CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 294	**Date: October 6, 2017**
	Change Request 10079

Transmittal 285, dated June 2, 2017, is being rescinded and replaced by Transmittal 294, dated, October 6, 2017, Year to change the effective and implementation date(s), revise eight business requirements, and add four new business requirements. In addition, Pub. 100-06, Chapter 4 revisions/additions include instructions for undeliverable initial demand and Intent to Refer (ITR) letters. All other information remains the same.

SUBJECT: Pub. 100-06, Chapter 3 and 4 Revisions

I. SUMMARY OF CHANGES: This Change Request (CR) will revise Chapters 3 and 4 of Pub. 100-6 to reflect the following:

- The inclusion of interest when determining the $25 threshold for non-Medicare Secondary Payer (MSP) debt referral to Treasury and termination of collection action;

- The requirement for a debtor to be notified at least 60 days before its debt can be referred to Treasury; and

- The without fault presumption change from 3 to 5 years.

EFFECTIVE DATE: July 3, 2017 - This effective date is for Business Requirements 10079.2, 10079.3, 10079.7, 10079.7.1, 10079.7.2, and 10079.10.; October 1, 2017 - This effective date is for Business Requirements 10079.1, 10079.1.1, 10079.1.2, 10079.4, 10079.5, 10079.6, 10079.8, and 10079.9.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2017 - This target implementation date is for Business Requirements 10079.2, 10079.3, 10079.7, 10079.7.1, 10079.7.2, and 10079.10.; October 1, 2017 - This target implementation date is for Business Requirements 10079.1, 10079.1.1, 10079.1.2, 10079.4, 10079.5, 10079.6, 10079.8, and 10079.9.

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	3/70/ Determining Liability and Waiver of Recovery for Overpayments
R	3/70/70.1/ 1879 Determination – Limitation of Liability
R	3/7070.2/ 1842(l) Determination
R	3/70/70.3/ 1870 Determination – Waiver of Recovery of an Overpayment
R	3/80/ Individual Overpayments Discovered Subsequent to the Third Year
R	3/80/80.1/ How to Determine the Third Calendar Year After the Payment was Approved
R	3/80/80.4/ Recovery of Overpayment Due to Cost Report
R	3/160/ Termination of Collection Action
R	3/160/160.1/ Termination of Collection Action – Provider Overpayments
R	3/160/160.2/ Termination of Collection Action- Beneficiary Overpayments
R	4/10/ Requirements for Collecting Part A and B Provider Non-MSP Overpayments
R	4/70/70.6/ Debt Ineligible for Referral
R	4/70/70.7/ Intent to Refer Letter
R	4/70/70.8/ Response to Intent to Refer Letter
R	4/70/70.16/ Intermediary Claims Accounts Receivable (A/R)
R	4/70/70.17.3/ Debts RTA by Treasury as Dispute Response not Received Timely (RX)
R	4/70/70.17.4/ Debts RTA by Treasury as a Miscellaneous Dispute, a Manual RTA, Complaint or as Recall Approved (RD)
R	4/70/Exhibit 1/ Intent to Refer Letter

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: 294	Date: October 6, 2017	Change Request: 10079

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I. GENERAL INFORMATION

A. Background: This CR will provide changes that will reflect the correct and current policy for the following:

- Currently, Pub. 100-06, Chapters 3 and 4 do not provide instructions for factoring in interest when determining the $25 threshold for referring non-Medicare Secondary Payer (MSP) debts to Treasury and termination of collections. The United States Department of the Treasury's (Treasury) Managing Federal Receivables Guide requires that principal, interest, and penalties be factored in when determining the amount referred to Treasury.

- Currently, there is a part of Chapter 4, Section 10 that incorrectly instructs the contractor to enter a debt into the Debt Collection System (DCS) for referral to the Treasury within 10 days if the Intent to Refer (ITR) letter is returned undeliverable and a better address cannot be located. This instruction conflicts with Treasury's requirement for an agency to refer debt no earlier than 60 days after the agency's last demand letter, which would be the Centers for Medicare & Medicaid Services' (CMS) ITR letter.

- Chapter 3, Sections 70.2, 70.3, 80, and 80.1 have not been updated to reflect Section 638 of the American Taxpayer Relief Act (ATRA) which amended the timeframe in the Social Security Act §1870(b) "without fault" presumption from 3 to 5 years. The presumption of "without fault" only applies if the Medicare fee-for-service overpayment determination is subsequent to the fifth year (instead of the third year) following the year the claim was paid.

B. Policy:

- The United States Department of the Treasury's Managing Federal Receivables Guide (Chapter 6) requires that principal, interest, and penalties be factored in when determining the amount referred to Treasury.

- The United States Department of the Treasury's Managing Federal Receivables Guide (Chapter 6) requires that a debtor be notified at least 60 days prior to when its debt is referred to Treasury.

- Section 638 of ATRA amended the timeframe in the Social Security Act §1870(b) "without fault" presumption from 3 to 5 years. The presumption of "without fault" only applies if the Medicare fee-for-service overpayment determination is subsequent to the fifth year (instead of the third year) following the year the claim was paid.

