

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13825	Date: June 11, 2026
	Change Request 14418

SUBJECT: Updates to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayments, Section 140-140.8.4 - Bankruptcy

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 3, Bankruptcy, Sections 140-140.8.4. This section outlines the required actions that contractors must implement to safeguard the Medicare Trust Fund when a provider files for bankruptcy. Bankruptcy law and the bankruptcy court affect all the actions the Centers for Medicare & Medicaid Services (CMS) and its Contractors take concerning a bankrupt Medicare provider.

EFFECTIVE DATE: July 13, 2026

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

IMPLEMENTATION DATE: July 13, 2026

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

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/Table of Contents
R	3/140/Bankruptcy
R	3/140/1/Bankruptcy Forms
R	3/140/2/Basic Bankruptcy Terms and Definitions
R	3/140/2/1/Bankruptcy is Litigation
R	3/140/2/2/Types of Bankruptcies
R	3/140/2/3/Filing Bankruptcy Draws a Line in the Sand
R	3/140/2/4/Bankruptcy Affects Nearly All Medicare Operations
R	3/140/2/5/Recoupment and Set-off (see also §140.6.4)
R	3/140/2/6/Time is of the Essence
D	3/140/2/7/Definitions
R	3/140/3/Contractors Establishment of Relationships to Ensure Effective Actions Regarding Providers in Bankruptcy
R	3/140/3/1/Contractor Staff Must Establish Relationships to Ensure That the CMS Office and CMS Counsel Receive Prompt Notice of Provider Bankruptcies, so That Medicare Can Take Quick Action
R	3/140/3/2/Contractors Must Recognize and Advise CMS Staff About Potential Provider Bankruptcies
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R	3/140/4/1/Establish Effective Lines of Communications
R	3/140/4/2/Respond to the CMS Office Requests for Information
R	3/140/4/3/Immediate Contractor Directives from the CMS Office
R	3/140/4/4/Tracking Debts/CMS Communications
R	3/140/5/1/Chain Providers
R	3/140/5/2/Single Provider Serviced by a Contractor
R	3/140/6/1/Working With the CMS Office and CMS Counsel
R	3/140/6/2/Assumption of the Medicare Provider Agreement
R	3/140/6/3/ Settlement Agreements or Stipulations
R	3/140/6/4/Recoupment

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/140/6/5/Administrative Freeze/Set-off
R	3/140/7/Preparing and Filing Proof of Claim
R	3/140/8/2/Debt Located at the Department of Treasury
R	3/140/8/3/Managing Bankruptcy Debt at the Contractor
N	3/140/8/4/Closure of Bankruptcy Cases and Treatment of Overpayment Reporting Systems at End of Bankruptcy

III. FUNDING:

For Medicare Administrative Contractors (MACs):

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

IV. ATTACHMENTS:

**Business Requirements
Manual Instruction**

Attachment - Business Requirements

Pub. 100-06	Transmittal: 13825	Date: June 11, 2026	Change Request: 14418
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SUBJECT: Updates to the Internet Only Manual, Publication 100-06, Chapter 3, Overpayments, Section 140-140.8.4 - Bankruptcy

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I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 3, Bankruptcy, Sections 140-140.8.4. This section outlines the required actions that contractors must implement to safeguard the Medicare Trust Fund when a provider files for bankruptcy. Bankruptcy law and the bankruptcy court affect all the actions the Centers for Medicare & Medicaid Services (CMS) and its Contractors take concerning a bankrupt Medicare provider.

II. GENERAL INFORMATION

A. Background: This chapter will guide Contractor staff through the initial stages of a provider bankruptcy. Bankruptcy law and the bankruptcy court affect all the actions CMS and its Contractors take concerning a bankrupt Medicare provider. An individual or company declares bankruptcy by filing a petition for bankruptcy in the United States Bankruptcy Court. The Bankruptcy Court then opens a bankruptcy case. The Bankruptcy Court closely monitors the affairs of the individual or company (the debtor), including the creditors' treatment of the debtor.

B. Policy: Medicare policy is to protect the interests of the Medicare Trust Funds while complying with applicable provisions of the U.S. Bankruptcy Code. The filing of a bankruptcy petition by a Medicare provider or supplier does not, by itself, relieve the provider or supplier of its obligations under the Medicare program.

Medicare payments, overpayments, and other program-related debts are subject to applicable bankruptcy laws and court orders. CMS and its Contractors must ensure that actions taken with respect to providers or suppliers in bankruptcy are consistent with the automatic stay, discharge provisions, and other requirements of the Bankruptcy Code, as interpreted by applicable law.

III. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
14418.1	Contractors shall do the following upon receipt of a bankruptcy notice.	X	X	X	X					CM S
14418.1.1	Contractors shall send the bankruptcy notice to the OPOLE IFM Bankruptcy mailbox at OPOLE IFM Bankruptcy@cms.h	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
	hs.gov for review.									
14418.1.2	Contractors shall provide a Bankruptcy Referral Checklist for the bankrupt provider/s.	X	X	X	X					
14418.1.2.1	<p>Contractors shall utilize the Bankruptcy Referral Checklist which consists of two (2) tiers, each designed to gather the bankruptcy information within a reasonable timeframe.</p> <ul style="list-style-type: none"> • Tier I - Information shall be submitted to the CMS Office within ten (10) business days of receipt of the CMS instructions regarding the bankruptcy notification. If the CPI Fraud Check results have not been received within ten (10) business days, the Contractor shall submit the Tier I checklist with all required information and indicate that the CPI Fraud Check results are pending. The Contractor shall forward the CPI Fraud Check results to the CMS Office immediately upon request. • Tier II - Information shall be submitted to the CMS upon request. 	X	X	X	X					
14418.2	Contractors are no longer required to submit notices of program reimbursement (NPRs) or revised NPRs to the CMS Office for review and approval when dealing with bankrupt providers. However, if the CMS Office determines that a bankruptcy case is unique or exceptional, it may require the Contractor to submit NPRs or revised NPRs for the CMS Office's review and approval prior to issuance to the	X		X						

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
	provider.									
14418.3	Contractors shall send information regarding an imminent provider/s bankruptcy to the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hs.gov and follow Section 140.1 – Bankruptcy Forms.	X	X	X	X					
14418.4	Contractors shall notify the servicing CMS Office of any new bankruptcy notices not flagged in systems as bankrupt. The CMS point of contact will consolidate information and manage, report, and coordinate ongoing communication and activities among the appropriate parties involved (e.g., Contractors, other CMS Offices, Chief Counsels, and CO) regarding bankruptcies. The CMS Office will communicate the name, phone number, fax and e-mail address of the CMS Office point of contact in writing or via email to the assigned CMS Counsel, and respective Contractors.	X	X	X	X					
14418.5	Contractors shall immediately inform the OPOLE IFM Bankruptcy team via email at OPOLE_IFM_Bankruptcy@cms.hs.gov , upon becoming aware that a provider has filed for bankruptcy within two (2) business days.	X	X	X	X					
14418.6	Contractors shall suspend payments if the provider does not timely file a cost report, unless the CMS Office or CMS Counsel contacts the Contractor that suspension is not appropriate due to other circumstances requiring further review.	X		X						
14418.7	Contractors shall post these adjustments to the Contractors' internal systems and to the Healthcare Integrated General	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
	Ledger Accounting System (HIGLAS).									
14418.7.1	Contractors shall post the adjustments to the Treasury Report on Receivables (TROR).	X	X	X	X					
14418.8	The servicing CMS Office shall instruct the Contractor to update the provider in bankruptcy status in HIGLAS and whether recoupment of overpayments is permitted or not permitted.	X	X	X	X					CM S
14418.8.1	Contractors shall allow for recoupment or netting of overpayments if recoupment of overpayments is permitted,	X	X	X	X					
14418.8.2	Contractors shall not allow recoupment or netting of overpayments, if recoupment of overpayments is not permitted.	X	X	X	X					
14418.8.3	Contractors shall ensure that the System for Tracking Audit and Reimbursement (STAR) is updated with the effective date of the bankruptcy, if the bankrupt provider participates in the Medicare program under Part A.	X		X						
14418.9	Contractors shall recall the debt from Treasury as debts in bankruptcy status are ineligible for cross servicing and offset.	X	X	X	X					
14418.10	Debts for unfiled cost reports are not reported on the TROR. Therefore, if these debts become "bankrupt," the Contractors shall record no transactions on these forms.	X		X						
14418.11	Contractors shall discuss with the CMS Office or CMS Counsel whether it should put payments in an administrative freeze (a holding account) until Medicare has time to	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DM E MA C	Shared-System Maintainers				Oth er
		A	B	HH H		FIS S	MC S	VM S	CW F	
	assess its position in the bankruptcy.									
14418.12	Contractors shall not initiate new withholding or discontinue withholding without the CMS Office or CMS Counsel approval.	X	X	X	X					
14418.13	Contractors shall research and rectify the issue when a provider has a bankruptcy in a hold status, in the Accounts Payable (AP) module but no bankruptcy status in the AR module.	X	X	X	X					
14418.14	Contractors shall ensure that their internal processing systems and financial reports no longer reflect the case as one under bankruptcy, and interest should be reassessed upon termination of the case.	X	X	X	X					
14418.15	Contractors shall update the AR Status for Treasury-eligible debts, to 'RESUME-COL-BNK-TERMINATED' on transactions emerging from bankruptcy.	X	X	X	X					
14418.16	Contractors shall update STAR, for providers classified under Part A, to reflect the bankruptcy termination date.	X		X						

