Medicare Secondary Payer (MSP) Manual

Chapter 7 - Contractor MSP Recovery Rules

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(Rev. 15, 4-30-04)

10 - General

(Rev. 1, 10-01-03)

A3-3490.3.G, A3-3491.13, B3-3329.9

If a contractor receives information that a GHP should have been primary payer for services provided to an identified beneficiary, they take the actions described below.

10.1 – IRS/SSA/CMS Data Match (Data Match) Identified Cases

(Rev. 1, 10-01-03)

Contractors take the actions described below for services identified within the time period specified in CMS' current fiscal intermediary budget and performance requirements (BPR)s.

1. Search claims history for the time period specified in the BPR to determine if the Medicare payments made with respect to any report ID (or group of report IDs) equals or exceeds the recovery tolerance for Data March cases specified in the BPR.

2. Prior to mailing out a demand, Medicare contractors must validate the MSP record on the Common Working File (CWF) and include a screen print of the CWF information in the case file;

3. For valid cases, contractors send the employer demand letter found at the end of this section to the identified employer. They include claims facsimiles (showing the amount Medicare paid) for the claims for which Medicare seeks payment and the other identified enclosures to the letter. (Examples are provided with the demand letter.) They aggregate all Data Match letters with respect to report IDs on any Data Match cycle linked to a single employer.

NOTE: If a contractor's system will recognize an existing termination date on an MSP record prior to the generation of a demand, that contractor is not required to check CWF prior to the mailing of the demand. If a contractor's system does not recognize an existing termination date on an MSP record, that contractor is required to check CWF prior to mailing.

4. The employer or other entity acting on the employer's behalf may respond with a full or partial payment. If the employer or other entity repays Medicare in full (including any applicable interest), contractors close the case.

5. If the employer or other entity provides a full payment for certain services and provides a valid documented defense for all other services, contractors close the case. (A valid documented defense consists of evidentiary material demonstrating that the GHP was not obligated to repay Medicare pursuant to the MSP provision. (An assertion of a defense without supporting evidence is **not** a valid documented defense.)

6. If the employer or other entity makes less than a full payment or provides less than a valid documented defense, contractors must adjust the recovery claim as appropriate and keep the case open.

7. To the extent that an employer or the other entity responds with a valid documented defense to any portion of a recovery claim, contractors must adjust the claim accordingly. If the valid documented defense is that the GHP made

primary payment to a provider or beneficiary, contractors must recover from the provider or beneficiary as explained in §10.3.

8. If an employer or other entity requests specific information or asks a specific question about the recovery claim, contractors must provide the information or answer the questions. If a contractor is unsure how to proceed in a specific situation, they should consult with their RO.

Data Match cases are tracked in a special tracking system, the Mistaken Primary Payment Recovery Tracking System (MPaRTS), which is maintained by CMS.

9. Contractors are required to update the MPaRTS and keep the information in the system current as specified in the systems documentation and the current year BPR.

10.2 – Other Than Data Match Identified Cases

(Rev. 1, 10-01-03)

A3-3491.13, B3-3329.9

Contractors take the following actions within the time period specified in CMS' current fiscal year BPRs.

1. Contractors search their claims history for the time period specified in the BPR to determine if payments they made with respect to the case equals or exceeds the recovery tolerance for non-Data Match cases specified in the BPR.

2. Contractors check the CWF MSP Auxiliary File. If the CWF MSP Auxiliary File identifies the employer with sufficient specificity (name and address) or the contractor otherwise knows the identity of the employer, they notify the COB contractor through an ECRS CWF MSP Inquiry Transaction to add the employment information to the MSP Auxiliary File.

3. Contractors send the employer demand letter found at the §10.5 to the identified employer. They include claims facsimiles (showing the amount Medicare paid) for the claims for which Medicare seeks repayment and the other identified enclosures to the letter. (Examples are provided with the demand letter.) Contractors must aggregate employer demand letters to the extent possible for the purpose of bulk mailing.

4. If the CWF MSP Auxiliary File does not identify the employer with sufficient specificity and the contractor otherwise does not know the identity of the employer, but the CWF MSP Auxiliary File does identify the "insurer," the contractor must send the insurer/TPA/Plan (insurer) demand letter to the insurer. Include claims facsimiles (showing the amount Medicare paid) for the claims for which Medicare seeks repayment and other identified enclosures to the letter. (Examples are provided with the demand letter.)

5. The employer or other entity acting on the employer's behalf may respond with a full or partial payment. The contractor must close the case if the employer or other entity repays Medicare in full (including any applicable interest).

6. The contractor closes the case if the employer or other entity provides a full payment for certain services and provides a valid document defense for all other services. (A valid documented defense consists of evidentiary material demonstrating that the GHP was not obligated to repay Medicare pursuant to the MSP provision. (An assertion of a defense without supporting evidence is **not** valid documented defense.)

7. If the employer or other entity makes less than a full payment or provides less than a valid documented defense, the contractor adjusts the recovery claim as appropriate and keeps the case open.

8. To the extent that an employer or the other entity responds with a valid documented defense to any portion of a recovery claim, the contractor adjusts the claim accordingly.

9. If the valid documented defense is that the GHP made primary payment to a provider or beneficiary, the contractor recovers from the provider or beneficiary as explained in §10.3.

10. If an employer or other entity requests specific information or asks a specific question about the recovery claim, contractors must provide the information or answer the questions. If a contractor is unsure how to proceed in a specific situation, they should consult with their RO.

10.3 – Source of Recovery Action

(Rev. 1, 10-01-03)

A. GHP Acknowledges Specific Debt

If a group health plan (or insurer, TPA, or employer) specifically acknowledges that Medicare made a mistaken primary payment for a specific service and specifically acknowledges that it should have or did make primary payment, the contractor recovers the Medicare primary payment from the appropriate entity.

B. Recovery From the Provider, Physician, or Supplier

If both Medicare and the GHP made primary payment to the provider, physician, or supplier, the contractor recovers from the provider, physician, or supplier.

C. Recovery From the Beneficiary

If both Medicare and the GHP made primary payment to the beneficiary, the contractor recovers from the beneficiary.

D. Recovery When a State Medicaid Agency Has Also Requested a Refund From the GHP

Situations may arise in which both Medicare and another insurer or a State Medicaid agency have conditionally or mistakenly paid for services and the amount payable by a GHP is insufficient to reimburse both programs. Under the law, Medicare has the right to recover its benefits from a GHP before any other entity does, including a State Medicaid agency. Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that was paid by a GHP.

The superiority of Medicare's recovery right over other entities including Medicaid derives from the Medicare statute. It states that where Medicare is secondary to another insurer:

- Medicare may recover Medicare benefits from the responsible insurer;
- Medicare is subrogated to the right of the Medicare beneficiary and the right of **any other** entity to payment by the responsible insurer, and
- Medicare may recover its payments from **any** entity that has been paid by the responsible insurer.

Medicare's right to recover from a GHP or from a beneficiary that has been paid by a GHP is higher than Medicaid notwithstanding the fact that Medicaid is the payer of last resort, and therefore does not pay until after Medicare. Medicare priority right of recovery from insurance plans that are primary to Medicare does not violate the concept of Medicaid's being payer of last resort. Under §1862(b)(2) of the Act, Medicare's statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by a GHP which is primary to Medicare. Where the GHP pays right away, Medicare makes no payment to the extent of the GHP payment. A delay of GHP payment does not change Medicare obligation to pay the correct amount, if any, regardless of any conditional payments made. Thus, if the GHP pays less than the charges, Medicare may be responsible to pay secondary benefits. And, if a third party pays the charges, Medicare may not pay at all. Pro-rata or other sharing of recoveries with Medicaid would create a Medicare payment where none is authorized under the law, or improperly increase the amount of a Medicare secondary payment.

The right of Medicaid agencies to recover benefits derives from an assignment by Medicaid beneficiaries to the States of their rights to third party reimbursement. The beneficiary can assign a right no higher than his/her own, and since Medicare statutory right is higher than the beneficiary's, Medicare right is higher than the State. Where both Medicare and Medicaid are seeking reimbursement, the contractor must inform the GHP that it must first reimburse the Medicare program before it can pay any other entity, including a State Medicaid agency.

Where a beneficiary, provider, physician, or supplier receives payment from a GHP, the contractor must inform the payee that it is obligated to refund the Medicare payment up to the full amount of the GHP payment before payment can be made to the State Medicaid agency. Only after Medicare has recovered the full amount does the beneficiary, provider, physician, or supplier have the right to reimburse Medicaid or another entity.

If a State Medicaid agency is reimbursed from a GHP payment before Medicare, ask the State Medicaid to reimburse Medicare up to the full amount it received. The contractor must explain the legal basis for Medicare's right to recover and if the State refuses, the contractor refers the case to the RO.

10.4 – Contractor Recovery Case Files (Audit Trails)

(Rev. 1, 10-01-03)

A3-3329.6.G, B3-3491.13.G

Contractors must maintain a recovery case file for all cases in which they have attempted recovery. Each case file must be organized as follows:

- Place the label on the outside of the folder where it can be readily seen, preferably at the upper left hand corner of the file folder with the name of the third party payer;
- Label the upper right hand corner of the file folder with the name and HICN of the beneficiary;
- The following documents should be inside the file folder;
- Copies of all demand letters;
- A copy of the accountability worksheet (see example at the end of this section)
- Copies of the return receipt mail card;
- Copies of any responses from the third party payer;
- Copies of all claims for which a recovery is being sought;
- Copies of the IRS/SSA/CO Data Match report (where applicable);
- Any other materials related to the case;
- All these materials should be fastened to the right hand side of the file folder.

10.5 - Employer Letter

(Rev. 16, 05-21-04)

B3-3329.13, A3-3491.17

Dear Employer:

We are writing to advise you that your organization either has sole liability or shares liability for a debt to the Medicare program. The following explains how this happened and what you must do to resolve this matter.

How This Happened

This repayment claim arises because Medicare mistakenly made primary payments for services furnished to the Medicare beneficiaries identified below that should have been the primary payment responsibility of a group health plan that you sponsor or to which you contribute. The Medicare Secondary Payer (MSP) provisions of the Social Security Act require group health plans to make primary payment for services provided to Medicare beneficiaries if those individuals are also covered by the group health plan and certain conditions delineated in the Medicare law (42 U.S.C. 1395y(b)) and regulations (42 CFR 411.20*ff*) are satisfied. Medicare did not know that these conditions were satisfied at the time that Medicare made primary payment for certain services. The information now available to Medicare indicates that these conditions were satisfied when the services were provided.

The Medicare law obligates us to recover primary payments that Medicare mistakenly made when a group health plan is the proper primary payer. We may recover from any entity responsible for making primary payment, including employers *that sponsor or contribute to group health plans,* other plan sponsors, and insurers.[1] We are sending this letter to you because you are an entity responsible for payment under the Medicare law and are subject to an excise tax under the Internal Revenue Service if any group health plan that you sponsor, or to which you contribute, fails to comply with the MSP requirements. We want to afford you every opportunity to resolve this matter. We also encourage you to contact other entities, such as the plan itself or the plan's insurer (if

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[1] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(iii), in order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.*

any), that are also entities responsible for payment, for assistance in resolving this matter. An enclosure entitled, "**Important Information for Employers**" explains further how your obligations arise and what happens if you do not satisfy your obligations.

The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized below. Detailed information about each beneficiary and the services for which Medicare mistakenly paid primary are provided in an enclosure to this letter.

Name:
Health Insurance Claim Number:
Total Repayment Requested:

How to Resolve This Matter:

Within 60 days of the date of this letter, you or someone acting on your behalf; e.g., your insurer or plan administrator, must provide one of the following responses.

