy of the payment summary form and/or claims detail with a proper accounting of all services/portion of the debt still owed Medicare; and

c) Provide a courtesy copy to the insurer/ TPA (for other than federal employer situations).

NOTE: When the ITR letter is issued and the amount of the debt has been previously reduced from the original demand letter, MSP *C*ontractors shall appropriately annotate the payment summary form and/or claims detail. 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, the MSP *C*ontractor shall:

a) Send an ITR to the identified debtor. Address the ITR letter to the identified debtor, with a copy to any authorized representative (if applicable). (See section 70.3 of this Chapter for debtor definition); and

b) Enclose a copy of the payment summary form and/or claims detail with a proper accounting of all services/portion of the debt still owed Medicare.

MSP *C*ontractors shall issue a separate ITR letter for each debt, and shall issue a separate ITR letter to each debtor who may be joint and/or severally liable on the debt. Multiple debts may not be aggregated or otherwise combined in a single ITR letter. An ITR letters shall be debt specific.

NOTE: MSP *C*ontractors 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 120 calendar days delinquency.

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

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors that receive a response to an ITR letter that challenges the amount of the debt, shall reply by standard U.S. mail using the appropriate letters. All replies to one of the jointly and severally liable debtors shall also be copied and sent to the non-responding joint and severally liable debtor.

The MSP *C*ontractor 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).

MSP *C*ontractors shall reply to ITR responses (i.e., posed defenses) within 30 calendar days of receipt and update all appropriate systems (including HIGLAS) accordingly and timely.

In the event the response from the debtor or debtors is an actual repayment (either in part or in full), the MSP *C*ontractor 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.

MSP *C*ontractors shall answer all inquiries resulting from the ITR letter. MSP *C*ontractors shall bring closure to all checks or posed defenses to a debt prior to any actual referral of the debt to Treasury for cross-servicing via the HIGLAS system.

NOTE: For debtors that have administrative appeal rights and/or the right to request a waiver of recovery under Section 1870 of the Act, the MSP *C*ontractor 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.

70.11 – MSP Contractor Actions Subsequent to Treasury Referral

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors shall cease active recovery efforts once a debt is referred to Treasury. However, MSP *C*ontractors shall maintain and track debts in HIGLAS. Interest shall continue to accrue on all debts referred to Treasury for cross-servicing. HIGLAS furnishes the MSP *C*ontractor with routine reports of debts transmitted to Treasury as of a certain date.

If Treasury or an entity acting on its behalf (Private Collection Agencies (PCAs) recovers on an MSP debt, notification of the recovery will be sent to the MSP *C*ontractor.

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

70.12 – DCIA Treasury Collection

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Collections from Treasury as a result of cross-servicing efforts are received by CMS through the Intra-governmental Payment and Collection (IPAC) system. Collections may be received as a result of collection efforts by Treasury's Servicing Center or by a Treasury contracted PCA including installment payments on Treasury approved ERS's, or payments from offsets from the TOP. Treasury provides the CMS with a collection report generated from the IPAC system.

70.13 – Intra-governmental Payment and Collection System

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The collection report generated from the IPAC system includes a *breakout* of principal and interest collected on individual debts; however, the report does not show the outstanding balance and the status of the debt after the collection. Due to system limitations, interest on the CMS debts that have been referred to Treasury and its PCAs does not continue to accrue on Treasury/PCA records during the entire collection process. Therefore, the amount of interest collected by Treasury or its PCAs may not equal the amount of interest shown as accrued by the MSP *C*ontractors.

70.14 – Collection/Refund Spreadsheet

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The MSP *C*ontractors will receive Treasury collections twice a month via the HIGLAS Collection Report and/or the Collection/Refund Spreadsheet. The collections are generally forwarded to the MSP *C*ontractors within a week from the date of the IPAC collection.