II. BUSINESS REQUIREMENTS TABLE

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

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	
10079.1	The contractor shall factor in a non-Medicare Secondary Payer (non-MSP) debt's principal and interest when calculating the $25 threshold for debt referral to the United States Department of the Treasury.	X	X	X	X					
10079.1.1	The Healthcare Integrated General Ledger Accounting System (HIGLAS) shall factor in a non-Medicare Secondary Payer (non-MSP) debt's principal and interest when calculating the $25 threshold for the debt referral, Currently Not Collectible (CNC) automation, debt write-off, Treasury Report on Receivables (TROR) mapping, and demand letter generation processes.									HIGLAS
10079.1.2	The Healthcare Integrated General Ledger Accounting System (HIGLAS) shall apply the $25 principal and interest threshold to non-Medicare Secondary Payer (non-MSP) debts with transaction dates beginning and after October 1, 2017 for demand letter generation, debt write-off, and Treasury Report on Receivables (TROR) reporting.									HIGLAS
10079.2	The contractor shall factor in a non-MSP debt's principal and interest when calculating the $25 threshold for termination of collection action and recall from Treasury.	X	X	X	X					HIGLAS
10079.3	The contractor shall refer (input into DCS for non-HIGLAS contractors) a debt to the United States Department of the Treasury 60 days from the letter date of an ITR letter.	X	X	X	X					HIGLAS
10079.4	The Healthcare Integrated General Ledger Accounting System (HIGLAS) shall create a new AR status code for undeliverable initial demand and ITR letters. The AR status code shall be 'LTR-UNDL.'									HIGLAS

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10079.5	If the initial demand letter is returned as undeliverable, the contractor utilizing HIGLAS shall update the AR status to 'LTR-UNDL.'	X	X	X						
10079.6	If the contractor locates a better address for the undeliverable initial demand letter, the contractor shall send the provider a manual demand notification letter, with the initial demand letter attached, to the better address. The original initial demand letter date shall remain in effect.	X	X	X	X					
10079.7	If the contractor cannot locate a better address within 10 days of receipt of the undeliverable initial demand letter, the contractor shall manually create and send the ITR letter immediately.	X	X	X	X					
10079.7.1	The contractor utilizing HIGLAS shall manually update the letter history in HIGLAS to reflect the date the manual ITR letter was sent.	X	X	X						
10079.7.2	The contractor utilizing HIGLAS shall manually update the AR status code in HIGLAS to 'LTR-SNT-ITR' to reflect the date the ITR was sent.	X	X	X						
10079.8	If the ITR letter is returned as undeliverable, the contractor utilizing HIGLAS shall update the AR status code to 'LTR-UNDL,' regardless if a better address can or cannot be located.	X	X	X						
10079.9	If the contractor locates a better address for the undeliverable ITR letter, the contractor shall send the provider a manual ITR notification letter, with the original ITR letter attached, to the better address. The original ITR letter date shall remain in effect.	X	X	X	X					
10079.10	The contractor shall deem a provider, physician, or other supplier without fault, in the absence of evidence to the contrary, if an overpayment is discovered subsequent to the fifth calendar year after the year of payment.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

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

IV. SUPPORTING INFORMATION

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

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Jay Blake, 410-786-9371 or jay.blake@cms.hhs.gov , Monica Potee, 410-786-4297 or monica.potee@cms.hhs.gov , Donna Sanders, 410-786-0289 or donna.sanders@cms.hhs.gov

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

VI. FUNDING

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

ATTACHMENTS: 0

80 – Individual Overpayments Discovered Subsequent to the *Fifth* Year
80.1 – How to Determine the *Fifth* Calendar Year After the Payment was Approved
80.*2* - Recovery of Overpayment Due to Cost Report

70 – Determining Liability and Waiver of Recovery for Overpayments

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

The Medicare law contains three provisions (§1870, §1879 and §1842(l)) dealing with liability for, and recovery of, individual overpayments. These provisions do not cover cost report overpayments. These provisions are reflected below and, for a more extensive treatment, in Medicare Claims Processing *Manual*, *Publication 100-04*, Chapter *31*, *Financial Liability Protections*.

The *contractor* shall determine whether the provider, physician, or beneficiary is liable for the overpayment. Most *contractor* payments for provider services are made to providers on behalf of the beneficiaries who received the services. If payment is made directly to the beneficiary, liability always lies with the beneficiary unless recovery is waived under the limitation of liability provision. Where the provider or physician has been overpaid, it is liable for the overpayment unless the *contractor* determines that it was without fault with respect to the overpayment.

If the *contractor* determines that an overpaid provider or physician was without fault and therefore not liable for the overpayment, it relieves the provider of liability for the overpayment. The beneficiary automatically becomes liable, whether or not the beneficiary was at fault.

However, recovery from the beneficiary may be waived if you determine the beneficiary is without fault and recovery would defeat the purposes of Title II or Title XVIII or would be against equity and good conscience.

70.1- 1879 Determination – Limitation of Liability

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

Section 1879 of the Social Security Act (the Act) provides financial relief to beneficiaries, providers, practitioners, and other suppliers who acted in good faith in accepting or providing services found to be not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or to constitute custodial care. The provision applies to all Part A/Part B claims decisions where claims are denied or reduced (prepay or postpay) under §1862(a) (9) and §1879 (e) and (g) of the Act.
Contractors must make an individualized determination for each claim that is denied as not reasonable and necessary. (See *Medicare Program Integrity Manual (*PIM*), Publication 100-08*, Exhibits, §14.1)

A. Limitation on Liability – Indemnification Procedures for Claims Filed under Part B

Section 1879(b) of the Act provides that, when a physician/supplier is held liable for the payment of expenses incurred by a beneficiary for items or services determined to be excluded and such physician/supplier requests and received payment from the beneficiary or any person(s) who assumed financial responsibility for payment of expenses, the Medicare program will indemnify the beneficiary or other person(s) for any payments made to the liable physician/supplier (including deductible and coinsurance payments). Further, any such indemnification payments are considered overpayments to the physician/supplier. (See PIM Exhibits, §14.1.)