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

VI. CONTACTS

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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

ATTACHMENTS: 1

Medicare Financial Management Manual

Chapter 3 - Overpayments

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 - 140.3.1 - Contractor Staff Must Establish Relationships to Ensure That the *CMS Office* and *CMS* Counsel Receive Prompt Notice of Provider Bankruptcies, so That Medicare Can Take Quick Action
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 - 140.4.1 - *Establish Effective Lines of Communications*
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 - 140.6.4 - *Recoupment*
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 - 140.7 - Preparing *and* Filing Proof of Claim
 - 140.8 - *Reserved for Future*
 - 140.8.1 - *Reserved for Future*
 - 140.8.2 - Debt Located at *the Department of Treasury*

140.8.3 - Managing Bankruptcy Debt at the *Contractor*

140.8.4 - Closure of Bankruptcy Cases and Treatment of Overpayment Reporting Systems at End of Bankruptcy

140 – Bankruptcy

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

This section *outlines the required* actions that *Contractors* must *implement* to safeguard the Medicare Trust Fund when a provider files for bankruptcy. *Although* the term "provider" *is used throughout this chapter for consistency, these provisions are equally applicable to suppliers and physicians.* However, use of the term "provider" does not *imply* that the Medicare program *classifies* suppliers and physicians *as providers under its definitions.* *The section* also explains how to *accurately* report the Centers for Medicare & Medicaid Services' (CMS) accounts receivable balances and support CMS's efforts *in* effectively *evaluating* and *managing* bankruptcy cases. *This section does not address bankruptcy issues related to debts arising under the Medicare Secondary Payer (MSP) provisions.*

This chapter will guide *Contractor* staff through the initial stages of a provider bankruptcy. It is not intended to be, and cannot *serve as*, a *step-by-step* process from beginning to end. **Bankruptcy is litigation.** Bankruptcy law and the bankruptcy court affect all the actions *CMS*, and its *Contractors* take concerning a bankrupt Medicare provider. Therefore, *Contractor* staff shall consult closely with the *servicing CMS Office or CMS Counsel.* In some cases, attorneys from the Department of Justice (DOJ) in Washington, D.C. or *the* United States Attorney's *Offices* will work directly with *CMS.* However, in most cases, *the servicing CMS Office* will be in contact with *the assigned CMS Counsel.*

140.1 - Bankruptcy Forms

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Upon receipt of a bankruptcy notice, Contractors shall do the following:

1. *Upon receipt of a bankruptcy notice, Contractors shall send the bankruptcy notice to the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov for review and place the provider in a bankruptcy status in the Health Integrated General Ledger Accounting System (HIGLAS).*
2. *The servicing CMS Office will review the bankruptcy notice and seek legal advice, if appropriate.*
3. *The CMS Office will contact the Contractor/s, via e-mail, that services the bankrupt provider/s and provide detailed instructions on the proper handling of the provider/s in the HIGLAS and the System for Tracking Audit & Reimbursement (STAR), if applicable.*
4. *The Contractor shall provide a Bankruptcy Referral Checklist for the bankrupt provider/s.*
5. *The Bankruptcy Referral Checklist is now divided into two (2) tiers, each designed to gather the bankruptcy information within a reasonable timeframe.*
 - *Tier I - Information shall be submitted to the CMS Office within ten (10) business days of receipt of the CMS instructions regarding the bankruptcy notification. If the CPI Fraud Check results have not been received within the ten (10) business days, the Contractor shall submit the Tier I checklist with all required information and indicate that the CPI Fraud Check results are pending. The Contractor shall forward the CPI Fraud Check results to the CMS Office immediately upon receipt.*
 - *Tier II - Information shall be submitted to the CMS Office upon request.*

Exhibit 1 provides the required information to be submitted for Tier 1 and Exhibit 2 provides examples of required information for Tier II.

Exhibit 1

Bankruptcy Referral Checklist Tier I

(Submit to the CMS Office as an Excel file, via e-mail, within ten business days from receipt of the CMS Office's instructions)

<u>Description</u>	<u>MAC Response</u>	<u>MAC Comments</u>
<i>BNK Case Number</i>		
<i>Bankruptcy Court</i>		
<i>Petition Date</i>		
<i>Provider Name</i>		
<i>Provider Number (s)</i>		
<i>Provider Tax ID Number</i>		
<i>Any Claims Under Appeal (Y/N)?</i>		
<i>Any Overpayments in Appeal Status (Y/N)?</i>		
<i>Open Cost Reports (Y/N or N/A)? (Part A Only)</i>		
<i>Year & Status of Open Cost Reports? (Part A Only)</i>		
<i>Pending Cost Reporting Years in Appeal? (Part A Only)</i>		
<i>Pending Cost Report Reopening(s) (Y/N)? (Part A Only)</i>		
<i>Any Fraud Overpayments or Investigations (Y/N)? ¹</i>		
<i>Date of Fraud Cases, if applicable</i>		
<i>Evidence of a Recent or Pending CHOW (Y/N)?</i>		

¹ Fraud Check Report Request Instructions

1. The **Contractor** shall email its fraud check request spreadsheet along with a completed CPI data request form (Attachment #1) to CPIFraudcheck-OFMDebt@cms.hhs.gov with the subject line "**Contractor**/Jurisdiction Fraud Check Request" (example – ABC/J2 Fraud Check Request).
2. The **Contractor** should expect to receive the fraud check report from CPI within one week of sending the fraud check request to CPI. The **Contractor** shall use the fraud check report to determine if the provider/supplier has an open fraud case.

The **Contractor** shall include a copy of CPI's completed fraud check report for the NPIs that are included in the Bankruptcy on the checklist spreadsheet Tier I that is sent to **CMS**.

*Note: The CPI Fraud check applies to bankrupt providers with NPI's. Bankrupt providers with no NPI's should follow the current process of checking for fraud.

Attachment #1 – Sample Fraud Check Request Form

Data Request Form

To request a fraud check report from CPI Unified Case Management (UCM) system, please complete and submit this form **one week before the desired delivery date** to CPIFraudcheck-OFMDebt@cms.hhs.gov.



Requestor Information			
Requester:		Component/Contractor	
Phone Number:		Date:	
Email Address:		Desired Date:	
Frequency :	<i>One time request</i>		

Data Request Information	
Summary	Contractor is requesting fraud checks for the National Provider Identifiers that are included on the attached spreadsheet(s).
Description	Fraud checks are required for providers/suppliers who have Medicare debts that are being reviewed for potential termination of collection. If it is determined that the provider/supplier has an open fraud case, its debts will not be eligible for termination of collection.
Business Need	See description.
Comments	

Exhibit 2

Bankruptcy Referral Checklist Tier II

(Submit to the CMS Office upon request, via email)

Examples:

Provider Participating in Medicaid program?

Provide copies of Demand Letters or Intent to Refer Letters

Provide copies of ERS approval or Denial Letters

Other Documents upon request such as provider agreements, surety bond letters, expected completion of cost report settlement, appeal outcomes, etc.