1. Repayment of the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan (as a primary payer). Please provide the report identification number, which is found in the upper right corner of the enclosed summary sheet, with the repayment. If the amount repaid for any item or service is less than the amount that Medicare paid, provide an explanation of how the amount repaid was determined. If primary benefits already have been paid to the beneficiary or provider of the services shown in the enclosures, please provide a copy of the explanation of benefits and proof of payment;

2. If the group health plan is not obligated to make primary payment under any circumstances for services provided to an identified beneficiary under the Medicare Secondary Payer provisions, provide an explanation as to why not and a copy of any applicable plan provision. Include the name, address and tax identification number on the plan and, if applicable, other plan sponsors, insurers and third party administrators.

    - If the specific basis upon which the group health plan is not obligated to make primary payment for services provided to an identified beneficiary under the Medicare Secondary Payer provisions is that the plan's claims filing requirements have not been met[2], submit a written statement indicating that all existing records of the plan have been searched and indicate whether a claim for the identified services was found under any plan (primary or

[2] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(v).*

supplemental) covering the individual. Identify the plan's claims filing requirements and provide a copy of the applicable plan provisions.

- If the claim is denied by the group health plan because the claim was not timely filed, consider this letter, pursuant to Medicare's subrogation rights, to constitute an appeal of the denial by the identified individual. Similarly, if the identified individual may seek waiver of this plan requirement, consider this letter to be a request for waiver. The plan must apply the same criteria to this appeal and request for waiver as it would had the appeal or waiver request been made by the identified individual. Please notify Medicare of the plan's decision regarding the appeal and waiver request and provide copies of any plan provisions upon which it bases its decisions.

Dates of coverage under the group health plan are shown on the enclosed summary sheet. If you believe the dates listed are inaccurate, please provide the correct dates of coverage along with your repayment or explanation of why Medicare is primary. Please include the Medicare report identification number *from* the summary sheet on all correspondence. This enables Medicare to reconcile its records.

Your failure to respond within sixty (60) days of the date of this letter will be taken as evidence of noncompliance with your responsibility, which may result in the initiation of additional recovery procedures.

If you fail to pay this debt to Medicare or take other action as described above within 60 days of the date of this letter, Medicare will assess interest beginning with the date of this letter (42 CFR 411.24(m), 42 U.S.C. 1395y(b)(2)(B)(*I*)). Any payments made in satisfaction of this debt will be applied first to the amount of interest due, then to the principal.

Medicare may also determine that the group health plan is a nonconforming group health plan. The basis upon which CMS will make a determination of nonconformance is explained at 42 CFR 411.110, et seq. If a group health plan is determined to be nonconforming, the Internal Revenue Service will impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations which contribute to the health plan (Section 5000 of the Internal Revenue Code). Moreover, 31 U.S.C. 3720(*a*) provides that agencies of the United States Government may refer debts to the Internal Revenue Service for collection by offset against tax refunds owed to individuals or entities by the Government. In addition, the Debt Collection Improvement Act of 1996 requires Federal Agencies to recover debts by offset against any monies otherwise payable to the debtor by the United States.

For further reference to the Medicare program's rights of recovery and potential penalties for noncompliance, please see 42 U.S.C. 1395y(b) and regulations found at 42 CFR 411.20-37, 411.100-206.

If you have any questions concerning this matter, please write or call _____ at _____.

Sincerely,

MSP Supervisor

Enclosures:
MSP Summary Data Sheet;
Summary of Medicare Payments;
Claims Facsimiles
Important Information for Employers

10.5.1 - Important Information for Employers

(Rev. 16, 05-21-04)

B3-3491.17, B3-3329.13

Important Information for Employers

Employers often ask us to explain why an employer, especially one who purchases insurance from an insurance company, has or shares liability for this debt and to explain the potential consequences if the employer fails to resolve this matter. We provide these explanations in this enclosure.

Congress has created a statutory framework in the Medicare statute and the Internal Revenue Code that imposes responsibility on an employer for its plan's actions in certain circumstances. The Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. *1*395y(b)) state that Medicare may seek to recover a mistaken primary payment from "any entity which is required or responsible" to pay for medical services under a primary plan. *The statute specifically identifies employers that sponsor or contribute to group health plans as such an entity. This means that Medicare may hold an employer responsible if the employer sponsors the group health plan, is a "self insurer" for the group health plan, contributes to the purchase of an underwritten health insurance product, or otherwise contributes to the group health plan.*

The MSP provisions generally require group health plans to make payments primary to Medicare for:

1. Individuals entitled to Medicare on the basis of age or disability if the individual has coverage under the group health plan on the basis of the individual's own or a family member's current employment status; and

2. Individuals who are or could be entitled to Medicare on the basis of end stage renal disease for a thirty-month coordination period if the individual is covered under a group health plan on any basis.

A group health plan is defined in the Internal Revenue Code at 26 U.S.C. §5000(b) as a "plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families." Taken together, the MSP provisions and the Internal Revenue Code definition of group health plan establish that employers have, or at least share, responsibility for the group health plan's c*o*mpliance with the MSP rules.

Employer accountability is also reflected by Internal Revenue Code provisions allowing the employer to claim health plan expenditures as a deductible business expense (26 U.S.C. §162), and subjecting the employer to an excise tax if a plan to which it contributes does not conform to the MSP provisions (26 U.S.C. §5000(a) and (b)). Employers create, direct, authorize and control their health plans. Where an employer establishes a plan to provide health benefits indirectly through insurance, the employer determines the nature of the coverage and has the right to enforce its insurance contract to assure compliance with applicable laws.

Regulations under the Federal Claims Collection Act establish that all entities responsible for paying a debt to the Federal Government are jointly and severally liable for payment of the debt. As previously explained, the employer is one of potentially several entities responsible for making primary payment under the MSP provisions. If the United States must take legal action to recover this debt, the Government may take action against any or all entities responsible for payment, including the insurer, the plan and the employer (See 42 U.S.C. §1395y(b)(2)(B)(*iii*); and 42 CFR 401.623.) If the Government is unable to recover the total debt from one of the entities responsible for payment, it may then pursue recovery from another.

If an employer does not repay Medicare or arrange for Medicare to be paid in full, any tax refunds that may be due the employer under the Internal Revenue Code may be applied toward satisfaction of the MSP debt (31 U.S.C. 3720(*a*)). In addition, the MSP provisions state that a plan that does not repay Medicare may be held to be a "nonconforming" plan (See 42 U.S.C. §1395y(b)(3)(B) and 42 CFR 411.100 et seq.) The Internal Revenue Code at §5000 imposes a 25 percent excise tax on all employers, except government entities; on all health plan expenditures of employers and employee organizations that contribute to a nonconforming group health plan. A plan may be found to be nonconforming both in the year that it failed to repay Medicare and in the year in which it was originally obligated to have made primary payment. In addition, the Debt

Collection Improvement Act of 1996 (Chapter 10 of P.L. 104-134) requires Federal Agencies to collect debts by offset from any monies otherwise payable to the debtor by the United States.

10.6 – Insurer Letter

(Rev. 16, 05-21-04)

A3-3491.17, B3-3329.13

Dear Sir or Madam:

It has come to our attention that Medicare has made payment for services, under the Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)(*2*)), when payment may be or is the responsibility of a group health plan for which you are/were the insurer, underwriter, sponsor, or claims processor. The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized below. Detailed information about each beneficiary and the services for which Medicare mistakenly paid primary are provided in an enclosure to this letter.

Name:
Health Insurance Claim Number:
Total Repayment Requested:

How This Happened

The MSP provisions of the Social Security Act require group health plans to make primary payment for services provided to Medicare beneficiaries if those individuals are also covered by the group health plan and certain conditions delineated in the Medicare law (*4*2 U.S.C. 1395(y)(b)) and regulations (42 CFR411.20ff) are satisfied. Medicare did not know that these conditions were satisfied at the time that Medicare made primary payment for certain services. The information now available to Medicare indicates that these conditions were satisfied when the services were provided.

The Medicare law obligates us to recover primary payments that Medicare mistakenly made when a group health plan is the proper primary payer. We may recover from any entity responsible for making primary payment, including employers *that sponsor or contribute to group health plans*, other plan sponsors, and insurers.[1]

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[1] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(iii), in order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.*

How To Resolve This Matter

Within 60 days of the date of this letter, you must provide one of the following responses:

1. Repayment of the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan (as a primary payer). Provide the report identification number, which is found in the upper right corner of the enclosed summary data sheet, with the repayment. If the amount repaid for any item or service is less than the amount that Medicare paid, provide an explanation of how the amount repaid was determined;

2. If primary benefits already have been paid to the beneficiary or provider of the services shown in the enclosures, provide a copy of the explanation of benefits and proof of payment;

3. If the group health plan is not obligated to make primary payment under any circumstances for service provided to an identified beneficiary under the Medicare Secondary Payer provisions, provide an explanation as to why not and a copy of any applicable plan provision. Include the name, address and tax identification number on the plan.

- If the specific basis upon which the group health plan is not obligated to make primary payment for services provided to an identified beneficiary under the MSP provision is that the plan's claims filing requirements have not been met,[2] submit a written statement indicating that all existing records of the plan have been searched and indicate whether a claim for the identified services was found under any plan (primary or supplemental) covering the individual. Identify the plan's claims filing requirements and provide a copy of the applicable plan provision;

- If the claim is denied by the group health plan because the claim was not timely filed, consider this letter, pursuant to Medicare's subrogation rights, to constitute an appeal of the denial by the identified individual. Similarly, if the identified individual may seek waiver of this plan requirement, consider this letter to be a request for waiver. The plan must apply the same criteria to this appeal and request for waiver as it would *had* the appeal or waiver request been made by the identified individual. *Please* notify Medicare of the plan's decision regarding the appeal and waiver request and provide copies of any plan provisions upon which it bases its decisions.

Dates of coverage under the group health plan are shown on the enclosed summary data sheet. If you believe the dates listed are inaccurate, please provide the correct dates of coverage along with your repayment or explanation of why Medicare is primary. Include the report identification number from the summary sheet on all correspondence. This

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[2] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(v).*

enables Medicare to reconcile its records. Your failure to respond within sixty (60) days of the date of this letter will be taken as evidence of noncompliance with your responsibility, which may result in the initiation of additional recovery procedures. If you fail to pay this debt to Medicare or take other action as described above within 60 days of the date of this letter, Medicare will assess interest beginning with the date of this letter (42 CFR 411.24(m), 42 U.S.C. 1395y(b)(2)(B)(I)). Any payments made in satisfaction of this debt will be applied first to the amount of interest due, then to the principal.

Medicare may also determine that the group health plan is a nonconforming group health plan. The basis upon which CMS will make a determination of nonconformance is explained at 42 CFR 411.110, et seq. If a group health plan is determined to be nonconforming, the Internal Revenue Service will impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations which contribute to the health plan (§5000 of Internal Revenue Code). Moreover, 31 U.S.C. 3720(*a*) provides that agencies of the United States Government may refer debts to the Internal Revenue Service for collection by offset against tax refunds owed to individuals or entities by the Government. In addition, the Debt Collection Improvement Act of 1996 requires Federal agencies to recover debts by offset against any monies otherwise payable to the debtor by the United States.

If you have any questions concerning this matter, please write *or call* _____ at _____.

Sincerely,

MSP Supervisor

Enclosure*s*:
MSP Summary Data Sheet
Summary of Medicare Payment
Requested Reimbursement Summary Report
Summary of Medicare Reimbursement Key
Claims Facsimiles

10.7 - Accountability Worksheet

(Rev. 1, 10-01-03)

Data Match Report (if applicable): _____

Data Match Report Date (if applicable): _____

Beneficiary Name: _____

Beneficiary HICN: _____

Third Party Payer: _____

First Demand Sent: _____

Second Demand Sent: _____

Recovery Status: _____

Recovery Status Date: _____

Total Potential Mistaken Payment Identified: $_____

Additions: _____$_____

Total Recovered: _____$_____

Difference Between Identified Amount and Amount Recovered (1) $_____

Briefly Explain Above Entry:

If the identified third party payer paid primary, list the entities from whom you were required to recoup duplication payment and amount recovered on an attachment.