B. Limitation on Liability Where Physician and Beneficiary Did Not Have Prior Knowledge With Respect to Services Found To Be Not Reasonable And Necessary Services (§1879 of Act)

When both the physician and the beneficiary did not have prior knowledge with respect to services found to be not reasonable and necessary, permit Medicare payment to be made under the limitation on liability provision. (See *Medicare Program Integrity Manual (PIM), Publication 100-08,* Exhibits, §14.1) An overpayment does not exist if a determination is made that the limitation of liability provision applies. The claim decision must incorporate a limitation of liability determination.

70.2 - 1842(l) Determination

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

For denials of nonassigned claims based on §1862(a)(1) involving physician services, the *contractor* must make a determination under §1842(l) of the Act regarding whether the physician or supplier must refund any payment collected from the beneficiary. This should be done for initial determinations (prepay) and for postpayment denials. (See *Medicare Program Integrity Manual (PIM), Publication 100-08,* Exhibits, §14.3)

70.3 - 1870 Determination – Waiver of Recovery of an Overpayment

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

Once the contractor has concluded that an overpayment exists (that is, a finding that payment cannot be made under the waiver of liability provisions) it makes a §1870(b) determination regarding whether the provider/beneficiary was without fault with respect to the overpayment. Once this determination has been made, then waiver of recovery of the overpayment from the provider/beneficiary should be considered per §1870(c).

The contractors make a §1870 determination for all assigned and non-assigned claims, however, §1870 (b) or (c) of the Act, does not apply to the provider on non-assigned post-payment §1862(a)(1) denied claims. However, it can apply to the beneficiary meaning that the beneficiary was not at fault in causing the overpayment. The provider may have a refund obligation to the beneficiary, but the provider did not receive an overpayment from the Medicare program.

Section 1870 is not limited to claims denied under §1862(a)(1) of the Act for not being reasonable and necessary. Section 1870 is the framework for determining who is liable for the overpayment and whether the overpayment recovery can be waived. For providers taking assignment, waiving recovery of an overpayment is appropriate where the provider was without fault with respect to causing the overpayment. Where recovery from the provider is waived per 1870(c), the overpayment becomes an overpayment to the beneficiary. However, if the provider was "at fault" in causing the overpayment, recovery of the overpayment from the provider must proceed. Section 1870 waiver of recovery determinations also must be made where the provider mistakenly receives direct payment on an unassigned claim and this is the basis for the overpayment.

Examples of §1870 determinations:

A. Overpaid Provider or Physician Not Liable Because It Was Without Fault (§1870(b) of the Act.)

If a provider was without fault with respect to an overpayment it received (or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the *fifth* calendar year after the year of payment) it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved. The *contractor* makes these determinations.

B. Beneficiary Liable for Overpayments to Provider That Was Without Fault With Respect to the Overpayment (§§1870(a) and (b) of the Act)

If an overpaid provider was without fault, or is deemed without fault and therefore not liable for refund, liability shifts to the beneficiary. If the overpayment involves services that are not reasonable and necessary, you should have made a §1879 determination regarding the beneficiary's liability for the overpayment. If the overpayment does not involve medically unnecessary services, then limitation on liability does not apply.

C. Contractor Waiver of Recovery from Beneficiary (§1870(c) of the Act)

If a beneficiary is liable for an incorrect payment, recovery may be waived if the beneficiary was without fault with respect to the overpayment and recovery would defeat the purposes of title II or title XVIII of the Social Security Act (i.e., cause financial hardship) or would be against equity and good conscience. (Where

an overpayment is discovered subsequent to the *fifth* calendar year after the year the payment was made, recovery is deemed against equity and good conscience if the beneficiary was without fault.)

If §1879 of the Act is applicable, then §1879 determination is made first since an overpayment does not exist if payment can be made under §1879 because there was lack of knowledge by both the beneficiary and the provider.

80 – Individual Overpayments Discovered Subsequent to the *Fifth* Year

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

There are special rules that apply when an overpayment is discovered subsequent to the *fifth* year following the year in which notice was sent that the amount was paid. Ordinarily, the provider or beneficiary will be considered without fault unless there is evidence to the contrary. In the absence of evidence to the contrary, the *contractor* will not *demand and* recover the determined overpayment. (One example of evidence to the contrary would be a pattern of billing errors. See *Medicare Program Integrity Manual, Publication (*PIM*) 100-08*, Chapter 3.)

EXAMPLE 1: On May 9, *2016* Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On January 6, *2022* the contractor determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The *contractor* will not recover this overpayment as long as there is no evidence to the contrary because it was determined subsequent to the *fifth* year after notification of payment. (Any determination date *on or after* Jan. 1, *2022* will not be recovered.)(If evidence to the contrary existed, recoupment may be initiated. The PIM should be referenced and if necessary the appropriate Benefits Integrity unit at the contractor for guidance.)

EXAMPLE 2: On May 9, *2016* Dr. A is notified that he has been paid $1005.00 for services provided to Mr. Smith, beneficiary. On September 20, *2019* the contractor determines that Dr. A was overpaid for the services to Mr. Smith, beneficiary. The *contractor* will attempt recovery of the overpayment. (Any determination dates up to *and including* Dec. 31, *2021* will be recovered.)