Referral Checklist Instructions for Tier I:

Category	Data Element	Instruction	Example
Tier I	Bankruptcy Case Number	Prescribed format for this field is Court Abbreviation + BNK Case Number	TNMBKE-19-12345
Tier I	Bankruptcy Court	Court State and Region (if applicable)	Tennessee Middle
Tier I	Petition Date	Date Petition Filed in US Bankruptcy Court	01/01/2019
Tier I	Provider Name		
Tier I	Provider Number (s)	HIGLAS Provider or Supplier Number	12-3456
Tier I	Provider Tax ID Number		12-3456789
Tier I	Any Claims Under Appeal (Y/N)		
Tier I	Any Overpayments in Appeal Status (Y/N)	If Yes, provide stage of Appeal (Ex: Reconsideration)	
Tier I	Open Cost Reports (Y/N or N/A)? (Part A Only)	If not Part A workload, list N/A	
Tier I	Year & Status of Open Cost Reports? (Part A Only)	If not Part A workload, list N/A	
Tier I	Cost Reporting Years in Appeal (Part A Only)	If not Part A workload, list N/A	

Tier I	Pending Cost Report Reopening(s) (Y/N)? (Part A Only)		
Tier I	Any Fraud Overpayments or Investigations (Y/N)?	CPI Fraud Check Request	
Tier I	Date of fraud cases, if applicable	CPI Fraud Check Request	
Tier I	Evidence of a Recent or Pending CHOW (Y/N)?	Recent = Within a year of the Petition Date	

140.2 - Basic Bankruptcy Terms and Definitions

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

The definitions below are generally accepted. Jurisdictional bankruptcy rules may impact the interpretation of these terms. CMS Counsel's guidance takes precedence over definitions listed below.

***Adversary Proceeding** is litigation in bankruptcy court to recover money or property; determine the validity, priority or ranking of an interest in property; get approval for selling an estate's property interest; revoke a discharge or an order of confirmation; and obtain declaratory judgments related to matters of the bankruptcy estate. Litigation against the CMS to turn over recouped monies is an example of an adversary proceeding.*

***Affirmative Recovery Actions** is the debtor's assumption of its executory contract (its provider agreement).*

***Automatic Stay** is an injunction that automatically springs into effect concurrently with the filing of the bankruptcy petition. The automatic stay protects the assets of the estate from lawsuits, foreclosures, garnishments, and any other collection activities that are not specifically exempt from the stay by statute or specifically approved by the bankruptcy court. The automatic stay applies to Medicare overpayment letters that demand repayment, assess interest or otherwise attempt to gain possession of property of the bankruptcy estate.*

***Bankruptcy Trustee** is a private individual or corporation appointed to represent the interests of the bankruptcy estate and the debtor's creditors.*

***Bar Date** is the deadline for filing a proof of claim. In general, the bar date for government agencies such as the CMS is 180 days after the date of the order for relief (usually, the date the provider files for bankruptcy). In some bankruptcies, however, the court may set a different date.*

***Claim** is the creditor's right to payment or equitable relief creating a right to payment from a debtor or the debtor's property whether that right is reduced to judgment, liquidated, unliquidated, fixed, contingent, matured, unmatured, disputed, undisputed, legal, equitable, secured or unsecured. The date a claim arises determines whether it is pre-petition or post-petition. In Medicare, the date of service is the date of the claim.*

***Confirmation** is bankruptcy court approval of a plan of reorganization.*

***Contingent Claim** is a claim that may be owed by the debtor under certain circumstances, for example, where the debtor is a co-signer on another person's loan and that person has not yet defaulted but may fail to pay.*

***Creditor** is a person or a business to which the debtor owes money, or which claims to be owed money by the debtor.*

***Debtor** is a person or business who has filed a bankruptcy petition.*

Discharge is a release of a debtor from liability for certain dischargeable debts. It prevents the creditors that are owed those debts from taking any action to collect those debts from the debtor or the debtor's property. Prohibited actions include making telephone calls, sending letters, and having contact that is intended to induce the debtor to pay the debt.

Dischargeable Debt is a debt for which the Bankruptcy Code allows the debtor's personal liability to be eliminated.

Dismiss does not release a debtor from liability on any debts. It does not prevent creditors that are owed those debts from taking appropriate action to collect those debts from the debtor or the debtor's property. When a case is dismissed, it is as if the debtor never filed. Therefore, you may proceed with actions that include making telephone calls, sending demand letters, and having contact that is intended to induce the debtor to pay the debt.

Estate is the name for the Debtor's property interests overseen by the bankruptcy court. Filing a petition in bankruptcy creates an estate consisting of all legal and equitable interests the Debtor has. In general, a legal interest is direct ownership of property. In contrast, an equitable interest typically is indirect and may require court involvement to obtain control or exercise the property rights.

Executory Contract is a contract under which the parties to an agreement have duties remaining to be performed. A Medicare Part A provider agreement is treated as an executory contract.

Exemption is property that the Bankruptcy Code or applicable State law permits a debtor to keep from creditors.

Fraudulent Transfer is a known and fraudulent transfer or concealment of property by the debtor with the intent to defeat the provisions of the Bankruptcy Code.

Lien is a recorded claim upon specific property to secure payment of a specific debt or performance of an obligation. Medicare does not have a lien on overpayments.

Liquidation is the conversion of the debtor's property into cash with the proceeds to be used for the benefit of creditors.

Liquidated Claim is a creditor's claim for a fixed amount of money.

Motion to Lift the Automatic Stay is a request by a creditor to allow the creditor to take an action against a debtor or the debtor's property that would otherwise be prohibited by the automatic stay.

Non-Dischargeable Debt is a debt that cannot be eliminated in bankruptcy. Overpayments resulting from fraud are non-dischargeable. A complaint to determine discharge ability must be filed in the bankruptcy court. See Adversarial Proceeding, above.

Plan of Reorganization is a debtor's detailed description of how the debtor proposes to pay creditors' claims over a fixed period of time.

Priority is the Bankruptcy Code's statutory ranking of unsecured claims. It determines the order in which unsecured claims will be paid if there is not enough money to pay all unsecured claims in full.

Priority Claim is an unsecured claim that is entitled to be paid ahead of other unsecured claims that are not entitled to priority status. Administrative expenses for preserving the estate (e.g., certain accounting fees or post-petition Medicare overpayments) are considered priority claims.

Secured Debt is a debt backed by a mortgage, pledged collateral, or another lien. The creditor that has a secured debt has the right to pursue specific pledged property upon default. See lien above.

Schedule is a list submitted by the debtor along with the petition (or shortly thereafter) showing the debtor's assets, liabilities, and other financial information. (There are official forms a debtor must use.)

Settlement Agreement is an agreement settling a dispute between two or more parties.

Stipulation is an agreement between parties respecting the conduct of legal proceedings approved by the Bankruptcy Court. With appropriate approval, Medicare may enter into a stipulation agreement to facilitate a change of ownership or to resolve an overpayment earlier than could be expected by litigation.

United States Trustee is an officer of the Department of Justice responsible for supervising the administration of bankruptcy cases, estates, and trustees, monitoring plans and disclosure statements, monitoring creditors' committees, monitoring fee applications, and performing other statutory duties.

Unsecured debt is one that is not backed by property or collateral. Medicare claims are generally unsecured.

140.2.1 - Bankruptcy is Litigation

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

An individual or company declares bankruptcy by filing a petition for bankruptcy in a United States Bankruptcy Court. The Bankruptcy Court then opens a bankruptcy case. The Bankruptcy Court closely monitors the affairs of the individual or company (the debtor) including the creditors' treatment of the debtor. Bankruptcy may appear to be "business as usual" for a debtor, **but it is not.** *Upon receipt of a bankruptcy notice, Contractors must place the provider in a bankruptcy status in HIGLAS and refer the case to the CMS Office. Contractors* should not take **any further action** against a debtor until *they* consult the *servicing CMS Office* who will consult with the *CMS Counsel assigned* the bankruptcy. Do not share any information about bankruptcy *strategies* or activities with the bankrupt provider.

140.2.2 - Types of Bankruptcies

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Title 11 of the United States Code (the Bankruptcy Code) identifies four types of bankruptcies that may involve Medicare providers: Chapter 7, 9, 11 and 13. We briefly describe each type here to familiarize *the Contractor* with these types of bankruptcy. However, these general descriptions do not replace your attorney's specific advice in a particular bankruptcy case.