10.8 – MSP Summary Data Sheet

(Rev. 1, 10-01-03)

A3-3491, B3-3329.13

MSP SUMMARY DATA SHEET | | REPORT ID:
TYPE OF MSP SITUATION: WORKING AGED
DATE OF ACTUAL NOTICE:
BENEFICIARY NAME:
HEALTH INSURANCE CLAIM NUMBER (HICN):
DATE OF BIRTH:
THIRD PARTY PAYER NAME:
THIRD PARTY PAYER ADDRESS:
COVERAGE BEGIN DATE: | COVERAGE END DATE:
GROUP IDENTIFICATION:
PATIENT POLICY IDENTIFICATION:
SUBSCRIBER NAME:
EMPLOYEE ID NUMBER:
EMPLOYER NAME:
EMPLOYER ADDRESS:
REPAYMENT AMOUNT REQUESTED | *SEE ATTACHED DOCUMENTATION |
ACCRUED INTEREST/RATE/DATE
TOTAL REPAYMENT AMOUNT | REQUESTED INCLUDING INTEREST |

MAKE YOUR CHECK OUT TO: THE MEDICARE PROGRAM MEDICARE SECONDARY PAYER UNIT AT TAX EIN: PLEASE INSURE THAT THE REPORT ID AND HICN LISTED ON THE SUMMARY SHEET IS REFERENCED ON YOUR CHECK.
X | CHECK BOX IF CASE WAS IDENTIFIED THROUGH THE IRS/SSA/CMS DATAMATCH

10.8.1 - Field Descriptions on the MSP Summary Data Sheet

(Rev. 1, 10-01-03)

Draft B3-dated 4/14/94

Type of MSP Situation - The FI or carrier must indicate whether the situation is working aged, ESRD, or disability.

Date of Actual Notice - For IRS/SSA/CMS Data Match recoveries this is the date the mistaken payment report (mailed by CMS to the contractor) is run against the FI or carrier internal history file For NON-IRS/SSA/CMS Data Match recoveries this is the date the contractor had actual notice. Actual notice is when the contractor is aware of the following information:

- Name and Address of the insurer, underwriter, third party administrator;
- Name of the beneficiary;
- Health Insurance Claim Number or Social Security Number of the beneficiary;
- Name of the subscriber; and
- Effective dates of coverage under the plan.

For some recoveries, contractors will not list a date because all the information to constitute actual notice is not available. However, contractors should still attempt recoveries and attempt to obtain this information through the recovery process. If enough information is not available to establish actual notice, indicate “Actual Notice Not Established” in this field.

Beneficiary Name - Self Explanatory;

Health Insurance Claim Number - Self Explanatory;

Date of Birth - Self Explanatory;

Third Party Payer Name - The name of the entity that is identified as the primary insurer for the beneficiary. (For example, Blue Cross and Blue Shield of Maryland, United Healthcare, etc);

Third Party Payer Address - The address of the entity identified above as the third party payer;

Coverage Begin Date - The date the coverage under the third party payer plan began;

Coverage End Date - The date the coverage under the third party payer plan ended (if applicable);

Group Identification - The number or code assigned by the third party payer to represent the group the beneficiary has coverage under. NOTE: Not all third party payers use group identification numbers;

Patient Policy Identification - The number or code assigned by the third party payer to represent the policy number the beneficiary has coverage under. NOTE: Not all third party payers use policy identification numbers;

Subscriber Identification Number - The social security number of the employee (beneficiary or spouse);

Employer Name - The name of the employer for whom the subscriber is/was employed. Also the entity to whom the request is being addressed;

Employer Address - The address of the employer. Also, the address to whom to request for repayment is being addressed;

Repayment Amount Requested - The total amount that the contractor is seeking for repayment during the period of coverage under the third party plan. A summary of the identified mistaken payments and documentation should be attached to this cover sheet;

Accrued Interest - Insert data for first demand letter or second demand letter indicated as follows:

- First Demand Letter - Insert the date on which interest will begin to be charged and the rate of interest; or

- Second Demand Letter - The total amount of accrued interest, (also indicate the rate of interest) applicable to a debt which has not been repaid timely;

Total Repayment Amount Requested - the total mistaken Medicare payments, plus any accrued interest;

Make Your Check Out To - Inform the debtor to whom the check for repayment should be made out to and where to send the check. The check sent should also contain a reference to the demand for repayment; and

IRS/SSA/CMS Data Match Line - Check the box if the recovery is based on a mistaken payment report based on information obtained through the IRS/SSA/CMS Data Match process.

10.9 – Payment Record Summary

(Rev. 1, 10-01-03)

A3-3491, B3-3329.13

PAYMENT RECORD SUMMARY

BENEFICIARY NAME:	HICN:	REPORT ID NBR:
PROVIDER NAME:		PROVIDER ID NBR:
DOC CNTL NBR:		
SERVICE DATES: FROM	THRU:	TOTAL CHARGES:
AMOUNT REQUESTED:		ACCRUED INTEREST:
TOTAL AMOUNT REQUESTED:		
TOTAL MEDICARE CHARGES:		
TOTAL ACCRUED INTEREST		
TOTAL AMOUNT DUE:		

10.10 – MSP Demand Letters to Insurers/Third Party Administrators (TPAs) of Employes

(Rev. 1, 10-01-03)

PM-AB-03-120

Contractors must supply copies of all GHP-based recovery demand packages issued to employers to the employer's insurer/TPA. Demand packages include the initial recovery demand letter and enclosures and the subsequent "intent to refer" letter and all enclosures.

All Medicare contractors currently initiate Data Match and Non-Data Match GHP-based recoveries of mistaken payments to the employer if the employer is known. In order to facilitate employer efforts to respond to demand packages, contractors must send a copy

of these demand packages to the insurer/TPA of the employer debtor if the insurer/TPA is known.

Contractors must:

- Send a copy of all initial and subsequent demand packages to the employer's insurer/TPA at the same time they issue the original or subsequent demand package to the employer. The copy does not need to be sent certified mail.
    - In the event the insurer/TPA is not known or the address is incomplete, the contractor should send the demand package only to the employer. Do not develop further for the insurer/TPA name or address or send Electronic Correspondence Referral System (ECRS) inquiries to the Coordination of Benefits Contractor.
    - In the event the insurer/TPA copy is returned to the contractor as "undeliverable," do not attempt to find a better address.
    - Send insurer/TPA copies to the address on the Common Working File (CWF) MSP Auxiliary File.
- Contractors use the cover letter with the copy of the demand package sent to the insurer/TPA. This letter is mandatory in order to ensure consistency. This cover letter should be PC generated.
- Contractors maintain copies of all letters and demand packages sent to employers and insurers/TPAs within the case file.
- Respond to the appropriate individual/entity when contacted about a debt.
    - If the insurer/TPA is acting as an agent of the employer, the contractor must address correspondence to the employer with a copy to the insurer/TPA. The cover letter for the copy of the demand package sent to the insurer/TPA sets forth the documentation required when an insurer/TPA wishes to resolve a debt on behalf of its client, an employer debtor.
    - If an insurer/TPA submits payment or an alleged valid document defense but has not submitted documentation establishing its authority to act on behalf of the employer to resolve the debt, responses should be addressed only to the employer.

Contractors continue existing debt referral procedures in §60. The fact that the insurer/TPA receives a copy of the demand package or that the insurer/TPA may be given authority to resolve a debt on behalf of its client, an employer debtor, does **not** change the status of the employer as the debtor and as the entity to be referred to Treasury as the debtor.

Contractors must use extra care when evaluating defenses submitted by the insurer/TPA when the debtor is the employer. This is because a defense raised by the insurer/TPA might be valid if the insurer/TPA were being pursued with respect to the debt, but invalid as a defense for the employer. For example, the insurer might respond that it did not provide coverage during the period in question; or the TPA might respond that its contract was not in effect during the period in question. While proper documentation could establish these as defenses for the insurer or TPA **they are not defenses for the employer**. The employer could have provided coverage through another insurer or had a different TPA contract in effect. Where the offered defense is an issue involving the specific coverage or payment limits of the policy, this should not be an issue. For example, a defense of exhaustion of the payment limits of the policy applies equally to the employer and the TPA/insurer. Contractors continue to evaluate alleged defenses and accompanying documentation as addressed in §60.10.1.5.

10.10.1 – Insurer/TPA Letter

(Rev. 1, 10-01-03)

PM-AB-03-120

Insurer/TPA Name
Insurer/TPA Address 1
Insurer/TPA Address 2

Insurer/TPA City, State, Zip

Re: Medicare Secondary Payer (MSP) Recovery Demand Letter Package and/or intent to Refer Debt to Treasury Package to Your Client: (Name of Client)

Dear Insurer/TPA:

Enclosed is a copy of an MSP demand package that we have sent to your client: (Name of Employer). We are sending you this copy so that you are aware that Medicare has identified a debt arising under the MSP laws involving a group health plan that you either insured or administered as a TPA (per information available to Medicare) on the dates of service identified. Frequently employers expect their insurers/TPAs to resolve these matters on the employer's behalf.

If you are to act as the agent of the employer in resolving this matter, please obtain specific authorization from the employer to do so. The authorization must be on employer letterhead and must specifically authorize the Centers for Medicare & Medicaid Services, its Medicare contractors, their employees and agents, and the Department of the Treasury and its employees, contractors and agents to disclose for a period of 1 year, any and all information related to a debt identified in an MSP recovery demand letter dated (date of demand letter) from (name of entity sending demand letter) regarding the following Medicare beneficiaries (beneficiary names and Health Insurance Claims Numbers). It must also specifically authorize the insurer/TPA to resolve the identified

debts on the employer's behalf. A copy of the authorization must be included in any communication to any of the named entities (to which the disclosure authorization applies) regarding this debt if you wish to be copied on the reply to the employer.

If you wish to discuss this matter, please call (contractor contact phone number).

Sincerely,

(Name of MSP Manager)

cc (without enclosure):
(Employer Name)
(Employer Address 1)
(Employer Address 2)
(Employer City, State, Zip)

20 - Medicare Right of Recovery

(Rev. 1, 10-01-03)

A3-3407.9, B3-2370.9, B3-3328.11, A3-3492.F, A3-3489.3.B, HO-263.13, HO-289.9 SNF-336.13, SNF-326.3, HH-253.12, HH 250.9, A3-3492.G

Section 1862(b)(2) of the Social Security Act (the Act) gives the Government the right to recover conditional Medicare benefits from entities responsible for or required to make payment on behalf of private insurers that are the primary payers for Medicare beneficiaries. Therefore, primary payers must reimburse Medicare when Medicare mistakenly paid primary benefits.

All Medicare payments are conditioned on reimbursement to the appropriate trust fund, when notice or other information is received that payment with respect to the same items or services has also been made, or could be made by a GHP.

Section 1862(b)(1) as amended, expressly provides that the Government:

- May recover directly from employers, Workers' Compensation (WC) carriers, or GHPs, Medicare benefits paid for services furnished to an individual for whom Medicare is the secondary payer. The Government may recover from WC whether or not the beneficiary files a WC claim;

- May recover or take legal action to recover erroneous primary benefits paid from any entity that has been paid by an employer, WC carrier or any GHP;

- May join or intervene in any WC claim where the compensability of the injury is at issue or in any legal action against a GHP related to the events that gave rise to the need for the items or services;

- Is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from a GHP, an employer or a WC carrier; and

- May bring legal action against any entity that is required to make or is responsible for payment and may collect double damages.