80.1 How to Determine the *Fifth* Calendar Year after the Year the Payment Was Approved

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

Only the year of the payment and the year it was found to be an overpayment enter into the determination of the *5*-calendar year period. The day and the month are irrelevant. With respect to payments made in *2016*, the *fifth* calendar year thereafter is *2021*. For payments made in *2017*, the *fifth* calendar year thereafter is *2022*, etc. Thus, the rules apply to payments made in *2016* and discovered to be overpayments after *2021*, to payments made in *2017* and discovered to be overpayments after *2022*, etc.

Where an overpayment to a provider, or a physician assignee for medically unnecessary services or custodial care is discovered (i.e., demanded) subsequent to the *fifth* calendar year after the year in which the payment was approved, the provider or physician assignee is prohibited from charging the beneficiary or any other person for the services notwithstanding the fact that the provider or physician assignee has refunded the overpayment if:

- The provider or physician assignee was at fault with respect to the overpayment; and

- The beneficiary was without fault with respect to the overpayment. (Where the overpayment is discovered in, or before, the *fifth* calendar year, an "at fault" provider or physician assignee is not prohibited from charging the beneficiary for the overpayment if it has refunded it. However, a without fault beneficiary who pays an at fault provider's or physician assignee's bill for medically unnecessary services or custodial care, can be indemnified in accordance with Medicare Claims Processing *Manual, Publication 100-04*, Chapter 30, *Financial Liability Protections*.

Reopenings (See Medicare Claims Processing *Manual,* Publication 100-*0*4, Chapter 29 Appeals of Claims Decisions for additional information)

Your initial, or review determination or a decision by a Hearing Officer may be reopened under the following conditions:

Within 12 months after the date of the determination or decision it may be reopened for any reason;

After such 12-month period, but within 4 years after the date of the initial determination, it may be reopened for good cause; or

At any time, if:

- Such initial or review determination was procured by fraud or similar fault of the beneficiary or some other person.

If an overpayment is determined based on a reopening outside of the above parameters, the *contractor* will not recover the overpayment.

80.4 - Recovery of Overpayment Due to Overdue Cost Report

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

Where CMS approves a change of *contractor*, the change is effective on the first day following the close of the fiscal year in which the provider gave timely notice. (See Pub 100-04, Medicare Claims Processing Manual*, Publication 100-04*, Chapter 1, General Billing Requirements.)

A. Reminder Letter

The outgoing *contractor* is responsible for effecting final settlement for the cost report periods during which it serviced the provider. It issues the reminder letter required under §*30.1* to ensure the timely receipt of the cost report.

B. First Demand Letter

If no cost report has been filed by the first day after the due date of the cost report (including extensions), the outgoing *contractor* sends the first demand letter in *Medicare Financial Management Manual, Publication 100-06,* Chapter 4, Debt Collection, §*20.2*, Exhibit l, Column B. It sends copies of the reminder letter and the first demand letter to the RO and incoming *contractor*. Upon receipt of its copy of the letter, the incoming *contractor* suspends the interim payment.

C. Second Demand Letter

The outgoing *contractor* is responsible for personal contact with the provider, issuing the *second* demand letter, and notifying the RO if appropriate. The *contractor* shall issue a "modified Intent *to Refer (ITR)* Letter for Unfiled Cost Reports," if the provider has not filed the cost report and the overpayment balance has not been paid. (See *Medicare Financial Management Manual, Publication 100-06,* Chapter 4*,* §20.2 Exhibit 7 for a sample intent letter)

***D.* Receipt of Delinquent Cost Report**

If the delinquent cost report is sent to the incoming *contractor*, it sends the cost report to the outgoing *contractor* to make the final settlement.

After the outgoing *contractor* has completed its review of the delinquent cost report, it notifies the incoming *contractor* whether the cost report is acceptable, and the final settlement. The incoming *contractor*, in

accordance with *Medicare Financial Management Manual, Publication 100-06, Chapter 4,* §40.1, disposes of funds withheld during the suspension of interim payments.

160 - Termination of Collection Action

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

The *contractor* can *request termination of* collection action *for* any debt. In addition, a *contractor's accounting* system *will* automatically identify certain debts for termination of collection action. *However, the final* decision to terminate collection action and write off*/close out* any debt must be approved by CMS RO or CO.

160.1- Termination of Collection Action – Provider Overpayments

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

Under normal circumstances if the *contractor* is unable to collect an overpayment, the overpayment will be referred to the Department of Treasury for additional collection efforts.
However, if the principal *and interest* balance of the overpayment is less than $25.00 the overpayment is not eligible for referral to the Department of Treasury.

Therefore, once an overpayment with a principal *and interest* balance less than $25.00 becomes 180 days old (from the date of the first demand letter), the overpayment should be forwarded to the regional office for termination of collection action and write off closed approval. This process of referring debts to the servicing regional office for termination of collection action and write off closed approval should occur on a quarterly basis. These requests should be sent by hard copy no later than the first day of the second month of each quarter (i.e., November 1, February 1, May 1, and August 1). The actual overpayment case files should not be referred, the overpayment and the following information should be submitted to the regional office via a spreadsheet or other similar method:

- Provider/Physician number
- Current principal amount of overpayment
- Current interest amount of overpayment
- Original amount of overpayment
- Other outstanding overpayments
- Cost Report Year (Part A) or Claim Paid Date (Part B)
- Determination Date
- Overpayment Type

The above list is the minimum amount of information that must be sent to the servicing regional office. The servicing regional office may request additional information. Once received the servicing regional office will review and will send written approval or disapproval for each case regarding termination of collection action and write off closed by the first day of the last month of each quarter (i.e., December 1, March 1, June 1, and September 1). Once approval is received appropriate steps should be taken to close the overpayment *in the appropriate* internal accounting system and report it correctly on all necessary financial reports.