For each debt listed on the Collection/Refund Spreadsheet, MSP *C*ontractors shall apply the collection to principal and interest amounts as indicated on the Collection/Refund Spreadsheet. For collection of interest only, MSP *C*ontractors shall post the interest as shown on the Collection/Refund Spreadsheet; no interest adjustment is required prior to posting the collection. For collection of principal and interest, if the collection will satisfy the principal debt, MSP *C*ontractors shall manually adjust the amount of interest accrued to the amount of interest collected as listed on the Collection/Refund Spreadsheet. This will make the amount of the accrued interest equal to the amount of interest collected and listed on the Collection/Refund Spreadsheet and allow posting of the collection in MSP *C*ontractor systems, which require collections be applied first to interest accrued and the balance to principal. Once accrued interest is adjusted to the amount of interest collected, MSP *C*ontractors are able to post the amount of principal collected as indicated on the Collection/Refund Spreadsheet.

If a principal balance remains after posting the collection, interest, if appropriate, shall continue to accrue on the remaining principal balance. MSP *C*ontractors shall use the current date as the date of collection to post the Treasury collections to their systems.

MSP *C*ontractors shall complete the Collection/Refund Spreadsheet and return the completed spreadsheet to CMS within 15 business days of receipt.

Note: Any principal balance that remains in MSP *C*ontractor systems, after posting the collection activity, will be carried forward. Interest shall continue to accrue, as applicable, on any outstanding principal balances until notified by CMS that the debt is paid in full or compromised.

70.15 – Debt Paid in Full

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

A debt is generally considered paid in full if applied collections reduce the debt balance, (including both principal and interest, to zero in HIGLAS. If the principal balance of the debt in HIGLAS after the IPAC collection is posted is zero, the status code of the debt will not be systematically changed to a paid in full status.

There have been instances where a debt has been collected by Treasury and the collection received in one IPAC was reversed in a subsequent IPAC.

70.16 – Treasury Approved ERS

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Treasury has authority to approve ERS up to 60 months without requesting CMS approval. The ERS requests in excess of 60 months shall be referred to CMS for approval.

The periodic payments on the approved ERS received by Treasury or its PCAs will be forwarded to CMS on an IPAC collections report along with other collections.

MSP *C*ontractors shall apply each collection to principal and interest, based on the breakout as indicated on the Collection/Refund Spreadsheet and follow Collection/Refund Spreadsheet instructions as outlined in § 70.14 of this Chapter. MSP *C*ontractors shall continue to accrue interest on the remaining principal balance of the debt.

Debts that are in a Treasury approved ERS and not yet classified to CNC shall be reported as current on the Forms CMS H/M 751. Debts in CNC classification shall remain in CNC and continue to be reported as delinquent on the Forms CMS C/MC 751. Debts in CNC classification shall remain in CNC and continue to be reported as delinquent.

70.17 – Excess Collections

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

There may be instances where amounts collected exceed the amount of the debt that was referred for cross servicing/TOP. As an example, an excess collection may result from Treasury and its PCAs receiving a collection and MSP *C*ontractors recouping the same debt by internal withhold, or when a portion of the debt originally referred is reduced due to a partial valid documented defense.

70.18 – Applying an Excess Collection

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors shall apply an appropriate portion of the collection to the debt in order to bring the balance to zero. The Collection/Refund Spreadsheet shall be annotated with the portion of the collection that was posted to the debt. MSP *C*ontractors shall then determine if the debtor has any other outstanding debts, including interest, to which the excess collection may be applied.

70.18.1 – If the Debtor Has Other Outstanding Debt

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If the debtor has other outstanding debt, the excess collection shall then be applied to the oldest active debt first (then next oldest), that has not yet been referred to Treasury. If the only other outstanding debt is currently at Treasury, the excess collection shall then be applied to the oldest debt first. The breakout of principal and interest on the Collection/Refund Spreadsheet does not apply when the excess collection is applied to another outstanding debt. MSP *C*ontractors shall indicate on the Collection/Refund Spreadsheet the action taken and the way the collection was allocated to principal and interest on the other debt, and return the completed spreadsheet to CMS. If the collection is applied to other debt(s), the MSP *C*ontractor shall update HIGLAS. If the excess collection is applied to another debt currently at Treasury, the MSP *C*ontractor shall use HIGLAS update reason code “AD” to post the excess collection to the other debt(s). The MSP *C*ontractor shall annotate HIGLAS with the actions taken regarding the excess collection.