20.1 - Conflicting Claims by Medicare and Medicaid

(Rev. 1, 10-01-03)

A3-3407.11, B3-2370.11, B3-3331.5, A3-3414, B3-3338.3, B3-3340, A3-3490.3.G.5, A3-3491.13.C, A3-3489.3

Medicare and a State Medicaid agency may conditionally or erroneously pay for services, and the amount payable by a GHP is insufficient to reimburse both. Under the law, (§1862(b)(1)) of the Act, Medicare has the right to recover its benefits from a GHP before any other entity, including a State Medicaid agency. Medicare's recovery rights where a GHP is the primary payer are higher than, and take precedence over, the rights of any other entity. Medicare has the right to recover its benefits from any entity, including a State Medicaid agency that has been paid by a GHP.

If Medicare and Medicaid both have claims against a GHP, Medicare's right to recover its benefits from the GHP or from a beneficiary that has been paid by a GHP, is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort and, therefore, does not pay its benefits until after Medicare has paid.

Medicare's priority right of recovery from insurance plans that are primary to Medicare, does not violate the concept of Medicaid being payer of last resort. Under §1862(b) of the Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by a third party that is primary to Medicare. Where a GHP pays promptly, Medicare makes no payment for any services covered by the GHP. Delay of the GHP payment does not change Medicare's ultimate obligation to pay the correct amount, if any, regardless of any Medicare payments conditionally made. Thus, where a GHP pays less than the charges, Medicare may be responsible to pay secondary benefits. In addition, where the third party pays the charges, Medicare may not pay at all. Pro rata or other sharing of recoveries with Medicaid would create a Medicare payment where none is authorized under the law or improperly increasing the amount of a Medicare secondary payment.

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

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

If a State Medicaid agency is reimbursed from a GHP payment before Medicare, or if a beneficiary, after receiving a third party payment, has reimbursed a State Medicaid Agency, the FI or carrier asks the State agency or beneficiary to reimburse Medicare from the remainder of the third party payment. If the remainder of the third party payment is insufficient to reimburse Medicare in full, ask the State Agency to reimburse Medicare up to the full amount the Agency received. The FI/carrier explains the legal basis for Medicare's right to recover. If the State refuses to reimburse in full, the FI/carrier refers the case to the RO. The RO's recovery actions may include offset of Medicare's claim against any Federal Financial Participation funds otherwise due the State. The FI or carrier tells the GHP that in future cases involving claims by Medicare and Medicaid, it must reimburse Medicare first.

20.2 - State Law or Contract Provides That No-Fault Insurance Is Secondary to Other Insurance

(Rev. 1, 10-01-03)

A3-3489.5, A3-3489.3.G

Even though State laws or insurance contracts specify that benefits paid under their provisions are secondary to any other source of payment or that limit a portion of its benefits to payments only when all other sources of health insurance are exhausted, Medicare does not make payment when benefits are otherwise available. For example, a state provides $2,000 in no-fault benefits for medical expenses and an additional $6,000 in no-fault benefits are available, but only after the claimant has exhausted all other health insurance. In such cases, the Medicare law has precedence over state laws and private contracts. Therefore, Medicare makes secondary payments only after the total no-fault benefits are exhausted.

Denial by an insurer on the ground that Medicare is primary payer may be a forerunner of similar action on multiple claims. The FI or carrier contacts the insurer and explains that

under Federal law no-fault insurance is primary payer and Medicare is secondary regardless of the provisions of the no-fault insurance policy or the provisions of the State insurance law. It refers noncompliance cases to the RO.

20.3 - Coordination of Benefits Arrangements Between Private Plans

(Rev. 1, 10-01-03)

A3-3491.6.C, B3-3328.10.B

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

Where a plan's payment would normally be secondary to Medicare, but under coordination of benefit provisions, the payment is primary to a primary payer under §1862(b), the combined payment of both plans constitutes the primary payment to which Medicare is secondary.

EXAMPLE

John Jones, age 75, is a Medicare beneficiary with coverage under Part A and Part B. He retired from the Acme Tool Company in 1996 and received retirement health insurance coverage that is secondary to Medicare. His wife, Mary, age 64, has been employed continuously with the local police department since 1990 and since that time has received coverage for herself and her husband under the department's GHP. The priority of payment for John's medical expenses is as follows:

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

2. Medicare is secondary payer.

NOTE: If the retirement plan is permitted to pay after the GHP under the private coordination of benefits, the GHP will be primary, Medicare will be secondary, and the retirement plan will be tertiary payer.

20.4 - Procedures for Actions With Legal Implications in MSP Situations

(Rev. 1, 10-01-03)

A3-3418.3

20.4.1 - Handling Subpoenas Under Routine Use Rules

(Rev. 1, 10-01-03)

A3-3418.3.A

There are limitations on the type of Government information that can be released, even if the information is requested under subpoena. Therefore, if a contractor receives a subpoena, it immediately notifies the RO. The RO makes a determination as to how to handle the subpoenaed information.

20.4.2 - Referral of Cases to Regional Office for Possible Government Intervention and/or Legal Action

(Rev. 1, 10-01-03)

A3-3418.3.B

The FI or carrier refers the following situations to the RO:

- Any notice from a court that the Government (Medicare) has been made a party to a lawsuit involving a liability claim, or
- Any case involving a lawsuit in which CMS' claim is at issue.

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

20.4.3 - Other Referrals to CMS

(Rev. 1, 10-01-03)

A3-3490.3.G.6, A3-3491.10

The FI or carrier refers all cases where recovery is not made to the RO. In addition, it refers all cases where a GHP or employer claims that it is secondary to Medicare

(irrespective of whether or not any Medicare benefits were paid). See §60 of the DCIA for referral instructions.

When referring cases subsequent to the original case involving a particular GHP or employer, the FI or carrier advises the RO of the total number of cases that have been referred involving that GHP or employer, and the dollar amount of Medicare overpayments.

Whenever primary benefits are paid that should have been paid by a GHP or employer that refuses to reimburse Medicare, the FI or carrier refers the case to the RO.

The RO notifies the State Insurance Commissioner, or other official having jurisdiction over the GHP or employer, that evidence suggests that Federal law was violated and requests that the GHP's or employers actions be investigated, and that it be ordered to comply with Federal law and to make appropriate refund to Medicare.

The RO also advises the Insurance Commissioner, or other responsible official, that the Medicare beneficiary is placed at risk by the GHP's actions and that Medicare will not make future primary payments for items and services covered by the GHP for this individual.

The RO advises officials contacted of Medicare's right to recover from any parties to whom it has made improper payments. The RO will also consider possible legal action against the GHP or employer and/or referral of the case to the Equal Employment Opportunity Commission.

20.4.3.1 - Refer Nonresponsive Worker's Compensation Cases to the CMS

(Rev. 1, 10-01-03)

A3-3417.2 3rd paragraph

If the WC carrier does not make arrangements within 60 days after notification to refund the amount due, the Medicare FI or carrier asks the WC carrier for an explanation for the delay, whether it intends to refund the overpayment and, if not, why. If the WC carrier's response is negative, and the services are covered under WC, the Medicare FI or carrier refers the case to the RO. It includes copies of all correspondence. If an attorney represents the beneficiary, the FI or carrier addresses any correspondence on the WC issue to the attorney. It sends copies of all correspondence with the WC carrier and with the beneficiary concerning the WC issue to the State WC agency when the WC carrier does not cooperate.

If the WC carrier either declines to refund the overpayment or indicates a long delay will be necessary, the FI or carrier refers the file to its appropriate RO.

It fully explains the WC issue and recommendations for disposition of the case. It includes copies of all pertinent documents, including the WC award and correspondence

and reports of contact with the WC carrier, the State WC carrier, the State WC agency, and the beneficiary. The CMS RO reviews the case and determines what further action to take.

20.5 - Mistaken GHP Primary Payments

(Rev. 1, 10-01-03)

A3-3491.15, B3-3328.16, B3-3329.11

Cases may come to the FI or carrier's attention where a GHP has mistakenly paid primary benefits, e.g., primary payments by the GHP of an employer of less than 20 employees. The FI or carrier shall instruct the provider, physician, or supplier to bill Medicare as primary payer and to refund to the GHP any amount it paid in excess of the Medicare deductible and coinsurance amounts and charges for noncovered services, provided the time limits prescribed in the Medicare Claims Processing Manual, Chapter 29, "Appeals of Claims Decisions," for reopening and revising Medicare claims has not elapsed. If the beneficiary has not filed an authorization with the provider to file a Medicare claim, the provider may request, but cannot require, the beneficiary to do so.

If the Medicare secondary claim was submitted to the carrier on an assignment basis, they pay the additional amount to the physician/supplier. If the Medicare secondary claim was submitted on an unassigned basis, the carrier pays the additional amount to the beneficiary.

If a Medicare claim was not filed, e.g., because the insurer paid in full and the claims filing time limit has elapsed, the FI or carrier considers the date of receipt of the first written inquiry by either the beneficiary or the insurer to the contractors concerning the improperly paid GHP claims as a "protective filing date" on the claims for expenses that were not filed previously with Medicare.

20.5.1 - Third Party Payer Refund Requests Served on Medicare

(Rev. 1, 10-01-03)

FIs and carriers are to forward all refund requests from third party payers generated as a result of the Medicare Secondary Payer recovery demand letter to:

MSP Repayment Requests
AdminaStar of Ohio (AO)
Cincinatti, Ohio 45250-5442

FIs and carriers must respond to requests for information from AO related to those third party refund requests within the parameters established by AO in the request. Follow-up activities must also be performed as requested by AO.

30 – Mistaken Payment Report Activities and Record Layouts

(Rev. 1, 10-01-03)

30.1 - Contractor Actions Upon Receipt of the Mistaken Payment Report Records or Other Notice of Mistaken Payment

(Rev. 1, 10-01-03)

Memo dated 2/5/93 to: All Regional MSP Coordinators re: IRS/SSA/CMS Data Match issues.

A3-3490.3.G, A3-3491.13

The following table indicates the actions contractors must complete for IRS/SSA/CMS mistaken payment report records received from CMS and other notices indicating mistaken payments for Non-data match cases:

Contractor Action	IRS/SSA/CMS Data Match	Non-Data Match
Research the mistaken payment report and identify potential mistaken payments.	X	
Refer to COBC to Develop for Missing Information		X
Research claims history and identify mistaken payments.	X	X
Update the MPaRTS tracking system.	X	
Send the initial demand letter to the employer.	X	X
Close the case or refer the matter to the regional office for additional collection actions.	X	X

All of these actions should take place within six months of the actual notice that an improper payment was made or receipt of the mistaken payment report. Adherence to this standard for IRS/SSA/CMS Data Match cases will be monitored via the MPaRTS system.

30.1.1 - COBC Responsibility to Obtain Missing MSP Information

(Rev. 1, 10-01-03)

A3-3490.2, Memo from Office of Issuances of MSP Draft transmittal dated 4/14/94, A3-3492.J, A3-3491.5

Intermediaries do NOT develop with providers and carriers do NOT develop with beneficiaries to obtain GHP coverage information. Development for other insurance information is the responsibility of the Coordination of Benefits Contractor (COBC). See Medicare Secondary Payer (MSP) Manual, Chapter 4, "Coordination of Benefits Contractor (COBC) Requirements," for an explanation of development responsibilities.

If cases come to a contractor's attention in which primary benefits were paid by Medicare and GHP benefits may be payable, the contractor should send an ECRS MSP inquiry to the COBC for initial or additional development.

Prior to January 1, 2001, intermediaries and carriers performed development to obtain missing MSP information.