- 1. Chapter 7** - Debtors file Chapter 7 bankruptcies to obtain discharge of their debts. Companies that file under Chapter 7 generally close. A court-appointed trustee accumulates the assets of the debtor, sells them, and distributes the money among those whom the debtor owes (the creditors).
- 2. Chapter 9** - Chapter 9 bankruptcies involve municipalities, *including entities such as hospital districts. In a Chapter 9 case, the municipal entity itself – rather than the individual hospitals it operates – is eligible for bankruptcy relief. Chapter 9* provides for reorganization, much like Chapter 11.
- 3. Chapter 11** - Debtors file Chapter 11 to reorganize *a business or, in some cases, an individual's financial affairs.* To emerge from Chapter 11, the debtor in possession submits a Plan of Reorganization ("Plan"), *which specifies* the amount and schedule *of* payments to creditors. Creditors *whose claims are impaired under the Plan are entitled to vote on it, while creditors whose claims are unimpaired are deemed to accept the Plan. The Bankruptcy* Court must confirm *the Plan before it becomes effective.* Recovery amounts vary, *and once the Plan is confirmed, the* Bankruptcy Code provides for discharge of the *remaining debt, subject to certain exceptions.*

- 4. Chapter 13** - Chapter 13 bankruptcies *allow individuals* (including sole proprietorships) with regular income *to adjust their debts.* Generally, debtors must file a *repayment* plan within 15 days after filing *the*

petition. The Chapter 13 plan typically extends over a period of three to five years, during which the debtor makes regular payments to a trustee for distribution to creditors.

140.2.3 - Filing Bankruptcy Draws a Line in the Sand

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

The petition date (i.e., the date the debtor files its petition in bankruptcy with the Bankruptcy Court) draws a line in the sand between pre-petition and *post-petition* actions. Events that occur before the petition date are pre-petition. Events that occur on or after the petition date are *post-petition*. The automatic stay governs many actions that *Contractors* may take concerning a debtor *post-petition*. *Contractors* shall therefore consult with the *servicing CMS Office* before taking action, concerning the debtor *post-petition*.

Medicare's right to recover overpayments *in a bankruptcy* case *can* depend on whether the *overpayment relates to* pre-petition or *post-petition periods*. The *CMS Office directs its Contractors on the procedures for recovering both* pre-petition *and post-petition overpayments to ensure that Medicare maximizes its recovery in accordance with the Bankruptcy Code. The distinction between pre-petition and post-petition overpayments is based on the date of service, not the date of the demand for repayment. Additionally, the ability of Medicare to recover overpayments may vary depending on the district in which the bankruptcy is filed, as courts in different jurisdictions can interpret and apply bankruptcy and Medicare recovery rules differently.*

140.2.4 Bankruptcy Affects Nearly All Medicare Operations

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Bankruptcy can affect every aspect of the interaction between the Medicare program and a debtor. Each *Contractor* staff member who may *encounter* a debtor, is effectively a part of the Medicare "bankruptcy team" for that case. *The Contractor* point of contact must ensure that all potential bankruptcy team members *notify the servicing CMS Office of any anticipated* actions *regarding* the debtor *and* coordinate those actions with the *CMS Bankruptcy Analyst or the assigned CMS Counsel*. In bankruptcy, **both** inaction and inappropriate action hurt Medicare's chances of recovery. Some commonly affected areas are:

1. *Overpayment* Recovery

Medicare's right to recover pre-petition and *post-petition* overpayments varies by federal jurisdiction- (see discussion on set-off and recoupment in section F below). If the Contractor has overpaid a debtor, they shall consult the *servicing CMS Office and* take appropriate action to maximize recovery of Medicare overpayments. *Contractor* overpayment staff shall not send any *manual* letters to the debtor until the *CMS Office* approves them for release, *with the exception of NPRs and revised NPRs*.

2. *Fraud* and Abuse

The Contractor shall ensure consultation with *the* CMS Program Integrity staff and the *CMS Bankruptcy Analyst* before *suspending* an entity for fraud and/or abuse, recovering fraud overpayments, or continue suspensions. If there is evidence that the provider filed for bankruptcy due to fraud it committed, advise the *CMS Bankruptcy Analyst* handling the bankruptcy.

3. *Reimbursement*

Contractor reimbursement staff *shall suspend payments if the provider does not timely file a cost report, unless the CMS Office or CMS Counsel contacts the Contractor that suspension is not appropriate due to circumstances requiring further review. DO NOT* issue tentative settlement payments in bankruptcy cases unless explicitly requested by the *CMS Office*.

Unless otherwise directed, *Contractor* reimbursement staff should continue to review and audit cost reports following their usual procedures. The CMS Office will inform the Contractor of any stipulations or settlements that may affect the review or audit process. In such situations, the CMS Office will evaluate the costs and benefits of auditing cost reports when recovery is unlikely and will provide appropriate guidance.

Contractors are no longer required to submit notices of program reimbursement (NPRs) or revised NPRs to the CMS Office for review and approval when dealing with bankrupt providers. However, if the CMS Office determines that a bankruptcy case is unique or exceptional, it will provide written direction requesting the Contractor to submit NPRs or revised NPRs for the CMS Office's review and approval prior to issuance to the provider.

Once a final cost report settlement has been determined, Contractors shall ensure the required language is included in the NPR or revised NPR before issuing it to the provider. If needed, Contractors may contact the CMS Office to confirm any necessary actions for proper handling of the determination in the Health Integrated General Ledger Accounting System (HIGLAS).

a. Cost Report Overpayment Letters shall include the following language:

Note: If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, please follow the instructions found at the end of this letter.

If You Have Filed a Bankruptcy Petition

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Nothing in this letter should be considered as a request or demand for payment. Accordingly, we request that you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy, please include the name the bankruptcy is filed under, the docket number, and the district where the bankruptcy is filed.

If you have already notified CMS of the bankruptcy, the purpose of this letter is to inform you of the overpayment owed to Medicare. Due to the automatic stay in bankruptcy, this letter does not demand that you submit payment at this time. Because of the bankruptcy, recovery of Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process, and pursuant to applicable jurisdictional and other provisions of the Medicare Act and regulations. Please note that in bankruptcy, CMS may still exercise recoupment rights, which constitute a defense to payment. Thus, we do not believe that the bankruptcy petition prohibits Medicare's recoupment rights, subject to the limitation on Medicare recoupment at section 1893(f)(2) of the Social Security Act and the implementing regulations at 42 C.F.R. § 405.379.

If you dispute this overpayment determination, please follow the appropriate rebuttal and/or appeals process described elsewhere in this letter.

To the extent any of the general instructions in this letter is not consistent with the bankruptcy law and procedures, they may be modified to comport with bankruptcy law.

b. Cost Report Underpayment Letters shall include the following language:

Note: If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, please follow the instructions found at the end of this letter.

If You Have Filed a Bankruptcy Petition

If you have filed a bankruptcy petition or are involved in a bankruptcy proceeding, Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. Nothing in this letter should be considered as a request or demand for payment. Accordingly, we request that

you immediately notify us about this bankruptcy so that we may coordinate with both the Centers for Medicare & Medicaid Services and the Department of Justice to assure that we handle your situation properly. If possible, when notifying us about the bankruptcy, please include the name the bankruptcy is filed under, the docket number, and the district where the bankruptcy is filed.

If you have already notified CMS of the bankruptcy, the purpose of this letter is to inform you of the underpayment amount. Because of the bankruptcy, recovery of Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process, and pursuant to applicable jurisdictional and other provisions of the Medicare Act and regulations. Please note that in bankruptcy, CMS may still exercise recoupment rights, which constitute a defense to payment. Thus, we do not believe that the bankruptcy petition prohibits Medicare's recoupment rights, subject to the limitation on Medicare recoupment at section 1893(f)(2) of the Social Security Act and the implementing regulations at 42 C.F.R. § 405.379.

If you dispute this underpayment determination, please follow the appropriate rebuttal and/or appeals process described elsewhere in this letter.

To the extent any of the general instructions in this letter is not consistent with the bankruptcy law and procedures, they may be modified to comport with bankruptcy law.