70.18.2 – If the Debtor Has No Other Outstanding Debt

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If there are no other outstanding debts, the excess portion of the collection, after bringing the debt to a zero balance, shall be refunded. The amount of the refund shall be annotated on the Collection/Refund Spreadsheet. If the refund cannot be processed within the timeframe allotted for returning the Collection/Refund Spreadsheet: (1) the MSP *C*ontractor shall annotate the spreadsheet as partially complete, (2) return the spreadsheet to CMS; and 3) CMS may allow additional time for processing the refund. See Medicare Financial Manual, Chapter 4, Section 70.14.8.2. Once the refunds are processed, the completed Collection/Refund Spreadsheet shall be forwarded to CMS. A copy of the Collection/Refund spreadsheet, with annotations regarding the refund, shall be kept in the debtor file for audit trail purposes. The MSP *C*ontractor shall make appropriate adjustments HIGLAS to reflect the refund activity.

70.18.3 – Additional Instructions for MSP Excess Collections

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

If the debtor is an employer, and the payment creating the excess collection on a specific employer debt is made by an Insurer, the Insurer is deemed to be acting as an agent of the employer. If the amount paid exceeds the sum due on the individual debt for which payment was made, the excess monies have to be applied to the same combination of employer/Insurer only. If there is no other outstanding debt for that same combination of Employer/Insurer, the MSP *C*ontractor shall issue a refund.

If an employer has outstanding debts, and the monies were received from that employer, the excess collection can be applied to other debts of the same employer regardless of the employer/insurer combination. If there is no other outstanding debt for that employer, the MSP *C*ontractor shall issue a refund.

70.19 – Disputed Treasury Debts

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors shall update HIGLAS as well as its records when reviewing a valid defense or appeal or request for reopening, either submitted directly to the *MSP C*ontractor by the identified debtor or via a Treasury Action Form (TAF) from Treasury.

If Treasury discovers an error, receives information that establishes a valid dispute or appeal, or receives information that would exclude all or part of a debt from DCIA referral, the MSP *C*ontractors shall receive a TAF along with any supporting documentation.

The TAF is not a resolution of a debt by Treasury; it is a request for the MSP *C*ontractor to review the documentation and provide a decision. The MSP *C*ontractors shall, after review of the TAF and supporting documentation, initiate any required actions including debt recalls or adjustments. MSP *C*ontractors shall update all systems, including HIGLAS, if the decision so warrants within 30 calendar days. MSP *C*ontractors shall notify Treasury of their decision, following the instructions on the TAF.

If an MSP *C*ontractor discovers an error, receives a direct repayment, directly receives information from the debtor establishing a valid documented defense or appeal, or otherwise receives information that would exclude all or part of a debt from DCIA referral, the *MSP C*ontractor shall update HIGLAS with status updates and changes to the dollar amount.

MSP *C*ontractors may receive correspondence stating the insurer or employer has paid the provider/physician or other supplier. In this situation, the *MSP C*ontractor 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 *printouts* on the insurer's letterhead that establish that the insurer in fact paid the provider, physician, or other supplier.)

NOTE: If a debt is recalled/returned from Treasury due to a bankruptcy notification, the *MSP C*ontractor shall follow bankruptcy procedures.

70.20 – Financial Reporting for Collections

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

MSP *C*ontractors shall follow the instructions as outlined in Chapter 5, § 270 of the Medicare Financial Management Manual (CMS Pub. 100-06). The MSP *C*ontractor shall report and post all activities related to MSP debts according to CMS guidelines and instructions.

MSP *C*ontractors shall document all accounting actions taken on any debt, whether the debt is actively being collected by the MSP *C*ontractor or by Treasury/PCA/TOP. MSP *C*ontractors shall follow all applicable financial reporting requirements defined in Chapters 4 and 5 of the Medicare Financial Management Manual (CMS Pub. 100-06) and in § 70 of this Chapter.