Note that demand letters have been issued to employers only, insurers only, or both employers and insurers, depending upon CMS instructions for any particular Fiscal Year

Medicare contractors send MSP recovery demand letters in MSP situations involving group health plans to the employer who sponsors or contributes to the group health plan that provides coverage to the identified beneficiaries. There are two types of such recovery situations: The IRS/SSA/CMS Data Match situations where the requisite employer identification is always provided to the contractors by CMS; and Non-Data Match situations that are identified in other ways which do not always identify the employer. Contractors refer Non-Data Match situations where the employer is not identified to the COBC via ECRS for development of missing information. The COBC will update the MSP Auxiliary File with complete employer information once it is obtained.

30.1.1.2 - When Time Limitation for Non-Data Match Recovery Begins

(Rev. 1, 10-01-03)

Memo from Office of Issuance of MSP Draft transmittal dated 4/14/94, B3-3375.4

Time limitations for recovery must be considered in all debt collection activities. The basis for any recovery time periods is the authority at 42 USC 1395y(b)(2) and 42 CFR 411.24(f). As a general rule, the time limitation for recoveries begins with the date the contractor who has mistakenly paid a claim has sufficient notice to reasonably conclude that there is a primary payer that is responsible for paying for the particular services in question. The time period begins with the date of this actual notice, not the date the claim was initially paid.

30.1.1.2.1 - Actual Notice

(Rev. 1, 10-01-03)

Memo from Office of Issuance of MSP Draft transmittal dated 4/14/94

The time period begins when the contractor who has mistakenly paid the claim has the following information:

- Name of the third party payer;
- Address of the third party payer;
- Name of insured (beneficiary);
- HICN or SSN of insured;
- Name of the subscriber; and
- Knowledge that the particular services fall within the effective dates of coverage under the plan.

Therefore, if the contractor does not have the effective dates of coverage under the plan and a search of claims payment history reveals Medicare primary payments, the time period does not start until the dates of coverage under the plan are received and coincide with the date of the particular services. Contractors must annotate the date sufficient notice was received to establish a debt for particular services.

NOTE: Contractor recoveries should be pursued according to the priorities and tolerances sited above in §10.1.

30.1.2 - Contractor History Search

(Rev. 1, 10-01-03)

A3-3491.5, Draft B3 dated 4/14/94 3375.14.C as modified by conversation with Bill Zavoina

Upon receipt of data match records or other information indicating that a third party payer is primary to Medicare, the FI or carrier must search its history records according to the priorities and tolerances sited above in §10.1 to identify claims mistakenly processed as Medicare primary. If the effective dates of coverage under the plan are known, it limits the review of the beneficiary's claims payment history to this period. For Non-Data Match cases, it searches its records for all claims for services provided within the current and preceding 27 months. If it is determined to be cost-effective in a particular situation, it searches history records for a longer prior period (not to extend prior to January 1, 1983). There may be instances involving special projects that the FI or carrier may be directed to search history records for a prior period exceeding 27 months.

If Non-Data Match mistaken payments have previously been recovered and are subsequently identified as IRS/SSA/CMS Data Match records, the FI or carrier must update MPaRTS to reflect the recovery status and amount recovered. If Non-Data Match mistaken payments are in the process of being recovered, the FI or carrier continues the recovery process indicating the case as an IRS/SSA/CMS data match case and updates the MPaRTS tracking system.

30.1.2.1 - Aggregate Claims for Recovery

(Rev. 1, 10-01-03)

Memo dated 8/29/97 to All Associate Regional Administrators for Medicare From Chief MSP Operations. Subject: Group Health Plan Recovery Demand Letter to Employer Language.

Beginning with FY 1998, GHP recovery demand letters are sent only to employers, rather than to insurers and employers as in FY 1997 and prior years. The FI or carrier aggregates all Data Match recovery IDs on any Data Match cycle tape associated with any given employer identification number into a single recovery demand letter. Non-Data Match recoveries should be aggregated by employer to the extent possible.

30.1.3 - Contractor Recovery Case Files

(Rev. 1, 10-01-03)

Draft B3-dated 4/14/94 3375.14.F, References made to recover from the insurer were changed to recover from the employer to comply with the 98 BPRs.

Each recovery case must be maintained in a uniform manner. Each case file should be organized as follows:

- Maintain each case file in a manila file folder;
- Label the upper left hand corner of the file folder with the name of the insurer;
- Label the upper right hand corner of the file folder with the name and HICN of the beneficiary;
- Include a copy of the accountability sheet in the folder;
- Include copies of all demand letters;
- Include copies of the return receipt mail card;
- Include copies of any responses from the employer, insurer, third party payer, beneficiary or any entity that responds to the demand letter;
- Include copies of all claims for which a recovery is being sought;

- Include copies of the IRS/SSA/CMS Data Match Report (where applicable); and
- Include any other materials related to the case.

30.1.3.2 - Recovery Attempt Audit Trails

(Rev. 1, 10-01-03)

Maintain audit trails for all recovery attempts. They must link the following:

- Specific services provided on specific dates to Medicare beneficiaries;
- The amount which Medicare paid for each;
- The recovery request to each employer, provider, insurer, or third party administrator;
- The recovery received with explanation of benefits; and
- Analysis of the difference between the Medicare payment and the recovered amount.

30.1.4 - Documentation of Debt

(Rev. 1, 10-01-03)

Draft B3-dated 4/14/94 3375.6, References made to recover from the insurer were changed to comply with the 98 BPRs to recover from the employer.

The FI or carrier must provide the insurer with sufficient materials to document a debt owed Medicare. An MSP recovery package should be sent for each demand made to an employer. The MSP recovery package has four main components:

- Demand letter to the employer using language provided by CMS as shown in §10.5 below;
- MSP Summary Data Sheet;
- Summary of Medicare Reimbursement; and
- Claim Facsimiles for each claim mistakenly paid.

For IRS/SSA/CMS Data Match demands, the initial demand letter must be sent certified mail with return receipt requested. Demands to insurers should be aggregated to save on postage costs.

30.1.4.1 - Summary of Medicare Reimbursement

(Rev. 1, 10-01-03)

The following information must be contained on a Summary of Medicare Reimbursement.

A - Beneficiary General Information:

- Beneficiary Name;
- Beneficiary HICN; and
- Mistaken Payment Recovery Tracking System (MPaRTS) Identification Number.
- Claim Control Number;
- Date of Service (from-to);
- Provider Name;
- Submitted (Actual) Charges;
- Total Medicare Reimbursement;
- Payment Made to Indicator (Bene/Provider) OPTIONAL;
- Grand total of all Submitted Charges;
- Grand total of all Medicare Reimbursements; and
- An aggregated total of claims mistakenly paid for each identified beneficiary.

30.1.4.2 - Claim Facsimiles for Each Claim Mistakenly Paid

(Rev. 1, 10-01-03)

The Claim facsimiles must look exactly like a claim form (UB-92, Form CMS-1500). A claim facsimile is:

- Paid claims data in a standard claim format (UB-92 or Form CMS-1500). Any information contained in history that has a field on the claim form must be put into the form.

The facsimile should be labeled as a facsimile and in addition to the data listed above, must contain:

- MPaRTS Report Identification Number (for IRS/SSA/CMS Data Match Cases);

- Claim Control Number;
- For Providers:
- Provider's Federal Tax Identification Number; and,
- Provider's Address.

The facsimiles should be placed in the recovery package in the same order that they are shown on the Summary of Medicare Reimbursement.

30.1.5 - *Interest on MSP Recovery Claims*

(Rev.15, 4-30-04)

B3-7130.H

With respect to the recovery of payments for items and services furnished before October 31, 1994, CMS charges interest, exercising its common law authority (see 42 CFR 411.24(m)(1). With respect to the recovery of payments for items and services furnished on or after October 31, 1994, CMS charges interest in accordance with section 1862(b)(2)(B)(i) of the Act (see 42 CFR 411.24(m)(2). The method for calculating interest is set forth in 42 CFR 405.378. The interest rate on overpayments is determined in accordance with regulations promulgated by the Secretary of the Treasury and is the higher of the private consumer rate or the current value of funds rate prevailing on the date the recovery demand letter is issued.

Interest is waived if the debt is completely liquidated within the time frame specified in the recovery demand letter for payment. Interest is computed for both delinquent payments and installment payments as simple interest using a 360-day year. The U.S. Postal Service postmark date (or the date of physical receipt in the contractor's corporate mail area for a commercial shipper) is used to determine the receipt date of the payment.

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

- *Principal times Prevailing Interest Rate + Interest for Year, and*
- *Interest for Year divided by 12 = 30-day Interest*

Reminder regarding the first day of the 30 day interest period --The date of the recovery demand letter (not the day after) is the first day of the first 30-day period.

Note: Effective October 1, 2004, 42 CFR 405.378 and 42 CFR 411.24 were amended to change how interest is calculated on MSP recoveries. Under the new rule, interest is assessed for each full 30-day period when payment is not made in full (both principal and interest) and continues to be assessed for each full 30-day period on any portion of the debt that remains outstanding. This change in the manner in which interest is calculated

applies to all MSP debts, both GHP based debt and non-GHP based debt, regardless of who the debtor is. It applies to MSP debts established on or after October 1, 2004 (the effective date of the final rule). Interest on MSP debts established prior to October 1, 2004 will continue to be assessed under the former method (interest is due and payable as of the first day of each 30-day period for that full 30-day period) until recovered in full. (Contractors are reminded that in those rare instances where they have an "interest only" debt, that debt does not accrue interest.)

The general rule and specific examples of interest accrual for MSP recoveries are as follows:

Interest will accrue from the date the debt is established. MSP debts are routinely established as of the date of the recovery demand letter. Interest is owed when the debt is not fully resolved/paid within the time period specified in the recovery demand letter, either 30 or 60 days. If payment is received within the time frame specified in the recovery demand letter, interest is adjusted and no interest is due. If payment is not received when due, interest is assessed on the outstanding principal amount from the date of the recovery demand letter for each full 30-day period.

Examples:

MSP Debt Established ***Prior to 10/01/2004*** *– Example of Interest Accrual – Recovery Demand Letter Specified that Payment was Due Within 60 Days. On 08/31/2004, the contractor issues a recovery demand letter establishing a MSP based debt for $10,000 and stating that interest will be charged if payment in full is not made within 60 days. Payment is not remitted until 11/04/2004 (65 days after the date of the recovery demand letter). Interest has accrued on the $10,000 for three 30-day periods: one for the first 30 days, one for the period of time between day 31-60, and one for the period of time between day 61-65(because interest is due and payable for the full 30-day period as of the first day of that period).*

MSP Debt Established ***Prior to 10/01/2004*** *– Example of Interest Accrual – Recovery Demand Letter Specified that Payment was Due Within 30 Days. On 08/31/2004, the contractor issues a recovery demand letter establishing a MSP based debt for $10,000 and stating that interest will be charged if payment in full is not made within 30 days. Payment is not remitted until 10/03/2004 (33 days after the date of the recovery demand letter). Interest has accrued on the $10,000 for two 30-day periods: one for the first 30 days, and one for the period of time between day 31-60 (because interest is due and payable for the full 30-day period as of the first day of that period).*

MSP Debt Established ***On or After 10/01/2004*** *– Example of Interest Accrual – Recovery Demand Letter Specified that Payment was Due Within 60 Days. On 10/31/2004, the contractor issues a recovery demand letter establishing a MSP based MSP debt for $10,000 and stating that interest will be charged if payment in full is not made within 60 days. Payment is not remitted until 01/04/2005 (65 days after the date of the recovery demand letter). Since only two full 30-day periods have passed, interest has accrued on the $10,000 for two 30-day periods.*

