

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13966	Date: September 17, 2026
	Change Request 14020

Transmittal 13708 issued April 02, 2026, is being rescinded and replaced by Transmittal 13966, dated September 17, 2026, to CR14020 is being corrected to add several Business Requirements (BRs) 14020.2.1 through 14020.2.6.1, for the HIGLAS to allow the Accounts Receivable Customer Status Form to restrict the MACs from entering “No” in “Default To New Transactions” field while entering PROVIDER-TERMINATED status. In addition, this correction updates the IOM and BR 14020.2, and the implementation and effective dates have been changed to January 4, 2027. All other information remains the same.

SUBJECT: Creation of the 'PROVIDER-TERMINATED' Status at the Provider/Customer Level on the Healthcare Integrated General Ledger Accounting System (HIGLAS) Customer Status History Form

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to create the 'PROVIDER-TERMINATED' status at the provider/customer level on the HIGLAS Customer Status History Form. In addition, this CR will provide instructions for the contractors to apply the 'PROVIDER-TERMINATED' status at the provider/customer level which will allow the status to cascade to all of the provider's/customer's eligible Accounts Receivable (AR) transactions.

EFFECTIVE DATE: January 4, 2027

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

IMPLEMENTATION DATE: January 4, 2027

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	4/TOC
R	4/10 - Requirements for Collecting Part A and B Non-MSP Provider Overpayments
N	4/10.2 – Assigning the ‘PROVIDER-TERMINATED’ Status at the Customer Level

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: 13966	Date: September 17, 2026	Change Request: 14020
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II. GENERAL INFORMATION

A. Background: Currently, the 'PROVIDER-TERMINATED' status in HIGLAS is only utilized at the transaction level which means that if a provider/customer has been terminated, every AR transaction of that provider/customer will be required to be manually updated to indicate the provider/customer has been terminated. This change request will add the 'PROVIDER-TERMINATED' status to the HIGLAS Customer Status History Form.

Identifying the terminated providers in the HIGLAS Customer Status History Form will allow the status to automatically cascade to existing and new AR transactions. This will eliminate the need for users to monitor terminated providers for new AR transactions and automates the assignment of the 'PROVIDER-TERMINATED' status on each AR transaction. This will reduce the chance of misclassified AR transactions which will allow these overpayments to be referred to Treasury earlier, thereby increasing the potential for collections.

B. Policy: 42 CFR 489.53 - Termination by CMS

III. BUSINESS REQUIREMENTS TABLE

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

[illegible]

Number	Requirement	Responsibility								
		A/B MAC			D M E M A C	Shared- System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	added or inactivated.									
14020.2.3 .1	The contractor shall cascade for all other statuses using Customer status history form, transaction cascade form, webADI or WebServices API.	X	X	X	X					BCRC, CRC, HITECH, IPC, RRB-SMAC
14020.2.4	HIGLAS shall give an option for SECONDARY STATUS in case another status co-exist with PROVIDER TERMINATED status. The other status will be added as transaction status with PROVIDER TERMINATED as status description.									HIGLAS
14020.2.5	HIGLAS shall display the list of historical statuses as SECONDARY STATUS to derive the default basis criteria.									HIGLAS
14020.2.6	HIGLAS shall allow end date of the current status.									HIGLAS
14020.2.6 .1	HIGLAS shall not allow the user to end date the current status when SECONDARY STATUS is available.									HIGLAS

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

VI. CONTACTS

Pre-Implementation Contact(s): Jay Blake, 443-934-3984 or jay.blake@cms.hhs.gov

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

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

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

ATTACHMENTS: 0

Medicare Financial Management

Chapter 4 - Debt Collection

Table of Contents

(Rev. 13966; Issued: 09-17-2026)

10.2 – Assigning the ‘PROVIDER-TERMINATED’ Accounts Receivable Status at the Customer Level

10 - Requirements for Collecting Part A and B Non-MSP Provider Overpayments

(Rev.13966; Issued: 09-17-2026; Effective: 01-04-2027; Implementation: 01-04-2027)

For purposes of these instructions, the term Provider, Physician and other Supplier will be referred to as “Provider”.

The following collection activities are the minimum requirements the Medicare contractor (contractor) shall follow for all Non-MSP provider overpayments. Where additional information is located elsewhere in the manual chapter, an annotation of the specific section is included. (See Medicare Financial Management Manual, Publication 100-06, Chapter 3, §40).