4. Payment

Contractor payment staff must receive approval from the *CMS Office* before taking any action that changes the amounts payable or owed by a debtor.

5. Appeals

Contractor staff will be asked about *any recent or ongoing appeals involving a provider in bankruptcy, including Redeterminations, Qualified Independent Contractor (QIC) reviews, Administrative Law Judge (ALJ) hearings, Provider Reimbursement Review Board (PRRB) cases and Department Appeal Board (DAB) cases.*

The Contractor should keep the CMS Office or CMS Counsel informed of material developments related to appeals activity in bankruptcy cases that become known to it in the course of its operational responsibilities that may affect the overpayment amount or CMS' proof of claim.

If an appeal decision is favorable to the provider and reduces the overpayment amount, CMS or CMS Counsel may determine that amendment of the proof of claim is required. In some cases, the CMS Office may also direct the contractor to suspend or freeze outgoing funds.

6. Change of Ownership (CHOW)

A debtor may attempt to transfer provider agreements so that both parties may avoid overpayment recovery. The Center for Clinical Standards and Quality (*CCSQ*) staff will notify *the servicing CMS Office* when a debtor provider files for a *CHOW* and immediately notify the *CMS Counsel* who is *assigned* the bankruptcy. The CHOW will not be processed until the *CCSQ Office* obtains the concurrence of the *CMS Counsel assigned* the bankruptcy. *In addition to CCSQ, the Medicare Administrative Contractor's provider enrollment staff and the Provider Enrollment Operations Group (PEOG) within CPI also coordinate with the CMS Office assigned to the bankruptcy upon learning that a debtor provider has initiated or plans to initiate a CHOW.*

140.2.5 - Recoupment and Set-off (see also §140.6.4)

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Recoupment and set-off are two of Medicare's *primary* tools for recovering overpayments *from* debtor providers, *but these terms may be used differently in other federal contexts, including under the Federal Claims Collection Act. In bankruptcy*, jurisdictions vary in their decisions about how Medicare can use these tools. Some jurisdictions consider the Medicare *Part A* provider agreement one contract/transaction and allow it to be the basis for broad powers of recoupment. Other jurisdictions consider each cost report year as a distinct contract and restrict recoupment to periods within a particular cost report year. *The CMS Office/CMS Counsel can advise the Contractor* whether current law in a *specified* jurisdiction permits recoupment.

1. Recoupment

Recoupment permits a party to reduce current payments to account for prior overpayments made under the same contract or transaction. Recoupment permits adjustment across the petition date and does not require approval of the bankruptcy court. Therefore, Medicare should recoup in any jurisdiction where it is permitted.

2. Set-off

If recoupment is not permitted, set-off will be considered. Medicare must take quick action to recover overpayments using set-off. Set-off should not take place without specific instructions by the *CMS Office or CMS Counsel*.

Set-off permits making similar adjustments in situations involving one or more contracts or transactions. For example, suppose B owes A \$40.00 under one contract and A owes B \$50.00 under another contract. If set-off is *allowed*, then A can take her \$40 from the \$50 she is holding for B (A would only pay B \$10.00). Generally, parties can request court permission to set-off. If allowed, parties can set-off pre-petition claims against pre-petition payments or *post-petition* claims against *post-petition* payments. They cannot set-off pre-petition claims against *post-petition* claims.

3. Administrative Freeze

Once it is discovered that a provider is in bankruptcy, Medicare can enact a **temporary** administrative freeze. An administrative freeze (sometimes called a Strumpf freeze, named after a Supreme Court case) will allow time for Medicare to determine if there are any overpayments and to ask the bankruptcy court to allow set-off. Speed is essential because courts do not permit set-off across the petition date. A pre-petition overpayment can only be set-off against a pre-petition claim.

140.2.6 - Time is of the Essence

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Upon receiving credible information regarding an impending bankruptcy, the Contractor shall immediately notify the CMS *Office or CMS Counsel*. This notification is essential to avoid forfeiting the opportunity to recover Medicare overpayments. It is imperative not to wait for formal notice, and do not assume that someone else has notified CMS, as timely communication is crucial. Various sources may provide early bankruptcy information such as the Internet, newspapers, trade journals, and business magazines. *Contractors shall send information regarding an imminent provider/s bankruptcy to the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov.*

140.3 - *Contractors* Establishment of Relationships to Ensure Effective Actions Regarding Providers in Bankruptcy

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

140.3.1 - *Contractor* Staff Must Establish Relationships to Ensure That the *CMS Office and CMS* Counsel Receive Prompt Notice of Provider Bankruptcies, so That Medicare Can Take Quick Action

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

The *Contractor* may receive notice of a bankruptcy from many sources including the provider, other *Medicare Administrative Contractors*, the State, the *CMS CCSQ*, or *CMS* Counsel. It is imperative that *Contractor* staff act quickly when a provider files for bankruptcy in order for *CMS* to meet filing deadlines in the bankruptcy court. Therefore, *Contractor* staff must establish relationships to ensure that they receive information promptly about provider bankruptcies. *Contractors shall send a notification of bankruptcy to the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov*

140.3.2 - *Contractors* Must Recognize and Advise *CMS* Staff About Potential Provider Bankruptcies

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Contractor staff must be alert to news or notices of bankruptcy and notify *CMS* staff immediately. *Contractor* staff should alert the *CMS staff* to all potential bankruptcies to the *OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov*

Bankruptcy warning signs for *Contractors* (indications that a provider is experiencing financial difficulty, and may file for bankruptcy):

1. Frequent unfiled or late-filed cost reports.
2. Failure to make timely payments on an extended repayment plan schedule.
3. Frequent changes of ownership.
4. Litigation
5. Voluntary or involuntary termination from the Medicare Program.
6. Provider has difficulty meeting payroll.
7. History of significant overpayment determinations.
8. Significant decline in Medicare and/or total patient census.

If the Contractor sees multiple early warning signs, contact the OPOLE IFM Bankruptcy mailbox at OPOLE_IFM_Bankruptcy@cms.hhs.gov

140.3.3 - *Contractor* Staff will Establish a Relationship *with* the *CMS Office* that *has Jurisdiction Over the Bankruptcy*

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Contractors shall proactively establish *a relationship with* the *CMS Office* that *handles bankruptcy cases*. This is important because bankruptcy *laws* may differ significantly from one jurisdiction to another, due to the structure of the federal court system.

In the federal system, a party may appeal *lower-level* court decisions to a higher court, which has the power to affirm or reverse the lower court. In order of increasing rank and authority, the federal system is comprised of Bankruptcy Courts, District Courts, Courts of Appeals, and the Supreme Court. Each court *on*

this list generally hears appeals from the court immediately preceding it. Although the Supreme Court has the final word, it hears a highly limited number of cases each year. This permits conflicts between lower court decisions to continue for many years until they are resolved by the Supreme Court.

As a result, absent a Supreme Court decision, the most authoritative precedents that may exist (and which may conflict with one another) are issued by the Courts of Appeals. There are 11 Courts of Appeals (known as Circuits) covering various States, plus a District of Columbia Circuit. The decision of each Court of Appeals is *controlled* within the States covered by that Circuit.

As discussed in greater detail below, *the* CMS may want to take different actions in a bankruptcy case for different providers, including suspending payments, or recouping overpayments. In addition, *the* CMS may have taken such actions before the provider filed for bankruptcy. Whether *the* CMS can legally take or leave in place such actions may well depend on where the provider filed for bankruptcy, and the existing legal precedents within that Circuit.

For example, at the time of this writing there is conflict in the Circuits about whether *the* CMS may recoup pre-petition overpayments from *post-petition* payments without obtaining *relief* from the automatic stay. The Third Circuit (covering **Pennsylvania, New Jersey, Delaware, and the Virgin Islands**) forbids recoupment over different fiscal years without such relief. By contrast, the Ninth Circuit (**Alaska, Arizona, California, Guam, Hawaii, Idaho, Nevada, Oregon, and Washington**) and the District of Columbia Circuit permit such recoupment. No other Court of Appeals has decided the issue. There are various District Court decisions going both ways.

There are also conflicting decisions by District Courts on whether *the* CMS may continue to suspend payments due to suspected fraud when the provider files for bankruptcy.