70.21 – Accrual of Interest

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Section 1862(b)(2)(B)(i) of the Social Security Act (the Act) and 42 C.F.R. 411.24(m) provide express authority to assess interest on Medicare Secondary Payer (MSP) debts. Interest is calculated as stated in 42 C.F.R. 405.378, and the instructions are found in Pub. 100-06, Chapter 4, Medicare Financial Management Manual. Interest is calculated in full 30-day periods using simple interest method. The U.S. Postal Service postmark date is used to determine the receipt date of the payment.

Interest is calculated for a 30-day period as follows:

- *Principal × applicable Interest Rate = Annual Interest*
- *Annual Interest ÷ 12 = 30-day Interest*

If any payment (partial or full) is received for a delinquent debt (on or after 61 days from the date of demand), it is applied to the interest first, and the remaining balance is applied to the principal.

Example of Interest accrual:

The MSP Contractor issues a demand letter for $1,000 stating that interest will be charged if not paid/resolved within 60 days. Payment is remitted 65 days after the date of demand. Since only two full 30-day periods have passed, interest will be accrued/assessed on the $1,000 for two 30-day periods.

70.21.1 – MSP Debt Interest Accrual

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Interest accrues from the date of the original demand letter but is not "assessed" unless/until the debt becomes delinquent, (i.e., if the debt is not fully resolved or paid within 60 days from the date of demand, it becomes delinquent on day 61). If payment is received within the timeframe specified in the recovery demand letter, no interest will be due or assessed. If payment is not received when due, interest is assessed on the outstanding principal amount from the date of the initial recovery demand letter for each full 30-day period. 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.

70.21.2 – MSP Debt Interest Accrual on Partial Payments
(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

For situations where partial payment is received on a debt with outstanding interest, the payment is normally credited to interest first and principal second, leaving an outstanding amount of principal due, or in some situations, leaving both principal and interest due if the partial payment is insufficient to satisfy the outstanding interest amount.

Example of Interest Accrual After Partial Payment:

The MSP Contractor issues a demand letter for $1,000 and receives a partial payment of $500 dollars 65 days after the date of demand. The payment is applied to the interest accrued on $1,000 for 2 full 30-day periods first, then the remaining balance is applied to the principal. The outstanding principal will continue to accrue interest. Interest for an additional 30-day period for the principal balance would be due on day 91 (the day after the end of a current 30-day period), as additional interest is due only after each full 30-day period for that portion of unpaid/unresolved principal.

70.21.3 – Additional Rules with Regard to the Assessment and Collection of Interest for MSP-based Debts
(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

• Interest must be charged on all MSP debts except for the debts where the identified debtor is a Federal entity.

• Interest charged is simple interest, not compound interest. CMS does not charge interest on any outstanding interest. Interest accrues only on unpaid principal amounts.

• When compromising an MSP debt, CMS's primary concern is protection of the Trust Funds. When CMS compromises a debt, the policy is to compromise interest first and principal second; otherwise, compromises would often be of little or no benefit to the Trust Funds. The only exception to this policy would be if a compromise agreement specifically allocates the amount to be repaid in some other manner. The amount compromised is written off. Two examples of the correct application of payment received from the debtor when CMS has notified the MSP Contractor of a compromise agreement include:

- *Assume there is an AR with principal due of $1000, interest due of $200 as of the date of receipt of payment, and CMS has agreed to compromise for $700. When the payment of $700 is received, the end result must be: $200 interest written off, $300 principal written off, and the $700 payment applied to principal.*
- *Assume there is an AR with principal due of $2000, interest due of $1000 as of the date of receipt of payment, and CMS has agreed to compromise for $2200. When the payment of $2200 is received, the end result must be: $800 interest written off, $200 of the payment applied to interest, and $2000 of the payment applied to principal.*

As long as the agreed upon compromise amount is paid within the time frame specified by the RO, any interest accrued after the date of the compromise agreement is written off closed as bad debt.