160.2 - Termination of Collection Action – Beneficiary Overpayments

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

A demand letter is not sent for beneficiary overpayments less than $50. Therefore, no recovery action should take place on these overpayments. Beneficiary overpayments less than $50 should be forwarded to the regional office for termination of collection action and write off closed approval. This process of referring debts to the servicing regional office for termination of collection action and write off closed approval should occur on a monthly basis. The actual overpayment case files should not be referred, the overpayment and the following information should be submitted to the regional office via a spreadsheet or other similar method:

- Beneficiary HIC number
- Current principal amount of overpayment
- Other outstanding overpayments
- Claim Paid Date (Part B)
- Determination Date

Once received the servicing regional office will review and will send written approval or disapproval for each case regarding termination of collection action and write off closed. Once approval is received appropriate steps should be taken to close the overpayment on the internal accounting system and report it correctly on all necessary financial reports.

NOTE: *Contractors* utilizing the VMS System automatically abandon beneficiary overpayments less than $50. This instruction does not apply to these *contractors* until such time that standard system changes can be made to stop the abandonment.

Medicare Financial Management Manual
Chapter 4 – Debt Collection

70.16 – *Contractor* Claims Accounts Receivable (A/R)
70.17.4 – Debts RTA by Treasury as a Miscellaneous Dispute, a Manual RTA, Complaint or as Recall Approved (RD)
Exhibit 1 - Intent to Refer *(ITR)* Letter

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

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

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 and chapter 4, §70.16 for additional instructions related to Part A provider initiated claim adjustment accounts receivable).

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 only)*. 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 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)

- Refer to chapter 4, §70.16 for Claims Accounts Receivable (A/R) instructions.

- 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:**

  o The telephone contact shall be made within 10 days of the contractor's notification of termination/revocation/withdrawal.

- **Active Providers:**

  o 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.

  o The telephone contact may be made sooner if the contractor believes that earlier contact may result in a collection.

  o In situations where the provider cannot be reached by telephone the contractor shall leave a voicemail as needed.

- **Successful Phone Contact:**

  o 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.

  o 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 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, or

- When the contractor has verified in PECOS or Provider Enrollment that the provider is terminated or out of business.

If a better address cannot be located, the contractor shall send the *manual* ITR *letter* within 10 days of receipt of the undeliverable *initial demand* letter or knowledge that the provider is out of business or terminated.

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 initial demand letter is returned as undeliverable, the contractor utilizing HIGLAS shall update the AR status to 'LTR-UNDL.'*

2. *If the contractor locates a better address for the undeliverable initial demand letter, the contractor shall send the provider a manual 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 cannot locate a better address within 10 days of receipt of the undeliverable initial demand letter, the contractor shall manually create the ITR letter immediately.*

4. *The contractor utilizing HIGLAS shall manually update the letter history in HIGLAS to reflect the date the manual ITR letter was sent.*

5. *The contractor utilizing HIGLAS shall manually update the AR status code in HIGLAS to 'LTR-SNT-ITR' to reflect the date the ITR was sent.*

6. *If the ITR letter is returned as undeliverable, the contractor utilizing HIGLAS shall update the status code to 'LTR-UNDL,' regardless if a better address can or cannot be located.*

7. *If the contractor locates a better address for the undeliverable ITR letter, the contractor shall send the provider a manual 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. Debt Collection System (DCS)

The contractor shall ensure that debts are entered *into* DCS timely and accurately. *The* contractor shall provide at least 60 days' notice from the date of the ITR *letter*, before entering the debt *into* DCS *for referral to Treasury*. If the ITR *letter* is returned undeliverable and a better address cannot be located, the contractor shall, *no earlier than 60* days of the returned ITR *letter*, enter the debt *into* DCS for referral to Treasury. (Refer to Pub. 100-06, Chapter 4, §70 for further detail.)

9. 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.

70.6 - Debt Ineligible for Referral

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17,Implementation: 07-03-17)

Non-MSP debt ineligible for referral include those: (1) in bankruptcy status, (2) in an appeal status (pending at any level), (3) at the Department of Justice, (4) where the debtor is deceased,

(5) Federal entity debt where the debtor is a Federal agency, (6) where the principal *and interest* balance is less than $25, or (7) debt under fraud and abuse investigation where the investigating unit has provided the contractor with specific instructions not to attempt collection.

Treasury has also approved a waiver for the mandatory referral of unfiled cost report debt for cross servicing and/or TOP and for debts less than $100 that do not have a TIN.

Medicare contractors shall monitor debt previously ineligible for referral that become eligible for referral. If the status of the debt changes to an eligible status, Medicare contractors shall determine whether an *ITR letter* has been sent. If the *ITR letter* has been sent, and at least 60 days have passed since the date of the *ITR letter* (*including* the *ITR letter* returned undeliverable), Medicare contractors shall input the debt to the Debt Collection System (DCS) within ten calendar days of the status change making the debt eligible for referral. If the *ITR letter* has not been sent, Medicare contractors shall send the *ITR letter* within ten calendar days of the status change making the debt eligible for referral, and follow the normal debt referral process.

70.7 - Intent to Refer Letter

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

To comply with the DCIA requirements to provide specific notice to debtors before referring a debt for cross servicing and/or TOP, Medicare contractors shall send an Intent to Refer (*ITR*) letter as their final demand letter for all eligible delinquent debt. The "final demand letter" is defined as the last letter routinely sent to debtors to request payment, and shall be sent when or before the debt is 90 days delinquent (120 days from the determination date). This letter may be sent before the debt is 90 days delinquent; however, the letter should not be sent until the contractor has placed the debtor on recoupment status for at least 30 days. A sample *ITR* letter is included in Exhibit 1 of this section.