For these reasons, the *Contractors shall* neither initiate nor discontinue significant action affecting payment without first contacting *the CMS Office*.

140.3.4 – *The CMS Office Jurisdiction* Generally Parallels the Bankruptcy Court Where Case is Filed

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

140.3.5 - *Contractor and the CMS Office* Bankruptcy Point of Contact Staff Member

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

The Contractors shall notify the servicing CMS Office of any new bankruptcy notices not flagged in systems as bankrupt. The CMS point of contact will consolidate information and manage, report, and coordinate ongoing communication and activities among the appropriate parties involved (e.g., Contractors, other CMS Offices, Chief Counsels, and CO) regarding bankruptcies. The CMS Office will communicate the name, phone number, fax and e-mail address of the CMS Office point of contact in writing or via email to the assigned CMS Counsel, and respective Contractors.

140.4 - Actions to Take When a Provider Files for Bankruptcy

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

140.4.1 - Establish *Effective* Lines of Communications

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Upon becoming aware that a provider has filed for bankruptcy, the Contractor shall immediately inform the OPOLE IFM Bankruptcy team via email at OPOLE_IFM_Bankruptcy@cms.hhs.gov as soon as practicable, but no later than two (2) business days following such awareness.

Timely communication is critical due to court-imposed deadlines and the potential impact on Medicare's recovery rights.

The CMS Office will inform the Contractor of the CMS Bankruptcy Analyst assigned to the case. The Contractor can coordinate with the assigned analyst regarding matters related to the bankrupt provider.

140.4.2 - Respond to *the CMS Office* Requests for Information (Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Upon receiving notification of a new bankruptcy, the Contractor shall prepare a Bankruptcy Referral Checklist. The checklist is now divided into two (2) tiers, each designed to gather the bankruptcy information. The Contractor shall refer to Section 140.1 – Bankruptcy forms - for information required to be submitted to the CMS Office.

140.4.3 - Immediate *Contractor* Directives from the *CMS Office* (Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

The *assigned CMS Office* will give the *Contractor* the following guidance as soon as *the provider* files for bankruptcy.

1. The *CMS Office* will notify the *Contractor* of Provider Bankruptcy/Litigation.

a. Bankruptcy Filed

The *servicing CMS Office* will inform the *Contractor* that *CMS* has opened a bankruptcy case. *The CMS Office* will inform the *Contractor* that it *shall* clear any future actions concerning the bankrupt provider(s) through the *CMS Office*.

b. Bankruptcy Filing Date.

The *servicing CMS Office shall* notify the *Contractor* of the bankruptcy filing date, since it impacts actions that the *Contractor* can take and the evaluation of whether payments are pre-petition or *post-petition*.

c. Immediate response to requests.

Since bankruptcy has *court-imposed* deadlines, the *Contractor shall* take immediate action whenever the *CMS Office* or *CMS* Counsel makes a request.

d. Obtain approval of all correspondence to provider.

The *Contractor shall* submit all correspondence *that is not system generated* to the *servicing CMS Office* for approval prior to release, *except for routine cost report settlement letters (e.g. NPRs or revised NPRs), unless the CMS Office has directed that such correspondence be submitted for review due to the unique or exceptional nature of the bankruptcy case.* The *servicing CMS Office* will *modify all manual letters, obtain CMS Counsel approval, and will inform the Contractor of the final copy of the letter that shall be released to the bankrupt provider.*

e. *The Servicing CMS Office*

The servicing CMS Office will provide the *Contractor* with a contact name and telephone number. The *CMS Bankruptcy Analyst* that *provides oversight to* the *Contractor* may need to continue to assist the *Contractor* in an advisory role.

2. *The CMS Office* Will Notify *the Contractor* of Immediate Actions It Must Take.

a. Interim Rate Adjustment.

After consultation with *the CMS Counsel*, *the CMS Office* will direct the *Contractor* to immediately perform an interim rate adjustment to ensure that payments are accurate and that no future overpayments occur. (Medicare *Financial Management* Manual §2760.1(C). 42 CFR §413.64(i).

b. Recoupment.

The CMS Office will inform the *Contractor* (after discussion with *the CMS Counsel*) whether it should continue or cease any current recovery action.

c. Administrative Freeze.

The CMS Office will inform the *Contractor* (after discussion with *the CMS Counsel*) *whether* it should place payments in administrative freeze.

3. Actions *the Contractor* Must Take on an Ongoing Basis.

a. Expedite Cost Report Settlement

The CMS Office will *instruct* the *Contractor* to expedite the settlement of any open cost reports. *The CMS Office* will caution the *Contractor* not to *issue any tentative settlement payments* unless explicitly requested by the *CMS Office* (in consultation with *the CMS Counsel*). *The Contractor can issue final settlements to the provider without first obtaining permission from the CMS Office* (in consultation with *the CMS Counsel*) *providing there was no formal communication from CMS that the case is unique or exceptional in nature.*

b. *Contractors shall* suspend payments if *the* provider does not timely file *a* cost report.

If the bankrupt provider fails to submit a timely *and* acceptable cost report, immediately notify the *assigned CMS Office or the assigned CMS Counsel* prior to placing the provider in 100% withhold and immediately notify the *CMS Office or the CMS Counsel of the actions taken*. When the provider submits an acceptable cost report consult with the *CMS Office or CMS Counsel* prior to release of the withheld funds.

c. Part B - Tracking Refunds

The *Contractor* may need to track voluntary refunds for a bankrupt provider. The *assigned CMS Office* will work with *the CMS Counsel* to determine what information Counsel needs. The *Contractor* should be aware of the impact on beneficiary deductibles and coinsurance in a Part B bankruptcy.

d. *Contractors* should check with *the assigned CMS Office* before making other payments to *the provider*.

It is important that *all Contractors* establish a process to ensure they do not make payments (e.g., underpayments, lump sum payments, or payments resulting from appeals) to bankrupt providers who have outstanding overpayments unless the *CMS Office* (in consultation with *the CMS Counsel*) so *directs*. This is especially critical for *Contractors'* who must continue to settle open cost reports.

4. *Contractors Shall Track and Report Information to the CMS Office.*

a. Cost Report Settlements and Claims Processed

Contractor staff *should* notify the *CMS Office* promptly of *all* proposed cost report settlements, changes in the amount of determined overpayments or underpayments, and claims processed.

b. Appeals

If a bankrupt provider files an appeal *for* an overpayment, *Contractor* staff must keep *the CMS Office* staff informed on the outcome of the appeal. Appeals may take place at the *Contractor*, with an Administrative Law Judge, or at any *Office* of Hearings and Appeals, at the Provider Reimbursement Review Board, or at Federal District Court. If the appeal is favorable to the provider, it may require *the CMS Office or CMS Counsel* to amend its proof of claim because the provider would have a smaller overpayment. Alternatively, in some cases, the *CMS Office* may direct the *Contractor* to freeze any outgoing funds. The *Contractor shall* keep the *CMS Office or CMS Counsel* updated on the status of appeals.

5. Record-Keeping.

a. Interest

The *CMS* will advise the *Contractor* whether it should continue to *accrue* interest for overpayments. Medicare's ability to assess interest varies based on the circumstances of the case. *The CMS Office* will consult with the *CMS Counsel* before determining whether the *Contractor* should make an adjustment. If the bankruptcy is in a district where interest should stop accruing on the petition filing date, the *Contractor* must make an adjustment to remove the interest.

The *Contractor shall* post these adjustments to the *Contractors'* internal systems *and to the Healthcare Integrated General Ledger Accounting System (HIGLAS)*. *The Contractor shall* also post the adjustments to the *Treasury Report on Receivables (TROR)*.

b. *HIGLAS* Update

The servicing CMS Office will instruct the *Contractor to update* the *provider in bankruptcy status in HIGLAS and whether recoupment of overpayments is permitted or not permitted*.

- *The Contractor shall allow for recoupment or netting of overpayments if recoupment of overpayments is permitted,*
- *The Contractor shall not allow recoupment or netting of overpayments, if recoupment of overpayments is not permitted.*

c. Bankruptcy Case *at the Contractor*

Once the assigned CMS Office notifies the Contractor of a provider's bankruptcy, the Contractor shall ensure the bankruptcy debt is not referred to Treasury for collection under the Debt Collection Improvement Act.