NOTE: MSP Contractors may not take write-off closed actions for the compromised ("forgiven") portions of a debt until payment for the remaining portion of the debt has been received. MSP Contractors shall maintain the compromise instructions from CMS to support the associated write-off closed action(s) for principal and/or interest.

NOTE: MSP Contractors will be notified by CMS when Treasury has compromised a debt and instructed as to how the compromise portion of the debt shall be shown on the financial statements.

• Where the principal amount of the debt is adjusted downward due to a valid documented defense or a waiver of recovery under section 1870 of the Social Security Act, the interest amount must be re-calculated based upon the remaining principal. If an MSP Contractor's system does not automatically perform this function when the principal is adjusted, then the MSP Contractor must do this manually and enter an appropriate downward adjustment to the associated interest. (Decisions for waiver of recovery under section 1870 of the Act are decisions with regard to the principal amount of the debt. For any amount of principal waived under section 1870, the associated interest ceases to exist and must be adjusted downward accordingly.)

• MSP Contractors may receive a request for a "waiver of interest." This issue is not within MSP 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 CMS with a copy of the case file. CMS will review any such requests. When CMS makes a decision, it will communicate the decision to the MSP Contractors. The MSP Contractors shall take all actions necessary to implement the decision and update all appropriate records and systems.

MSP Contractors shall not refer requests for waiver of interest on cases in which the debtor has supplied to the MSP 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.

• Where an MSP Contractor is informed by CMS that CMS has waived some or all of the interest on a particular debt, the MSP Contractor must perform an adjustment for the amount of the waived interest before applying any payment. A waiver of interest is recorded as an adjustment.

Waiver of interest requests should be rare. If such a request is received, the request must state the basis for the request.

• MSP Contractors are reminded that where a beneficiary establishes that he/she did not receive settlement/judgment/award funds until after the issuance of the recovery demand letter, no interest is due until 60 days from his/her receipt of such funds. Receipt of such funds by the beneficiary or his/her representative constitutes receipt by the beneficiary. In such situations the MSP Contractor must adjust off any interest showing as owed within the MSP Contractor financial tracking systems for the period prior to 60 days from receipt of the funds. Such an adjustment is not a waiver of interest and shall not be treated as a waiver of interest and forwarded to the RO.

MSP Contractors are furnished with the applicable interest rates on a regular basis through a separate notification.

80.7– Notice of Bankruptcy/Liquidation

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Upon notice that DOJ and/or HHS OGC is pursuing a bankruptcy claim on behalf of Medicare, the MSP Contractor will gather information regarding debts where demand letters have been sent, and for cases where the entity in bankruptcy/liquidation is involved (e.g., as the WC or liability insurer), but demands have not yet been sent. All due dates will be specified in CMS's e-mail requests.

CMS anticipates that DOJ/HHS OGC may periodically request updates and additional information and will try to get as much time as possible for ROs and *MSP C*ontractors to gather and report such updated information.

If a*n* MSP *C*ontractor receives notification of a bankruptcy/liquidation or potential bankruptcy/liquidation situation from other than CMS, MSP *C*ontractors must report any bankruptcy/liquidation information immediately to CMS. MSP *C*ontractors are responsible to ensure that CMS is made aware of all non-provider, physician, or other supplier bankruptcy/liquidation notifications received by the MSP *C*ontractor.

When the MSP *C*ontractor receives a defense to an MSP recovery demand letter and the entity in bankruptcy/liquidation is the debtor (as opposed to the debtor's insurer, for example), the MSP *C*ontractor shall determine if the bankruptcy/liquidation is already known to CMS. If it has been previously identified, the MSP *C*ontractor shall follow prior guidance.

Reminder: The RO that has jurisdiction for the state in which the debtor/entity files bankruptcy usually is the designated lead. MSP *C*ontractors will be notified of any exceptions as they occur.

The MSP *C*ontractor will update and maintain a list of known bankrupt debtors and liquidated debtors.