*MSP Debt Established **On or After 10/01/2004** – Example of Interest Accrual – Recovery Demand Letter Specified that Payment was Due Within 30 Days. On 10/01/2004, the contractor issues a recovery demand letter establishing a MSP based debt for $10,000 and stating that interest will be charged if payment in full is not made within 30 days. Payment is not remitted until 11/03/2004 (33 days after the date of the recovery demand letter). Since only one full 30-day period has passed, interest has accrued on the $10,000 for one 30-day period.*

*Reminder for partial payments -- For situations where partial payment is received on a debt with outstanding interest -- Payment is normally credited to interest first, principal second, leaving an outstanding amount of principal due. **For debts established before 10/01/04**, interest for the entire 30-day period in which the partial payment was received is required to be accrued and posted before application of the partial payment. Consequently, further interest/any additional interest on the outstanding principal amount for an MSP debt established before 10/1/04 would be calculated starting with the first day of the next 30-day period following receipt of the check. **For debts established on or after 10/1/04** where a partial payment is received midway through the 30-day period, interest on the debt will not have accrued up to the date of payment, but only through the end of the prior 30-day period. Consequently, further interest/additional interest on the outstanding principal amount for an MSP debt established on or after 10/1/04 would be calculated on the principal amount outstanding as of the end of the 30 day period in which the partial payment was received and would be calculated from the first day of the 30-day period in which the partial payment was received.*

30.2 – Mistaken Payment Report Record Layouts

(Rev. 1, 10-01-03)

30.2.1 - Inpatient, Skilled Nursing Facility, and Religious Nonmedical Health Care (RNHC)

(Rev. 1, 10-01-03)

PM-AB-99-24 (CR815)

Following is the Inpatient, Skilled Nursing Facilities (SNF) and Religious Nonmedical Health Care (RNHC) Mistaken Payment Report record layout:

Contractor ID (current mailing)	x(5)
Other Contractor ID (originating)	x(5)
Report ID	x(9)
Beneficiary HI Claim Number (HICN)	x(11)

Internal Use (blank)	x(11)
GHI: MSP Identifying Information:	
Bene Surname	x(6)
Bane First Name Initial	x(1)
Bene Date of Birth (CCYYMMDD)	x(8)
MSP Code (values A, B, G, blank)	x(1)
Primary Insurer Type	x(1)
Primary Insurer Name	x(32)
Primary Insurer Address, line 1	x(32)
Primary Insurer Address, line 2	x(32)
Primary Insurer City	x(15)
Primary Insurer State Code	x(2)
Primary Insurer zip Code	x(9)
Primary Insurer Policy Number	x(17)
MSP Effective Date (CCYYMMDD)	9(8)
MSP Termination Date (CCYYMMDD)	9(8)
Patient Relationship (values 01, 02)	x(2)
Policyholder First Name	x(9)
Policyholder Surname	x(16)
Employee ID Number	x(12)
Employer Name	x(24)
Primary Insurance Group Number	x(20)
Primary Insurance Group Name (EIN)	x(17)
MADRS Common Data (all record types):	
Record Identification Code (RIC)	x(1)

Health Insurance Claim Number	x(11)
Date of Service (CCYYMMDD)	9 (5) Comp-3
Reimbursement Amount	S9(7)V99 Comp-3
Total Charges	S9(7)V99 Comp-3
MADRS Common Institutional Data:	
Payment/Edit Code (type of bill)	x(1)
Transaction Code (type of provider)	x(1)
Medicare Provider Number	x(6)
Number of Diagnostic Codes	x(1)
Diagnosis Codes (up to 5)	x(25)
Number of Surgical Procedures	x(1)
Procedures Codes (up to 3)	x(12)
MADRS Inpatient/SNF/CS specific Data:	
Diagnosis Related Group (DRG)	x(3)
Medical Record Number	x(17)
Date of Admission (CCYYMMDD)	9(5) Comp-3
Length of Stay	9(3) Comp-3
Inpatient Covered Days	9(3) Comp-3
Coinsurance Amount	S9 (5)V99 Comp-3
Primary Payer Code (values “C” blank)	x(1)

30.2.2 - Outpatient Mistaken Payment Report Record Layout

(Rev. 1, 10-01-03)

CMS Letter to Secondary Payer Coordinators dated 4-30-1992 from Barbara J. Gagel

Following is the Outpatient Mistaken Payment Report record layout:

Contractor ID (current mailing)	x(5)
Other Contractor ID (originating)	x(5)
Report ID	x(9)
Beneficiary HI Claim Number (HICN)	x(11)
Internal Use (blank)	x(1)
GHI MSP Identifying Information:	
Bene Surname	x(6)
Bene First Name Initial	x(1)
Bene Date of Birth (CCYYMMDD)	x(8)
MSP Code (values A, B, G, blank)	x(1)
Primary Insurer Type	x(1)
Primary Insurer Name	x(32)
Primary Insurer Address, line 1	x(32)
Primary Insurer Address, line 2	x(32)
Primary Insurer City	x(15)
Primary Insurer State Code	x(2)
Primary Insurer Zip Code	x(9)
Primary Insurer Policy Number	x(17)
MSP Effective Date (CCYYMMDD)	9(8)
MSP Termination Date (CCYYMMDD)	9(8)

Patient Relationship (values 01, 02)	x(2)
Policyholder First Name	x(9)
Policyholder Surname	x(16)
Employee ID Number	x(12)
Employer Name	x(24)
Primary Insurance Group Number	x(20)
Primary Insurance Group Name (EIN)	x(17)
MADRS Common Data (all record types):	
Record Identification Code (RIC)	x(1)
Health Insurance Claim Number	x(11)
Date of Service (CCYYMMDD)	9(5) Comp-3
Reimbursement Amount	S9 (7)V99 Comp-3
Total Charges	S9 (7)V99 Comp-3
MADRS Common Institutional Data:	
Payment/Edit Code (type of bill)	x(1)
Transaction Code (type of provider)	x(1)
Medicare Provider Number	x(6)
Number of Diagnostic Codes	x(1)
Diagnostic Codes (up to 5)	x(25)
Number of Surgical Procedures	x(1)
Procedures Codes (up to 3)	x(12)
MADRS Outpatient Specific Data:	
Number of HCPCS (surgical) Codes	x(1)
HCPCS Codes (up to 3)	x(15)
Date of 1st HCPCS Procedure (CCYYMMDD)	9 (5) Comp-3

Date of 2nd HCPCS Procedure (CCYYMMDD)	9 (5) Comp-3
Date of 3rd HCPCS Procedure (CCYYMMDD)	9 (5) Comp-3
Filler	x(7)

30.2.3 - Home Health Agency (HHA) Mistaken Payment Report Record Layout

(Rev. 1, 10-01-03)

CMS Letter to Secondary Payer Coordinators dated 4-30-1992 from Barbara J. Gagel

Following is the HHA Mistaken Payment Report record layout:

Contractor In (current mailing)	x(5)
Other Contractor ID (originating)	x(5)
Report ID	x(9)
Beneficiary HI Claim Number (HICN)	x(11)
Internal Use (blank)	x(1)

GHI MSP Identifying Information:

Bane Surname	x(6)
Bene First Name Initial	x(1)
Bene Date of Birth (CCYYMMDD)	x(8)
MSP Code (Values A , B, G, blank)	x(1)
Primary Insurer Type	x(1)
Primary Insurer Name	x(32)
Primary Insurer Address, line 1	x(32)
Primary Insurer Address, line 2	x(32)
Primary Insurer City	x(15)
Primary Insurer State Code	x(2)

Primary Insurer Zip Code	x(9)
Primary Insurer Policy Number	x(17)
MSP Effective Date (CCYYMMDD)	9 (8)
MSP Termination Date (CCYYMMDD)	9 (8)
Patient Relationship (values 01, 02)	x(2)
Policyholder First Name	x(9)
Policyholder Surname	x(16)
Employee ID Number	x(12)
Employer Name	x(24)
Primary Insurance Group Number	x(20)
Primary Insurance Group Name (EIN)	x(17)
MADRS Common Data (all record types):	
Record Identification Code (RIC)	x(1)
Health Insurance Claim Number	x(11)
Date of Service (CCYYMMDD)	9 (5) Comp-3
Reimbursement Amount	S9 (7) V99 Comp-3
Total Charges	S9 (7) V99 Comp-3
MADRS Common Institutional Data:	
Payment/Edit Code (type of bill)	x(1)
Transaction Code (type of provider)	x(1)
Medicare Provider Number	x(6)
Number of Diagnostic Codes	x(1)
Diagnosis Codes (up to 5)	x(25)
Number of Surgical Procedures	x(1)
Procedures Codes (up to 3)	x(12)

MADRS Home Health Agency Specific Data:

Service From Date (CCYYMMDD)	9 (5) Comp-3
Total HHA Visits	9 (3) Comp-3
Total HHA Visit Charges	S9(5)V99 Comp-3
Filler	x(23)

30.2.4 - Hospice Mistaken Payment Report Record Layout

(Rev. 1, 10-01-03)

CMS Letter to Secondary Payer Coordinators dated 4-30-1992 from Barbara J. Gagel

Following is the Hospice Mistaken Payment Report record layout:

Contractor ID (current mailing)	x(5)
Other Contractor ID (originating)	x(5)
Report ID	x(9)
Beneficiary HI Claim Number (HICN)	x(11)
Internal Use (blank)	x(1)

GHI MSP Identifying Information:

Bene Surname	x(6)
Bene First Name Initial	x(1)
Bene Date of Birth (CCYYMMDD)	x(6)
MSP Code (values A, B, G, blank)	x(1)
Primary Insurer Type	x(1)
Primary Insurer Name	x(32)
Primary Insurer Address, line 1	x(32)
Primary Insurer Address, line 2	x(32)
Primary Insurer City	x(15)

Primary Insurer State Code	x(2)
Primary Insurer Zip Code	x(9)
Primary Insurer Policy Number	x(17)
MSP Effective Date (CCYYMMDD)	9(8)
MSP Termination Date (CCYYMMDD)	9(8)
Patient Relationship (values 01, 02)	x(2)
Policyholder First Name	x(9)
Policyholder Surname	x(16)
Employee ID Number	x(12)
Employer Name	x(24)
Primary Insurance Group Number	x(20)
Primary Insurance Group Name (EIN)	x(17)
MADRS Common Data (all record types):	
Record Identification Code (RIC)	x(1)
Health Insurance Claim Number	x(11)
Date or Service (CCYYMMDD)	9(5) Comp-3
Reimbursement Amount	S9(7)V99 Comp-3
Total Charges	S9(7)V99 Comp-3
MADRS Common Institutional Data:	
Payment/Edit Code (type of bill)	x(1)
Transaction Code (type of provider)	x(1)
Medicare Provider Number	x(6)
Number of Diagnostic Codes	x(1)
Diagnosis Codes (up to 5)	x(25)
Number of Surgical Procedures	x(1)

Procedures Codes (up to 3)	x(12)

MADRS Hospice Specific Data

Service From Date (CCYYMMDD)	9(5) Comp-3
Inpatient Days of Care	9(3) Comp-3
Length of Billing Period	9(3) Comp-3
Filler	x(25)

30.2.5 - Part B Payment Record Mistaken Payment Report Record Layout

(Rev. 1, 10-01-03)

CMS Letter to Secondary Payer Coordinators dated 4-30-1992 from Barbara J. Gagel

Following is the Part B Record Mistaken Payment Report record layout:

Contractor ID (current mailing)	x(5)
Other Contractor ID (originating)	x(5)
Report ID	x(9)
Beneficiary HI Claim number (HICN)	x(11)
Internal Use (blank)	x(1)

GHI MSP Identifying Information:

Bene Surname	x(6)
Bene First Name Initial	x(1)
Bene Date of Birth (CCYYMMDD)	x(8)
MSP Code (values A, B, G, blank)	x(1)
Primary Insurer Type	x(1)
Primary Insurer Name	x(32)
Primary Insurer Address, line 1	x(32)