The *ITR letter* shall be sent regardless of previous collections on the debt, unless there is an approved current extended repayment agreement in effect.

When appropriate, the *ITR letter* shall include the amount of interest due, along with the date of the last interest accrual. Medicare contractors may add additional wording to this letter that shall provide additional instructions or clarification regarding the recoupment of the overpayment.

Medicare contractors should use their own language in the opening paragraphs to explain the reason for the overpayment and the current balance, including interest accrued and the interest rate.

The *ITR letter* shall be signed by the Medicare contractor official who routinely signs the demand letters.

The *ITR letter* may be sent for debt currently ineligible for referral based on the status if the contractor believes the debt shall become eligible for referral in the future. The language in the *ITR letter* shall include a sentence that says: "If, after sixty calendar days from the date of this letter we have not received such evidence, your debt, if it is still outstanding and eligible for referral, shall be referred to the Department of Treasury or its designated Debt Collection Center for cross servicing/offset." The *ITR letter* shall not be sent if the debt is in a status that excludes it from receiving demand letters.

70.8 - Response to Intent to Refer Letter

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

Medicare contractors shall respond to any inquiries received as a result of the *ITR letter* within 15 calendar days of receipt. If the status of the debt changes based on the communications with the debtor, Medicare contractors shall update all appropriate systems timely.

The *ITR letter* provides debtors with 60 calendar days to respond. If, by day 61 the debtor has not responded, Medicare contractors shall input the debt *into* DCS. The debt shall be entered to the DCS no later than 70 calendar days from the date of the *ITR letter*. Debt for which less than full payment was received, or there is

a current repayment agreement that is in default, are eligible for referral for cross servicing and/or TOP. Where there has been a partial recoupment or collection, but the collection is not the result of a current extended repayment agreement, the balance (if principal *and interest* balance is greater than or equal to $25) shall still be referred for cross servicing and/or TOP. Debts that are ineligible for referral or exempt from referral to cross servicing and/or TOP shall not be entered to the DCS.

Before inputting a debt *into* DCS for cross servicing, Medicare contractors shall first determine if the debt should be referred to the Regional Office (RO) for litigation rather than referral to Treasury for cross servicing. If it is determined that the debt should be litigated, contact the RO for further action.

If the *ITR letter* is returned as undeliverable, Medicare contractors shall follow established procedures to locate a better address. (See Chapter 4, *§§* 10 and 80.) If a better address is obtained, *the contractor shall send the provider a manual ITR notification letter, with the original ITR letter attached, to the better address. The original ITR letter date shall remain in effect.* If the *ITR letter* is returned as undeliverable and a better address cannot be located, Medicare contractors *not utilizing HIGLAS* shall input the debt *into* DCS *at least 60* calendar days of return of the letter.

70.16 - *Contractor* Claims Accounts Receivable (A/R)

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

Contractor claims A/R arises from adjustments in the *contractor's* claim processing systems (this type of adjustment may also be referred to as a carryover adjustment). The adjustments may be the result of duplicative processing of a claim, payment of a claim at the wrong Diagnostic Related Group (DRG) rate, a request from a provider, or for any reason an *contractor* adjusts a claim payment. These adjustments are usually recovered through recoupment and the recovered amounts are included in the remittance advices to the providers. If the overpayment has not been recouped, the balance remains outstanding and is reported on the *contractor's* financial records.

The CMS has determined that these types of debt are eligible for referral for cross servicing/Treasury Offset Program (TOP). The following outlines procedures for referral/collection/termination of collection action and write-off closed of these debts. Intermediaries shall use these procedures to:

- Address the current inventory of *contractor* claims A/R.
- Demand and refer delinquent *contractor* claims A/R as part of their on-going debt collection procedures.

To identify and address the current inventory of outstanding *contractor* claims A/R and to identify, on an ongoing basis, claims A/R to be demanded or recommended for termination of collection action and write-off closed, intermediaries' shared system shall be able to separately identify the following:

- Claims A/R, of any amount, regardless of age, that cannot be validated.
- Claims A/R, for an individual provider, totaling less than $25 for the aggregated principal *and interest* balance, where no adjustment/recoupment has occurred in the past 60 days.
- Claims A/R for an individual provider, greater than 10 years old, regardless of amount.
- Claims A/R, for an individual provider, with an aggregate principal *and interest* balance greater than or equal to $25, which is less than 10 years old, and no adjustment/recoupment has occurred in the past 60 days.

After these separations are made, the following procedures shall be followed:

For Recommendation of Write-Off (Termination of Collection Action):

When recommending write-off (termination of collection action), intermediaries shall follow instructions as outlined in the overpayment section of this manual, which begins at Section 100, or contact their regional office (RO) for guidance.

- Claims A/R for an individual provider, totaling less than $25 for the aggregated principal *and interest* balance, where no recoupment has occurred in the past 60 days, should be recommended for termination of collection action and write-off closed. A listing should be forwarded to the RO which contains the following information:
    - Provider number;
    - Provider name;
    - Amount of claims A/R being requested for termination of collection action and write-off closed;
    - Date of claims A/R;
    - Date of last activity; and
    - Reason for requesting/recommending termination of collection action and write-off closed.