80.8 – MSP Contractor Role in Bankruptcy/Liquidation

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The MSP *C*ontractor shall identify all MSP debts/cases/ARs specific to the bankruptcy/liquidation debtor/entity.

Reminder: If during the course of other business, the MSP *C*ontractor identifies additional debts/cases/ARs for a debtor/entity on a pending bankruptcy or adjudged bankruptcy, the MSP *C*ontractor shall take appropriate action with respect to the debt. As questions arise for a particular case, the *MSP C*ontractor shall refer such questions to the CMS.

If the bankruptcy/liquidation had not been previously identified, the MSP *C*ontractor shall take the following actions:

a) The MSP *C*ontractor shall request a copy of the petition for bankruptcy/liquidation from the debtor/entity.

b) If the MSP *C*ontractor does not receive a copy of the filing, the *MSP C*ontractor shall notify the debtor that the posed defense is not valid and the proper documentation must be submitted.

c) When the proper bankruptcy documentation is received, the MSP *C*ontractor shall update all internal systems (including HIGLAS) and financial reports with the bankruptcy status.

NOTE: Please note that the term "defense" here does not invalidate the debt but merely refers to a defense to Treasury referral and our active pursuit of recovery through other venues other than the bankruptcy court. Also note that in no way does the bankruptcy notice alleviate the debtor of its responsibility to repay Medicare. All debts for pending bankrupt debtors remain open on the MSP *C*ontractor's systems and financial reports.

d) MSP *C*ontractors shall cease new MSP recovery demand letters to the bankrupt debtor.

e) MSP *C*ontractors shall identify all existing open debts/ARs for that specific debtor. Do not refer any new debts to Treasury.

f) MSP *C*ontractors shall recall any debts that were previously referred to Treasury for that specific debtor.

g) MSP *C*ontractors shall report the debts on its financial statements within the appropriate bankruptcy detail line of the Form CMS-751 reports.

NOTE: When a bankruptcy notification is received from Treasury, via a Treasury Action Form, at CMS, CMS will update HIGLAS to reflect the bankruptcy status. CMS will send the information back to the MSP *C*ontractor.

REMINDER: The MSP *C*ontractor does not need to send a recall to Treasury; all updates to HIGLAS are automatically referred to Treasury.

NOTE: When a debtor/entity that is in Chapter 7 converts to Chapter 11 (an unusual occurrence), MSP *C*ontractors must contact CMS for further instructions.

NOTE: In the event that a*n* MSP *C*ontractor has or receives notice of Chapter 13 bankruptcy, the MSP *C*ontractor shall work with their RO and the HHS OGC for their region (There are many factors to be considered).

NOTE: In the case of State Ordered Liquidation, MSP *C*ontractor shall consult with your RO and the HHS OGC for your region before proceeding further.

NOTE: Once the bankruptcy has been finalized, consult with CMS before proceeding further.

80.9 – Discharge of Bankruptcy/Liquidation Debts

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Debts involved in a pending bankruptcy/liquidation cannot be recommended or approved for Write-off/Closed. Debts that are discharged/forgiven by a U.S. Bankruptcy Court/State Court are to be recommended for Write-off/Closed on the next quarter's Write-off/Closed report. If there are questions about the documentation requirements regarding discharge, the MSP *C*ontractor must obtain advice from CMS.

80.10 – Actions Dismissed by the U.S. Bankruptcy Court

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

Occasionally, the U.S. Bankruptcy Court dismisses a bankruptcy action because the debtor does not qualify for bankruptcy or for some other reason. When there is a dismissal, with the advice of regional counsel, the RO and MSP *C*ontractor can usually treat the case as if the bankruptcy action never occurred and continue the normal recovery process.

80.11 – Appeals Requests Citing Bankruptcy Defense

(Rev. 12438; Issued: 01-04-24; Effective: 02-06-24; Implementation: 02-06-24)

The MSP *C*ontractor shall refer all appeal requests with a bankruptcy defense to the CMS RO that has been designated to review bankruptcy matters; the MSP *C*ontractor can obtain the appropriate RO bankruptcy contact from its local RO.