Primary Insurer Address, line 2	x(32)
Primary Insurer City	x(15)
Primary Insurer State Code	x(2)
Primary Insurer Zip Code	x(9)
Primary Insurer Policy Number	x(17)
MSP Effective Date (CCYYMMDD)	9(8)
MSP Termination Date (CCYYMMDD)	9(8)
Patient Relationship (values 0l , 02)	x(2)
Policyholder First Name	x(9)
Policyholder Surname	x(16)
Employee ID Number	x(12)
Employer Name	x(24)
Primary Insurance Group Number	x(20)
Primary Insurance Group Name (EIN)	x(17)
MADRS Common Data (all record types):	
Record Identification Code (RIC)	x(1)
Health Insurance Claim Number	x(11)
Date of Service ((CCYYMMDD), or zeroes if "SUMRY" payment record)	9(5) Comp-3
Reimbursement Amount	S9(7)V99 Comp-3
Total Charges	S9(7)V99 Comp-3
MADRS Payment Record Data:	
Carrier # (Carrier # or "SUMRY")	x(5)
Place of Service	x(1)
Type of Service	x(1)

Physician/Supplier Specialty Code	x(2)
Physician Identification Number	x(9)
Date Reimbursement Paid (CCYYMMDD)	9(5) Comp-3
Filler	x(26)

30.3 - IRS/SSA/CMS Mistaken Payment Recovery Tracking System (MPaRTS)

(Rev. 1, 10-01-03)

Draft B3 dated 4/14/94 3375.14.B, Appendix D of the MPaRTS User Guide dated November 23,1993 for the Status Codes

The IRS/SSA/CMS Data match recovery progress is monitored via a contractor tracking system called Mistaken Payment Recovery Tracking System (MPaRTS) maintained at the CMS Data Center. The following data elements are contained on each report of the tracking system:

- Contractor ID Number;
- Report ID Number;
- Date Data Transmitted to Contractor;
- Beneficiary HICN;
- Beneficiary Last Name;
- MSP Type;
- Patient Relationship;
- Insurer Name;
- Employer Name;
- Insurance Group Name;
- Total Mistaken Payments - Intermediary (Part A);
- Total Mistaken Payments - Intermediary (Part B);
- Total Mistaken payments - Carrier (Part B);
- Total Summary Payments - Carrier (Part B - In office); and

- Total to Be Recovered.

In addition, contractors update the status of IRS/SSA/CMS Data Match cases using the following data elements:

- Case Status Indicator (e.g., Open, Closed, Referred to RO);
- Date Case Closed/referred to RO;
- Amount of Initial Demand;
- Total Amount Recovered; and
- Total Interest Recovered.

The status codes, definitions, and required fields to be completed by contractors to update the status of each MPaRTS case are in the following table:

STATUS CODE	DEFINITION	REQUIRED FIELD ENTRY
00	Open case: Case still under investigation, no Demand sent yet.	None System generates the code.
DR	Deferred Recovery: applies to any report with MSP termination date prior to 1/1/87	None System generates the code.
BR	Backlog Recovery Project Cases which are now tracked in MPaRTS	Status Code and Demand Amount
CB	Amounts identified previously recovered. No demand was sent	Status Code. The system generates closed date.
CD	Case Closed: Duplicate Report. Recovery will be made under another Report ID. No demand was sent.	Status Code and Closed Date
CN	Case Closed: No Recovery (After demand was sent.)	Status Code and Closed Date
CP	Case Closed: Partial Recovery (After Demand was sent.) **NOTE:** Total recovery amount must less than demand amount.	Status Code, Recovery Amount, Closed Date, Interest Amount (if any)
CT	Case Closed: Total Recovery (after demand was sent). **NOTE:** Total recovery amount must equal demand	Status Code, Recovery Amount, Closed Date, Interest Amount (if any)

STATUS CODE	DEFINITION	REQUIRED FIELD ENTRY
	amount.	any)
DS	Demand Letter will be sent.	Status Code and Demand Amount.
IL	“Intent to refer” letter is sent.	Status Code
NR	No Recovery Required: Contractor records show no mistaken payments made. (No demand sent).	Status Code, Incremental Recovery Amount, Interest Amount (if any).
PR	Partial Recovery (after demand was sent). Case Still Open: Additional recovery is expected, and multiple entries are allowed	Status Code, Incremental Recovery Amount (if any).
PS	Debt is referred to the PSC	Status Code
RR	Referred to Regional Office	Status Code
RC	Referred to Central Office	Status Code
UJ	Responsibility for pursuing the debt is at the PSC.)	Status Code
UN	Initial entry of the debt for referral	Status Code and Debt Amounnt
UU	Undeliverable intent to refer letter	Status Code and Debt Amount
XX	Litigation Referral	Status Code and Demand Amount

Contractors must update MPaRTS within 21 days of completing a search of claim history to identify incorrect primary payments and within 10 days of completing recovery action or receiving partial payment. Update the MPaRTS system prior to issuing any demand letters.

A critical data element on each data match mistaken payment report is the report identification number. This is the key variable in the MPaRTS. Contractors can update and aggregate recovery actions by insurer or employer using report identification numbers.

30.4 - Communications Received in Response to Recovery Actions

(Rev. 1, 10-01-03)

A3-3490, A3-3491

If a GHP or employer states that a primary payment was made, the FI or carrier requests an explanation of the benefits paid. It should recover any duplicate payment from the provider. If payment was made to the beneficiary, the FI or carrier obtains a copy of the EOB from the employer/GHP or the party that received the payment. It requests the party that received the GHP or employer payment to refund the excess Medicare payment. The excess Medicare payment is the difference between the Medicare conditional primary payment and the amount Medicare is obligated to pay as secondary payer.

If a GHP or employer that is primary to Medicare refuses to reimburse Medicare for conditional primary benefits, it must explain its reason. If the explanation is that plan benefits are not payable because, for example, the services are not covered under any circumstances, or benefits are exhausted, or the beneficiary is not entitled to benefits, the FI or carrier accepts the explanation in the absence of evidence to the contrary. If some other reason is given, it informs the employer that it is obligated to refund such payments to Medicare under the Medicare law.

Other unacceptable reasons may be:

- The plan has not received a claim from the beneficiary;
- The insurance policy does not provide for payments to third parties;
- The plan maintains it is secondary payer for individuals who are in a 30-month ESRD coordination period;
- The plan provides benefits secondary to Medicare regardless of the employment status of the individual or the individual's spouse; or
- The plan does not respond.

Section 1862(b)(2)(B) of the statute, as amended by §2344(b) of the Deficit Reduction Act of 1984 (Pub. L. 98-369), gives the Government the right to recover conditional Medicare payments. Medicare must be reimbursed conditional primary benefits paid. The FI or carrier advises the employer and the beneficiary of the private right of legal action to collect double damages. If the employer still refuses to reimburse Medicare or does not respond to requests, the FI or carrier refers the case to the RO.

If there is indication that, under the employer's/GHP's contract, that a higher payment amount should have been paid, the FI or carrier contacts the employer/plan and explains that under the statute the employer/plan must make full payment in accordance with its contract. If the employer/plan refuses to cooperate, the FI or carrier refers the case to the

RO if the amount in question exceeds the recovery tolerance above. The RO determines the need for further action.

30.5 - Recovery From the Provider

(Rev. 1, 10-01-03)

A3-3490.3.G.3, A3-3491.B reworded based on comments from RO 6-30-02

When a provider receives payment from a GHP where Medicare has also paid, the provider submits an adjustment bill showing the primary payment amount. The intermediary instructs the provider to return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. The provider may retain any excess GHP payment over the gross amount payable by Medicare.

If duplicate payment was or will be made to the provider, i.e., the provider received or expects to receive both primary GHP payments and primary Medicare benefits, the intermediary collects the overpayment from the provider. If Medicare paid the provider and the GHP paid the beneficiary, the beneficiary is liable. (See the Medicare Financial Management Manual, Chapter 3, §120.3.A.)

If an adjustment bill is not received from the provider within 120 days of notifying the provider to file a claim with the GHP, or the provider refunds the incorrect payment to the intermediary using the quarterly Credit Balance Report, the intermediary follows up to determine the status of the claim. If the GHP has denied the claim for an acceptable reason, the recovery action may be canceled. If the GHP has denied the claim for another reason, or has not responded to the provider's claim, the intermediary advises the provider that Medicare will attempt to recover from the employer. It advises the provider to notify it immediately upon receipt of payment from the GHP. (See §40.2.3 concerning workers' compensation.)

30.6 - Recovery From the Beneficiary

(Rev. 1, 10-01-03)

A3-3490.3.G.34, A3-3491.13.C

If Medicare paid the provider and the GHP paid the beneficiary, the intermediary recoups from the beneficiary subject to the tolerance in the Medicare Financial Management Manual, Chapter 3, §130.2, the lesser of that portion of the Medicare payment that exceeds Medicare's obligation as secondary payer, or an amount up to the provider's customary charges. (See the Medicare Financial Management Manual, Chapter 3, §150.4.A.3 and B.2.) The intermediary obtains a copy of the plan's EOB from either the beneficiary or the GHP/employer in order to determine the excess Medicare payment.

40 - Overpayment Due to Workers' Compensation Coverage

(Rev. 1, 10-01-03)

A3-3407.B, A3-3417, B3-2370.2, HO-289.24, SNF-330.3 HH-250.23

No Medicare payment may be made if WC has paid an amount:

- Which equals or exceeds the Medicare reasonable charge;
- Which equals or exceeds the provider's charges for Medicare covered services; or
- Which the provider/physician/supplier accepts or is required under the WC law to accept as payment in full.

40.1 - Action Subsequent to Conditional Payment

(Rev. 1, 10-01-03)

A3-3415.B, B3-3333.B, B3-3334.2

The FI or carrier may have paid for services and subsequently learned that the services were work-related. The information indicating that a particular injury or illness occurred on the job does not necessarily mean that Medicare payments made for that injury were incorrect. The FI or carrier should consider whether, in view of the circumstances, benefits are not payable under the policies in Chapter 1, §§10.4. This requires COBC development along the lines described in Chapter 5, §§20.3. Sometimes the development will show that there was a legitimate reason for the provider billing the Medicare program. For example, the particular services may have been for a condition not related to the work injury or the individual may have exhausted WC benefits.

The FI or carrier contacts the WC carrier at least every four months (and sends a copy to the beneficiary's attorney) to ascertain the status of any claim on which conditional payments have been made. If the WC carrier is not cooperative, the FI or carrier contacts the attorney instead.

40.1.1 - Time Limit for Filing Workers' Compensation (WC) Claim Has Expired

(Rev. 1, 10-01-03)

A3-3412, B3-3331.3

Most WC plans have time limits within which the employee must notify the employer that a work-related injury or illness occurred and file a claim. If it appears that WC benefits could have been paid for items or services for which benefits have been paid under Medicare, but the time limit for filing a WC claim has expired, the FI or carrier

refers the case with all pertinent documentation relating to the WC issue to CMS. (See §40.2.3.)

Intermediaries annotate item 13 (Remarks) of the Form CMS-2382 ("Intermediary Transmittal of Uncollected Medicare Overpayments") as follows: "Workers' Compensation Case-Referred for Waiver Consideration per §40.1.1 of Chapter 7 of the Medicare Secondary Payer (MSP) Manual." Carriers annotate Item 12 (Remarks) on Form CMS-1932 (Report of Uncollected Part B Overpayment) as follows: "Workers' Compensation Case-Referred for Waiver Consideration per §40.1.1 of Chapter 7 of the Medicare Secondary Payer (MSP) Manual." The FI or carrier includes in this item the following information:

- A full explanation of the basis for the contractor determination that WC benefits could have been paid for the items or services and that the time period for filing a WC claim has expired; and

- The reasons for the beneficiary's delay in filing a WC claim.