- Claims A/R, of any amount, regardless of age that cannot be validated, should be recommended for termination of collection action and write-off closed. This could include claims A/R received as a result of a Medicare contractor transition where no remittance advices are available, and other claims A/R where no remittance advice is available to support the balances. The *contractor* shall make a concerted effort to validate the claims A/R before selecting this option. A listing of this claims A/R shall be forwarded to the RO for approval. The list should contain the same information as above, with the reason for termination of collection action and write-off recommendation that provides reasonable evidence to substantiate that the claim is no longer available.

- Claims A/R for an individual provider greater than 10 years old, regardless of amount, shall be recommended and submitted to the RO for termination of collection action and write-off closed.

Intermediaries shall submit, at least quarterly, recommendations for write-off and termination of collection action of outstanding claims A/R meeting the above criteria. Requests shall be submitted to the RO no later than 30 days after the end of each calendar quarter. ROs shall have 30 days after receipt of the request to respond, except for cases exceeding the RO's delegated authority. For those cases exceeding the RO authority, the RO shall forward the case to CO with the RO's recommendation, within 30 days of receipt of the contractor's request.

For issuing an initial demand letter:

This instruction supersedes any other instructions for issuing demand letters for claims A/R, including those found in FMM Section 130. These instructions, however, do not apply to medical review and fraud overpayments. Claims A/R that are demanded shall age and accrue interest and the aging and interest accrual shall be reported in accordance with chapter 5, *§* 200.

Claims A/R for an individual provider with an aggregate principal *and interest* balance greater than or equal to $25 and less than 10 years old, and where no recoupment has occurred in the past 60 days, shall be validated and intermediaries shall send an initial demand letter for the outstanding amount claim A/R balance. The demand letter shall have a determination date equal to the date of the demand letter. In accordance with the *contractor's* established demand process, the provider shall have 15 days to respond to the demand letter. In addition, the demand letter shall contain the following:

- The letter shall explain the reason for the overpayment, provide the debtor with the opportunity to repay the debt, and explain that interest shall begin to accrue if the debt is not paid in full within 30 days. The letter shall provide the debtor with appeal rights and

contain all provisions of a standard initial demand letter. The letter shall also contain language that explains how the overpayment was determined and that the claims A/R have been outstanding as an adjustment, with no recoupment activity in the last 60 days. Intermediaries shall include the date(s) of the remittance advice and original amount(s) of the claims A/R.

- If the initial demand letter is returned as undeliverable, the *contractor* shall attempt to locate a *better* address. If a *better* address is found, or it is determined that there was a change of ownership, the *contractor* shall send the *provider a manual demand notification letter, with the initial demand letter attached* to the *better* address/owner.

- If a current address cannot be located, the *contractor* shall send the Debt Collection Improvement Act of 1996 (DCIA) intent to refer *(ITR* letter, and follow established debt referral procedures.

- If the initial demand letter is not returned undeliverable, the *contractor* shall follow established debt collection procedures similar to other accounts receivable overpayments as outlined in chapter 3, *§§* 20 and 40, with the exception that withhold does not stop for claims A/R for fifteen days from the initial demand letter. The claims A/R debt collection process shall include sending the DCIA *ITR letter* if the overpayment is not recouped. The DCIA *ITR letter* shall be sent no later than 120 days from the date of the initial demand letter.

- Each demanded claim A/R shall be considered a separate identifiable debt and shall not be aggregated with other demanded claim A/R.

- The contractors' shared system must be able to properly report these claims A/R in accordance with financial reporting requirements outlined in *Medicare Financial Management Manual, Publication* 100-6, Chapter 5, *§§* 200 through 400.

Exception to above procedures for issuing the initial demand letter:

If the *contractor* has knowledge that the letter to a debtor shall be returned undeliverable, based on prior attempts to contact the debtor, and where the *contractor* cannot obtain a current address, the initial demand letter may be expanded to include the DCIA *ITR letter* language. The *contractor* shall send the initial demand letter with the DCIA *ITR letter* language and follow established debt referral procedures. The date of the initial demand letter shall be the determination date for aging, interest accrual and DCIA referral purposes.

Claims A/R that are outstanding, but have not yet been demanded because they have not met the timeframe for issuing an initial demand letter or do not meet the dollar threshold for being demanded should be considered in cost report settlements if collection by withhold from interim payments or through the claims accounts receivable demand process is doubtful. Claims A/R that have been demanded, in accordance with these instructions, shall not be included in the cost report settlement process, as these are now considered as separate receivables.

If the *contractor* determines that the provider has filed bankruptcy, established procedures regarding bankruptcy in Chapter 3, *§*140 shall be followed, including administrative freezes on recoupment, exemption to DCIA, and issuance of letters regarding the overpayment. This instruction does not change any of the procedures to be followed for bankrupt providers.

70.17.3 - Debts RTA by Treasury as Dispute Response not Received Timely (RX)

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

The Treasury returns debts with this status code because the dispute response was not received timely. The debts in this status will update to RX (RTA - Dispute Timer Expired) in DCS, if the debt was still in a dispute status code or was updated to UJ or UX (Dispute Resolved, Debt Returned for Cross-Servicing). The contractor shall research and resolve the debts in RX status in order to determine the current status of the debts. No further action is necessary if the debts are already in a recalled status. The contractors shall add a comment on the DCS comment screen reflecting any action taken, the date of the RTA report in which the debts appear on and the financial statement reporting quarter in which the debts were resolved.