If any case has already been referred to Treasury – including debts automatically referred through HIGLAS due to delinquency thresholds — the Contractor shall immediately take appropriate action to recall the debt from Treasury upon notification of the bankruptcy.

All bankruptcy debts shall remain at the Contractor for financial reporting purposes. The Contractor is responsible for ensuring that each debt is maintained in a bankruptcy status in HIGLAS and that the correct netting indicator is applied or not applied, consistent with the CMS Office instructions.

Debts will remain with the Contractor until the CMS Office provides direction regarding the resolution of the debt, including whether to resume normal collection activities or proceed with debt closure (e.g. write-off).

d. System for Tracking Audit and Reimbursement (STAR)

If the bankrupt provider participates in the Medicare program under Part A, the Contractor shall ensure that STAR is updated with the effective date of the bankruptcy.

140.4.4 - Tracking Debts/*CMS* Communications

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Financial Reporting. While the *CMS Office* is responsible for managing the bankruptcy case, all bankruptcy debt will remain at the *Contractor* for financial reporting purposes on the *TROR*. *The CMS* staff must work with *Contractor* staff to ensure proper reporting on *the TROR* throughout the bankruptcy.

140.5 - Chain Bankruptcies

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

140.5.1 - *Chain* Providers

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

A chain provider is one that is owned by the same entity that owns another provider or *provider*. Chain affiliates may include facilities that are public, private, charitable, or proprietary. They may also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based clinics, are not chain affiliates (MFMM § 2760.1).

When a chain files bankruptcy, there may be multiple *Contractors* involved in processing payments for the chain. *The CMS Bankruptcy Analyst, in coordination with CMS Counsel, will oversee the initial bankruptcy case and* work directly with the *Contractors*, informing them of the proper actions to take with respect to recovering Medicare overpayments. The servicing *CMS Office* and *CMS Counsel* are responsible for making all decisions *and will communicate with Contractors regarding all aspects of the bankruptcy.*

140.5.2 - Single Provider Serviced *by a Contractor*

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

When a single provider, who is serviced by a *Contractor*, files for bankruptcy, the same principle for processing a bankruptcy of a chain provider will apply. *The CMS Bankruptcy Analyst, in coordination with CMS Counsel, will oversee the initial bankruptcy case and work directly with the Contractor/s, informing them of the proper actions to take with respect to recovering Medicare overpayments. The servicing CMS Office and CMS Counsel are responsible for making all decisions and will communicate with Contractors regarding all aspects of the bankruptcy.*

140.6 - Affirmative Recovery Actions

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

140.6.1 - Working With the *CMS Office* and *CMS Counsel*

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

The *Contractor notifies* the *servicing CMS Office or the CMS Counsel's Office* immediately after it receives information that a provider has filed for bankruptcy. It is essential *for the Contractor to* obtain information on all Part A, Part B, or *Durable Medical Equipment Administrative Contractor* entities involved in the

bankruptcy, including Medicare identifying information, such as provider and supplier numbers. If the *Contractor* has difficulty obtaining this information, it will consult with the *CMS Office*. After gathering the information described in §140.4.2, *the Contractor* sends to the *servicing CMS Office*.

The *Contractor shall* discuss with *the CMS Office or CMS* Counsel whether it should put payments in an administrative freeze (a holding account) until Medicare has time to assess its position in the bankruptcy. Also, the *CMS Office or CMS Counsel* will determine when the proof of claim is due and whether the *CMS Office* or *CMS Counsel* will need additional information to prepare the proof of claim. The *Contractor* shall share all new information regarding the provider's overpayments and underpayments, cost report settlements, etc. with *the CMS Office or CMS* Counsel *if asked*. The *Contractor cannot* take any further steps without obtaining the advice of *the CMS Office and CMS* Counsel.

As the bankruptcy progresses, the *CMS Office and* Counsel may ask the *Contractor* to expedite settlement of cost reports, update the *CMS* Counsel on provider overpayments or underpayments, and provide Counsel with assistance on all aspects of the bankruptcy. As bankruptcy cases often have short deadlines for filing pleadings and other documents, requests from *the CMS Office or CMS* Counsel must have the highest priority in the workload, *to* protect Trust Fund assets.

140.6.2 - Assumption of the *Medicare* Provider Agreement

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

The Medicare Provider Agreement is considered an executory contract for purposes of bankruptcy. Bankruptcy law permits a debtor to affirm ("assume") or reject each of its executory contracts. The debtor must first get the formal approval of the bankruptcy court. If the debtor formally assumes the Medicare provider agreement, and the Bankruptcy Court approves that assumption, the relationship between the provider and Medicare will generally return to the ordinary course of business. The *CMS Office* will inform the *Contractor* if the provider assumes the Provider Agreement.

If the debtor rejects the Provider Agreement, the rejection is a voluntary termination of the Provider Agreement. The *CMS Office* will inform the *Contractor* if the provider terminates its provider agreement in this way. The *Contractor* should not reimburse the provider for services it performs after the date it rejects/terminates the Provider Agreement. If the bankrupt provider sells a facility to another entity and that entity assumes the debtor's provider agreement, any outstanding Medicare underpayments or overpayments regarding that facility should be transferred to the new owner (the purchaser) when the new owner assumes the provider agreement. Although the debtor and the new owner may have a private agreement regarding who is responsible for refunding Medicare overpayments and who should receive any Medicare underpayments, CMS is not bound by such agreements.

The *Contractor* shall calculate net amounts that may be due to or owing from the *debtor*.

140.6.3 - Settlement Agreements *or* Stipulations

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

During a bankruptcy, the *servicing CMS Office* and the *CMS* Counsel, working with *the* DOJ, may negotiate a settlement agreement or stipulation with the debtor's attorney. Once a settlement agreement or stipulation goes into effect, the *CMS Office* will advise all affected *Contractors, other CMS Offices*, and the *Office* of Financial Management (CO). The *servicing CMS Office* will consult with the *Contractor* to ensure that they conform to the conditions established in the settlement agreement or stipulation.

140.6.4 - *Recoupment*

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Generally, bankruptcy law prohibits recovery of pre-petition debt (debt arising prior to the filing of the bankruptcy petition) from *post-petition* payments. However, Medicare Part A payments require adjustments of ongoing payments to a provider to account for overpayments previously made to that provider. 42 U.S.C.

§1395g(a); §1395x(v)(1)(A). Most courts recognize this method of adjusting payments as recoupment, which is permitted in bankruptcy, and is not subject to the automatic stay. Alternatively, they recognize that bankruptcy law does not alter the adjustment of payments that the Medicare statute requires. Thus, in most *jurisdictions*' recoupment is appropriate. Nevertheless, the *Contractor* always consult *the CMS Office/CMS Counsel's Office* about the adjustment (or recoupment) of any payments to a bankrupt provider **before taking, omitting, continuing or discontinuing any action**. (See also, discussion of Recoupment in §140.2.5).

Some courts do not agree that Medicare can recoup overpayments (without first obtaining relief from the automatic stay) *unless* the provider incurred the overpayments in the current fiscal year. For instance, in bankruptcy cases filed in Pennsylvania, New Jersey, Delaware and the Virgin Islands, Medicare cannot recoup overpayments across fiscal years unless the debtor assumes the Medicare provider agreement or *CMS Counsel* obtains permission from the court. *The servicing CMS Office or CMS Counsel* will advise the *Contractor* whether it can recoup overpayments in these jurisdictions. Again, the *Contractor* consults *the servicing CMS Office and the CMS Counsel before adjusting or recouping payments to a bankrupt provider*.

140.6.5 - Administrative Freeze/Set-off

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

Medicare can ask the court's permission to set-off pre-petition debts against pre-petition payments (payments for pre-petition services, even if made *post-petition*) and *post-petition* debts against *post-petition* payments (payments for *post-petition* services). *CMS Counsel*, through *the DOJ*, will file a motion requesting permission to set-off.

Bankruptcy law allows a creditor like Medicare to freeze payments if it thinks it has the right to set-off those payments. Generally, in the Part A context, the first 2-3 weeks of Medicare payments after a *debtor file* for bankruptcy resulting from pre-petition services. Therefore, the *CMS Office* and *CMS Counsel* might decide to freeze all payments for pre-petition services and then request bankruptcy court permission to set-off those payments against pre-petition overpayments. Because there is such a short period during which there might be pre-petition payments available to set-off available to freeze for set-off, it is critical to find out about the bankruptcy and the provider's overpayments quickly.