1. Initial Demand letter

The contractor shall send an initial demand letter within established timeframes of the identification or notification of an overpayment. The contractor shall ensure the date of the initial demand letter is the date the AR is established and the date the letter is mailed. The initial demand letter shall include all required language and shall meet timeliness standards as outlined in chapter 3 §200 and/or chapter 4 §§20 and 90.

a. Dollar threshold

The threshold amount to send the initial demand letters is \$25 (principal). The contractor shall aggregate all of the overpayments to the provider to meet the threshold amount for the initial demand letter.

b. Undeliverable demand letter

If the contractor receives the initial demand letter back as undeliverable, the contractor shall attempt to reach the provider by telephone within 10 business days of receiving the undeliverable letter.

If the contractor is unsuccessful at reaching the provider by telephone, the contractor shall at the minimum attempt to locate the provider through other means including:

- Querying the Provider Enrollment Change of Ownership System (PECOS) to determine if there is updated contact information (including an email address) for the provide);
- Contacting the medical review staff or fraud and abuse staff for possible updates on the debtor’s whereabouts;
- Conducting research to see if the provider is in bankruptcy or litigation, and by using the name of the owners, partners, or the corporation officers;
- Conducting an internet search site, including using Lexis-Nexis® or a similar program;
- Contacting the servicing regional office (RO) for assistance or further guidance, if the contractor does not have access to a search engine.

The contractor shall document in the case file all attempts to contact the provider.

2. Recoupment

The contractor shall initiate recoupment of the debt, or any remaining balance of the debt, as outlined below, except when the debt is in the following status: (1) appeal subject to the Limitation on Recoupment provisions (redetermination/reconsideration), (2) bankruptcy, (3) Extended Repayment Schedule (ERS) or (4) a pending ERS request.

For Part A (Non-935 Overpayments)

- Recoupment shall begin 16 days from the date of initial demand letter if the debt is not subject to Limitation on Recoupment provisions of Section 935(f)(2) of the MMA. (See chapter 3, §200)

For Part B (935 and Non-935) and Part A 935 Overpayments

- Recoupment shall begin 41 days from the date of the initial demand letter.
- Recoupment shall continue until the debt is collected in full or is in a status that excludes recoupment.

3. Interest

If the overpayment is not paid in full 30 days from the date of the initial demand letter, contractors shall ensure that interest is assessed beginning on day 31. Simple interest shall be charged on the outstanding principal balance of the debt starting with the date of the initial demand letter and for every 30-day period thereafter, until the debt is paid in full. Refer to chapter 4, §30 and 42 CFR 405.378 for additional information.

4. Telephone Contacts:

Contractors shall attempt to contact providers by phone, at least twice, as follows:

a. First telephone contact

- **Providers who have been terminated/revoked/ or have withdrawn from the Medicare program:**
 - The telephone contact shall be made within 10 business days of the contractor's notification of termination/revocation/withdrawal.
- **Active Providers:**
 - The telephone contact shall be made when the debt is at least 60 days delinquent (90 days from the date of the demand letter) and is not in an appeal, litigation, ERS, or bankruptcy status.
 - The telephone contact may be made sooner if the contractor believes that earlier contact may result in a collection.

- In situations where the provider cannot be reached by telephone the contractor shall leave a voicemail as needed.
- **Successful Phone Contact:**
 - The contractor shall inform the provider of repayment options (e.g. ERS) and explain that any unpaid delinquent debt will be referred to Treasury for further collection activity. If the provider has a surety bond, the contractor shall inform the provider that the debt will be collected through the surety, and any remaining balance will be referred to Treasury.
 - If the first call is successful, (second call would not be necessary) document the contact.
- **Unsuccessful Phone Contact**
 - The contractor shall discontinue telephone efforts when a provider's number is disconnected.
 - The contractor shall at the minimum attempt to locate the provider through other means as listed in discussion of undeliverable demand letters, section 1(b), above.

b. Second Phone Contact

The second phone call is only necessary if the contractor was unable to directly communicate with the provider on the first call.

- The contractor shall make a second phone call to the provider at least 7 business days before referring the debt to Treasury.
- The contractor shall leave a voicemail where the call is directed to voice messaging.
- Leaving the second voicemail message shall be sufficient for attempting to reach the provider by telephone.

The contractor shall document, in the case file, all attempts to contact the provider.

5. Extended Repayment Schedule (ERS)

If the provider submits an application for an ERS, the contractor shall follow the instructions in Chapter 4 §50. An ERS application may be requested at any time during the collection process.