If the debts are still valid and eligible for referral to Treasury, the contractors shall re-enter debts as new entries in DCS, even if a response to the disputes were previously submitted to Treasury. The contractors shall not issue a second Intent to Refer *(ITR)* letter. However, the contractors shall change the status code of the original debt in DCS from RX to 2R (See Exhibit 4 of this section, the DCS User Guide, Section 2.1). If the final determination indicates that the debts should be in recall status, the contractors shall update the original debts in DCS from RX to the appropriate recall status code.

70.17.4 - Debts RTA by Treasury as a Miscellaneous Dispute, a Manual RTA, Complaint or as Recall Approved (RD)

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

The CMS updates the DCS to status code RD if the debts are not already in a recalled status. The contractors shall research and resolve debts in status code RD and update the DCS with the final disposition of the debts. If any debts are still valid and eligible for referral to Treasury, the contractors shall change the status code of the debts from RD to 2R and re-enter the debts as new entries in the DCS to be resubmitted to Treasury. The contractors shall not issue a second Intent to Refer *(ITR)* letter for the debts. (See Exhibit 4 of this section, the DCS User Guide, Section 2.1). Lastly, the contractors shall add a comment on the DCS comment screen reflecting any action taken, the date of the RTA report in which the debts appear on and the financial statement reporting quarter in which the debts were resolved.

Exhibit 1 - *Intent to Refer (ITR) Letter*

(Rev. 294, Issued: 10-06-17, Effective: 07-03-17, Implementation: 07-03-17)

Intent to Refer Letter

Background

The DCIA requires Federal agencies to refer debt that is 120 days delinquent to the Department of Treasury or a Treasury designated Debt Collection Center for cross servicing.

Prior to debt transfer, the DCIA requires agencies to inform the debtor of the agency's intent to refer the debt, and to provide debtor information regarding the referral process.

Attached are specific paragraphs that explain the process and debtor rights. These paragraphs shall be included in the intent to refer letter sent to the debtor.

Medicare contractors should use their own language in the opening paragraphs to explain the reason for the overpayment and the current balance, including interest accrued and the interest rate.

Subject in Bold: **Notice of Intent to Refer Debt to the Department of Treasury's Debt Collection Center for Cross Servicing and Offset of Federal Payments and Certain Eligible State Payments**

Contractor opening paragraphs concerning the reason for the overpayment, date of determination and amount due. May refer to previous demand letters or other forms of contact regarding the debt.

Your debt to the Medicare Program is delinquent and, by this letter, we are providing notice that your debt will be referred to the Department of Treasury's Debt Collection Center (DCC) for Cross Servicing and Offset of Federal Payments. Your debt will be referred under provisions of Federal law, title 31 of the United States Code, Section 3720A and the authority of the Debt Collection Improvement Act of 1996.

The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer delinquent debts to the Department of Treasury and/or a designated Debt Collection Center (DCC) for collection through cross servicing and/or the Treasury Offset Program. Under the offset program, delinquent Federal debts are collected through offset of other Federal agency payments you may be entitled to, including the offset of your income tax return through the Internal Revenue Service (IRS). The TOP offsets can also be taken from eligible state payments to which you are entitled.

The Debt Collection Center will use various tools to collect the debt, including offset, demand letters, phone calls, referral to a private collection agency and referral to the Department of Justice for litigation. Other collection tools available, which may be used, include Federal salary offset and administrative wage garnishment. If the debt is discharged, it may be reported to the IRS as potential taxable income.

During the collection process, interest will continue to accrue on the debt and you will remain legally responsible for any amount not satisfied through the collection efforts.

For Individual Debtors Filing a Joint Federal Income Tax Return

The Treasury Offset Program automatically refers debts to the IRS for offset. Your Federal income tax refund is subject to offset under this program. If you file a joint income tax return, you should contact the IRS before filing your tax return to determine the steps to be taken to protect the share of the refund which may be payable to the non-debtor spouse.

Federal Salary Offset

If the facility ownership is either a sole proprietorship or partnership, your individual salary(s) may be offset if you are or become a federal employee.

Medicaid Offset

As authorized at 42 CFR 447.30, (Subsection 1885 of the Social Security Act), CMS may instruct the State Medicaid Agency to offset the Federal share of any Medicaid payment due you, your agency and/or related facilities. At that time, the offset will remain in effect until the Medicare overpayment is paid in full.

Please read the following instructions carefully to determine what action you may take to avoid referral for cross servicing/offset.

Due Process

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing to the address listed below. You have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise this right, this office must receive a copy of the evidence to support your position, along with a copy of this letter. You must submit any evidence that the debt is not owed or legally enforceable within 60 days of the date of this letter. If, after sixty days from the date of this letter, we have not received such evidence, your debt, if it is still outstanding and eligible for referral, will be referred to the Department of Treasury or its designated Debt Collection Center for cross servicing/offset.

Repayment

Your debt will not be referred to the Department of Treasury if you make payment in full. The past due amount of $____________owed to the Medicare Program as of _____________ includes interest accrued through _____________. (**Note: Medicare contractors may alter this sentence to read: The past due amount owed to the Medicare Program as of the date of this letter includes current accrued interest. This sentence may be omitted for debts that do not accrue interest.**) Interest is accrued monthly and is added to the balance of the debt.

Your check or money order for the amount due should be made payable to:

Medicare
Contractor Address
000 Street
Anywhere, USA 00000-0000.

Include a copy of this letter with your payment.

If you cannot make payment in full, you may be allowed to enter into an extended repayment agreement. If you are interested in an extended repayment agreement, please contact this office.

Bankruptcy

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

If you have any questions concerning this debt, please contact ________________
at ________________.

Sincerely,

____
Signature of Certifying Official

Official Position