Other pre-petition payments, such as underpayments or payments delayed because of medical review may be available to set-off against pre-petition overpayments. It is important to notify the *CMS Office* and *CMS Counsel* of any such underpayments or delayed payments.

Finally, because the U.S. Government is considered one creditor in bankruptcy, a Contractor may be asked to freeze pre-petition payments to recover the debts owed by the provider to other government agencies. However, we must use pre-petition payments to recover Medicare overpayments before applying them to debts owed to other agencies.

140.7 - Preparing and Filing Proof of Claim

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

CMS provides a working definition of the term "claim" in §140.2. The proof of claim form alerts the court to the existence of Medicare's claim. While exceptions exist, the general rule of thumb is *that* to share in the bankruptcy estate, Medicare must file a proof of claim. *The CMS Office or CMS Counsel* will file the proof of claim. It is critical that *Contractors* produce accurate and detailed overpayment data, *if requested*, to the *CMS Office or CMS Counsel* to file a timely proof of claim.

In Chapter 7 and Chapter 13 bankruptcies, the deadline ("bar date") for the Government to file a proof of claim is 180 days after the bankruptcy court's order granting relief from creditors (usually the date the provider files for bankruptcy). The bankruptcy court establishes the bar date by court order in Chapter 9 and Chapter 11 bankruptcies. *To* meet the bar *date*, the Government must:

1. Get notice of the bankruptcy
2. Direct that notice to the appropriate agency and appropriate personnel
3. Determine exactly how many payment agreements the entity in bankruptcy has with Medicare (i.e., do they owe Medicare and if *so*, how much)
4. Determine the status of each payment agreement
5. Prepare the proof of claim form
6. Get *CMS* Counsel approval
7. Sign it; and
8. File it in the bankruptcy court

Because the time to finalize a proof of claim can be short, *the Contractors* update overpayment information *as requested*.

140.8 - Reserved for Future

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

140.8.1 - Reserved for Future

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

140.8.2 - Debt Located at *the Department of Treasury*

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

If a debt is *located* at the *Department of Treasury (Treasury)* for *cross-servicing* and the provider files for bankruptcy, the *servicing Contractor* must immediately notify *Treasury*. The *Contractor shall* recall *the* debt from *Treasury* as debts in bankruptcy status are ineligible for *cross servicing* and offset.

If the Treasury receives the initial notification of a bankruptcy filing while servicing a debt, they will notify the Contractor, who, in turn, will notify the servicing CMS Office of the bankruptcy.

NOTE: Debts for unfiled cost reports are not reported on the *TROR*, therefore, if these debts become "bankrupt," *the Contractor shall* record no transaction on these forms.

140.8.3 - Managing Bankruptcy Debt at the *Contractor*

(Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

All bankruptcy debts *shall* remain at the *Contractor* throughout the life of the debt. The *servicing CMS Office* will assume full ownership and responsibility for managing the debt at the *Contractor*. *The Contractor and the servicing CMS Office* establish communication procedures *to ensure the Contractor* staff *adhere to the procedures*.

When chain providers are involved, the servicing CMS Office will contact the necessary contractors and set up procedures for timely and accurate information transfer as requested.

During the bankruptcy, the Contractor is required to periodically review the Medicare Provider Bankruptcy Dashboard within the HIGLAS Business Intelligence (HBI). This review ensures that any transactions with discrepancies between the accounts receivable (AR) bankruptcy status and the Provider or Customer bankruptcy status are addressed and resolved. For instance, if a provider is in a bankruptcy status at the customer level and there are AR transactions not in a bankruptcy status, the Contractor investigates the discrepancy to determine if the AR transactions should be placed in a bankruptcy status.

The Contractor shall research and rectify the issue when a provider has a bankruptcy in a hold status, in the Accounts Payable (AP) module but no bankruptcy status in the AR module.

The HBI Data Dictionary is available for Contractors as a source of information to understand the definitions of the fields on the Medicare Provider Bankruptcy Dashboard. The Data Dictionary also describes the situations that need to be researched and resolved by the Contractor in coordination with the CMS Office.

The *CMS Office or CMS Counsel* is responsible for management of the debt from the initial *petition date through filing* of the Proof of Claim, *and* the closure of the Bankruptcy. The *Group Director or Deputy Group Director* for the *Financial Operations & Oversight Group* will have the authority to terminate collection activity for cases that meet the criteria for being written off at the *Group Director or Deputy Group Director* level.

140.8.4 - Closure of Bankruptcy Cases and Treatment of Overpayment Reporting Systems at End of Bankruptcy (Rev.13825; Issued: 06-11-2026; Effective:07-13-2026; Implementation: 07-13-2026)

After a bankruptcy case is fully administered and the court discharges the trustee (if applicable), the bankruptcy court closes the case. Chapter 11 bankruptcy usually ends with a confirmed reorganization plan, beginning on the plan's "effective date", while Chapter 7 concludes when the Trustee dissolves the corporation, ends operations, and distributes assets to creditors. The CMS Office or CMS Counsel will provide specific guidance to the Contractor on required actions and resolving any remaining unpaid debts when a bankruptcy case closes.

When a bankruptcy case closes, whether Chapter 11, or a proceeding under some other chapter of the bankruptcy code, the Contractor must modify its financial records to reflect the outcome of the bankruptcy. In general, amounts that the bankruptcy court does not require the provider to repay are considered "discharged," and Medicare must release the provider from liability for the debt. All the Contractor's debt information must incorporate the bankruptcy outcome by writing off or resuming normal collection of debts.

The Contractors are responsible to maintain detailed support for all revisions, as well as for any extended repayment arrangements. Detailed documentation related to principal, interest charges, immediate recoupment and extended repayment plans without interest are especially important in global settlement adjustments which are common in some bankruptcy situations. These amounts may need to be modified based on the global settlement. In global settlements which may cut across providers in a chain, existing amounts may be removed from the provider listing and the new amount(s) substituted in accordance with the bankruptcy documents. This will require close coordination among the CMS Counsel, the CMS Office, CO and affected Contractor staff. Coordination and immediate action are especially important if it is discovered that a bankruptcy discharge for a provider has occurred in a previously unknown bankruptcy proceeding.

*Occasionally, the court dismisses a bankruptcy because the debtor does not qualify for bankruptcy or for some other reason. When there is a dismissal, with the advice of CMS Counsel, the CMS Office and Contractor can usually treat the case as if the bankruptcy had never occurred and continue the normal recovery process, which might include an "intent to refer" letter and subsequent transfer to Treasury. **Contractors shall ensure that their internal processing systems and financial reports no longer reflect the case as one under bankruptcy, and interest should be reassessed upon termination of the case.***

Always contact the CMS Office or CMS Counsel for guidance on the closure of a bankruptcy. There is no standard formula for closing a bankruptcy, as it all depends upon the nature of the proceedings and the court orders in the case. The closure could be preceded by a successful reorganization under Chapter 11, a conversion to Chapter 7, or the result of a settlement agreement or stipulation. In all cases, obtain approval from the CMS Office or CMS Counsel before closing the bankruptcy.

*The servicing CMS Office instructs the Contractor on how to resolve unpaid debts after a bankruptcy case closes. If the court terminates the bankruptcy case, without a discharge entered, the CMS Office may direct the Contractor to resume collection of overpayments, including referring unpaid debts to Treasury. **For Treasury-eligible debts, the Contractor shall update the AR Status to 'RESUME-COL-BNK-TERMINATED' on transactions emerging from bankruptcy.***

Note: This status code informs the Treasury to override the bankruptcy status and continue the normal collection process.

If the court concludes the bankruptcy case, with a discharge entered, the CMS Office will review the debts to determine if the discharge is applicable. If the discharge applies, either the Group Director or Deputy Group Director for the Financial Operations & Oversight Group will have the authority to terminate collection activity for cases that qualify to be written off at their respective level.

Contractors shall update STAR, for providers classified under Part A, to reflect the bankruptcy termination date. This ensures the continuation of the standard cost report settlement process without requiring manual referral of settlement letters to the CMS Office, unless otherwise directed by specific instructions from the CMS Office to halt the auditing of cost reports.