6. Intent to Refer (ITR) letter

For providers who have been terminated/revoked or have withdrawn from the Medicare program:

The contractor shall send the ITR letter:

- If the initial demand letter was returned undeliverable and a better address cannot be located (see below for Instructions Summary for Undeliverable Letters), or
- When the contractor has verified in *the Shared System*, PECOS, or Provider Enrollment that the provider is terminated or out of business.
 - *The contractor utilizing HIGLAS shall apply the 'PROVIDER-TERMINATED' status code at the customer level which will cascade the 'PROVIDER-TERMINATED' status to all of the customer's eligible accounts receivable. HIGLAS will not cascade the 'PROVIDER-TERMINATED' status code to the AR transaction status codes that are exempt from Treasury referral. The contractor shall monitor the provider's status monthly, for five consecutive months, to determine if the provider has appealed a revocation or has been removed from the Terminated/Revoked status. (Also see Chapter 4, §10.2)*
 - The contractor utilizing HIGLAS shall manually add a comment to the AR status indicating that the provider has been terminated or out of business, when a provider has been terminated or is out of business and has an AR with a status code that is ineligible for Treasury referral”
 - The contractor not utilizing HIGLAS shall manually create the ITR letter and send it as soon as possible if an ITR letter has not been issued and the contractor learns that the provider is terminated or out of business.

For active providers:

The contractor shall send the ITR letter when the debt is **at least** 30 days delinquent (60 days from the determination date) * and is not in a status excluded from debt referral.

NOTE: In all cases, the contractor shall ensure that the ITR letter is sent in enough time to allow the debtor 60 days' notice prior to referral to Treasury. In accordance with provisions of the Digital Accountability and Transparency Act of 2014 (DATA Act) which amended the Debt Collection Improvement Act of 1996 (DCIA), eligible delinquent debts must be referred to Treasury by the 120th day of delinquency. (Refer to chapter 4, §70 for further detail.)

* The Healthcare Integrated General Ledger Accounting System (HIGLAS) adds an additional 5 grace days when determining when to generate the ITR letter to allow for interest accruals to appear on the ITR letter; therefore, the ITR letter will be system generated on day 66.

*** Instructions Summary for Undeliverable Letters**

1. If the contractor utilizing HIGLAS cannot locate a better address within 10 business days of receipt of the undeliverable demand letter, the contractor shall manually update the status code to 'LTR-UNDL-1ST.'

2. If the contractor locates a better address for the undeliverable initial demand letter, the contractor shall send the provider a manual undeliverable demand notification letter, with the initial demand letter attached, to the better address. The original initial demand letter date shall remain in effect.
3. If the contractor not utilizing HIGLAS cannot locate a better address within 10 business days of receipt of the undeliverable initial demand letter, the contractor shall manually create the ITR letter immediately and send it as soon as possible.
4. If the ITR letter is returned as undeliverable and a better address cannot be located within 10 business days of receipt, the contractor utilizing HIGLAS shall update the status code to 'LTR-UNDL-ITR.'
5. If the contractor locates a better address for the undeliverable ITR letter, the contractor shall send the provider a manual undeliverable ITR notification letter, with the original ITR letter attached, to the better address. The original ITR letter date shall remain in effect.

Note: The HIGLAS logic will review the letter history and the debt will become eligible for referral to Treasury 66 days from the ITR letter date.

7. Surety Bond

Prior to referral to Treasury, DME contractors shall refer to instructions outlined in Medicare Program Integrity Manual, Publication100-08, chapter 15, §21.7.1.

8. Record Keeping

The contractor shall keep records of all collection activities through all stages of the debt collection process. This record shall be detailed and include all correspondence and conversations with the provider, checks, and any other documents associated with debt collection processes.

10.2 – Assigning the 'PROVIDER-TERMINATED' Status at the Customer Level (Rev.13966; Issued: 09-17-2026; Effective: 01-04-2027; Implementation: 01-04-2027)

When the contractor utilizing HIGLAS has verified in the Shared System, PECOS, or Provider Enrollment that a provider is terminated, the contractor shall apply the 'PROVIDER-TERMINATED' status code at the customer level which will cascade the 'PROVIDER-TERMINATED' status to all of the customer's eligible accounts receivable. HIGLAS will not cascade the 'PROVIDER-TERMINATED' status code to the AR transaction status codes that are exempt from Treasury referral.

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