40.2 - Recover Medicare Payments When Worker's Compensation is Responsible

(Rev. 1, 10-01-03)

40.2.1 - COBC Determines Lead Contractor for Recovery in WC Cases

(Rev. 1, 10-01-03)

A3-3410.1, B3-3331.1

When WC has paid for items or services for which Medicare benefits were also paid, effective January 8, 2001, the COBC will determine the contractor to take the lead in recovery of the overpayment. The COBC will update the ECRS. The FI/Carriers check the ECRS daily to determine the lead contractor in instances where the initial referral was through ECRS to the COBC. See Medicare Secondary Payer (MSP) Manual, Chapter 4, "Coordination of Benefits Contractor (COBC)," §§70, for COBC responsibilities and other contractor responsibilities in no-fault, Workers' Compensation, and liability situations.

40.2.2 - Duplicate Payment Received by Provider

(Rev. 1, 10-01-03)

A3-3417.1, B3-3334.1, A3-IM-3497.9

If a Medicare payment duplicates a WC payment, the FI or carrier recovers the Medicare payment from the provider/physician/supplier in accordance with the Medicare Financial Management Manual, Chapter 3, §§140, or Chapter 4, §§130.

Recovery of conditional payments is not subject to the reopening rules nor to the limitation on recovering incorrect Medicare payments discovered later than the third calendar year after the year of payment where a WC plan is primary payer. (See the note in the Medicare Financial Management Manual, Chapter 3, §120.4.)

In any case, in which a primary payment is received from Medicare and from a third party payer, Medicare must be reimbursed within 60 days of receipt of the duplicate payment.

40.2.3 - Medicare Paid for Services Which Should Have Been Paid for by Workers' Compensation

(Rev. 1, 10-01-03)

B3-3334.2, A3-3417.2, B3-3334

In any case in which it is clear that Medicare paid for services that should have been paid for by the WC carrier, the FI or carrier requests that the WC carrier reimburse the Medicare program for the amounts improperly paid by Medicare.

If it is determined that payment has been made for services covered by WC, the FI or carrier initiates recovery of the overpayment. Sections 40.2.2 and 40.2.3 provide guidelines for recovery of Medicare payments in some of the more common situations. However, since the circumstances in which work-related issues arise vary greatly, it is impossible to provide definitive rules to cover every situation. Therefore, the FI or carrier must use judgment and discretion in applying the guidelines.

The FI or carrier includes in the request, the reason(s) the services should be paid under WC, and the amount that Medicare paid. In addition, it explains that the Medicare law excludes payments for services covered under WC, and requires WC carriers to make direct refund to the Government where Medicare has paid for services that are reimbursable under WC.

If arrangements to refund the amount due are not made by the WC carrier within 30 days after notification, the FI or carrier asks the WC carrier for an explanation for the delay, whether it intends to refund the Medicare overpayment and, if not, why. If the WC carrier's response is negative, and there is evidence that the services are clearly covered under WC, the FI or carrier refers the case to the RO. If the beneficiary is represented by an attorney, the FI or carrier addresses any correspondence on the WC issue to the attorney. It sends copies of all correspondence with the WC carrier and with the beneficiary concerning the same issue to the State WC agency.

If the WC carrier either declines to refund the overpayment outright or indicates a long delay will be necessary, the FI or carrier refers the file to the RO together with a cover letter which fully explains the issue and contractor recommendations for disposition of the case in accordance with the applicable WC and overpayment recovery policies. It includes copies of all pertinent documents, including the WC award, and correspondence

and reports of contact with the carrier, the State agency, and the beneficiary. The RO reviews the case and determines what further action is to be taken.

40.3 - Settlement Issues

(Rev. 1, 10-01-03)

40.3.1 - Medicare Made Party to WC Hearing

(Rev. 1, 10-01-03)

A3-3411, B3-3331.2

If a WC agency has suggested that Medicare be represented at a WC hearing or has named Medicare as a party to a WC claim, or if the government's claim is otherwise in question at a hearing, the lead contractor represents Medicare. See §50.5.1 for contractor coordination responsibilities. In addition, if the lead contractor feels it would be beneficial to the recovery, its attorney can attend a WC hearing at the request of the plaintiff's attorney as long as under the applicable State law the hearing is not considered litigation.

However, if a court conducts the hearing, whether at the initial or the appellate level (in some States the WC program is administered by a court), the lead contractor consults with the RO as to what action to take. The RO will advise whether to refer the case to them or whether the contractor should represent the program at the hearing. The FI or carrier shall prompt action on such cases to avoid adverse action by the WC agency or court. If the case is referred, it shall include pertinent Medicare claims information.

40.3.2 - Party Requests That Medicare Accept Less Than Its Claim

(Rev. 1, 10-01-03)

B3-3331, A3-3410

If there is a request that Medicare accept less than the full amount of its claim (see Chapter 1, §20, for definitions) and less than the full amount of the WC settlement, the FI or carrier shall inform the party that legally Medicare has the right to recover its full claim up to the full amount of the settlement. However, a request for such a reduction is reviewed, provided it is submitted in writing and specifies the reasons why and to what extent, the Medicare claim should be reduced.

In addition to the right of direct recovery, §1862(b)(1) of the Act gives the Medicare program the right of subrogation for any amounts payable to the program under the MSP provisions. The Federal Claims Collection Act of 1966 (FCCA), as amended by the Debt Collection Act of 1982 and §1870(c) of the Act gives CMS the right to settle claims for reimbursement.

40.3.3 - Authorities for Agreeing to Compromise or Waive Medicare's Claim

(Rev. 1, 10-01-03)

A3-3407.12, B3-2370.12

A beneficiary may offer to refund to the FI or carrier less than the full amount of Medicare's claim against a WC settlement. The CMS may accept such an offer either as a compromise under authority in the Federal Claims Collection Act (FCCA), or as a waiver Authority Under §1870(c) of the Act.

A - CMS may agree to compromise a claim for reimbursement from WC settlements under the FCCA**,** if:

- The individual does not have the present or prospective ability to pay the full amount of the claim within a reasonable period;
- It is determined that it would be difficult to prevail in this case before a court of law; or
- The cost of collecting the claim is likely to be more than the amount collected.

The limit of CMS Regional Office's authority to compromise claims independently under the FCCA is $100,000. The CMS Central Office authority is for debts exceeding $100,000. The CMS has sole jurisdiction over Compromises.

B - Waiver Authority Under §1870(c) of the Act

Medicare claims (see Chapter 1, §20, for definition) that do not involve the FCCA could be considered for waiver based on "economic hardship" or "equity and good conscience." Lead contractors have sole jurisdiction over Waivers, without any threshold.

The FI or carrier sends compromise cases to:

Centers for Medicare & Medicaid Services
Medicare Secondary Payer Operations
7500 Security Boulevard
Baltimore, Maryland 21244-1850

40.3.4 - Effect of Lump Sum Compromise Settlement

(Rev. 1, 10-01-03)

A3-3416, B3-3333.1, B3-2370.7, A3-3407.7, A3-3413, B3-3331.4, B3-2370.8, A3-3407.8, A3-3416.1, B3-3333.2, HO-289.22, HO-289.7, HO-289.8, SNF-330.1, SNF-326.1, SNF-326.2 HH-250.21, HH-250.7, HH-250.8

Negotiated compromise settlements of WC claims, by their very nature, provide less than full benefits for both income replacement and medical expenses. If the beneficiary agrees to a compromise lump sum settlement, i.e., a settlement which provides less in total compensation than the individual would have received if the claim had not been compromised, **and** the settlement has given reasonable recognition to the income replacement objectives of the WC law, the settlement may be accepted as a basis for applying the WC limitations.

If a FI or carrier learns that a beneficiary has accepted an award as a compromise settlement of a WC claim, it reopens the prior allowance and determines the amount of overpayment. (See §§40.) It recovers any Medicare payments made for items or services determined to have also been paid for by the lump sum settlement from the beneficiary. (See the Medicare Financial Management Manual, Chapter 3, §§150.)

If the individual signed a final release of all rights under WC (which precludes the possibility of further WC benefits) medical expenses incurred after the date of the final release are reimbursable under Medicare.

Where the settlement specifies that a portion of the settlement is for future medical expenses, Medicare may not pay for those services until the beneficiary presents medical bills related to the injury totaling the amount of the lump sum settlement allocated to medical treatment. If the lump sum settlement includes payment for future services, the FI or carrier retains a copy of the lump sum agreement and flags any new claims for the condition for which the beneficiary received the lump sum payment.

When a beneficiary accepts a lump sum payment that represents a commutation of **all** future medical expenses and disability benefits, and the lump sum amount is reasonable considering the future medical services that can be anticipated for the medical condition, Medicare does not pay for any future items or services directly related to the injury for which the commutation lump sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of the lump sum settlement allocated to medical treatment.

Where the award does not identify the items of medical or hospital expense covered, the FI or carrier allocates the amount of the award to medical and hospital expense incurred up to the date of the award at the prevailing WC schedule in that jurisdiction in the following manner:

- **First** to any beneficiary payments for services payable under workers' compensation but not covered under Medicare,

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

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

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

EXAMPLE

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

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

In this situation, the beneficiary's payments totaled $3,920.

Services not covered under Medicare	$1,500
Excess of physicians' charges over reasonable charges	$500
Medicare Part B coinsurance	$1,400
Part A deductible	$520
Total	$3,920

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

Whenever a FI or carrier is informed of any lump sum agreement, it notifies the COBC via ECRS.

If a WC agency approves a lump sum settlement of a case where compensability is contested, the lump sum settlement is deemed to be a WC payment, even if the settlement agreement stipulates that there is no WC liability. (See §40.3.4.)

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

EXAMPLE 1

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

The State WC agency subsequently approved a compromise settlement, under the terms of which the WC carrier admitted liability for the hip fracture but not for the stroke. The settlement provided payment to the beneficiary of $18,000 plus payment to the hospital of $1,200 for his stay through the date of the surgery. Following the settlement, the beneficiary requested the intermediary to pay for the three months of hospitalization following the surgery, since the settlement did not stipulate that treatment of the stroke was work-related. The intermediary determined that payment under WC for treatment of the stroke could reasonably have been expected if the beneficiary had not agreed to give up his right to such compensation. It, therefore denied the claim. The provider has the right to bill the beneficiary, since these services would have been covered by WC and, therefore, are not payable by Medicare.

EXAMPLE 2

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

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

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

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

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

Although the compensation order was designed to reduce the obligation of the employer and carrier to pay for medical care by shifting medical expenses to Medicare and other government programs where possible, the agreement recognized the WC carrier's continuing responsibility for the individual's medical care. Since Medicare is not bound by such covenants, benefits were denied for all expenses subsequently incurred for treatment of the work injury. As in Example 1, the Medicare beneficiary may be billed for these services.

EXAMPLE 3

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

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

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

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

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

40.3.4.1 - Apportionment of a Lump Sum Compromise Settlement of Contested WC Claim

(Rev. 1, 10-01-03)

A3-3416.2, B3-3333.3, HO-289.23, SNF-330.2, HH-250.22

If the settlement covers both medical care and disability benefits but does not apportion the sum granted between them and income replacement, or does not give reasonable recognition to both medical care and disability, the FI or carrier calculates the amount of the award deemed to be payment of medical and hospital expenses as follows:

- It determines the ratio which the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount which would have been payable under WC for both medical and hospital expenses (including expenses not covered under Medicare) **and** income replacement, if the claim had not been settled by compromise; and

- It multiplies this ratio by the total medical and hospital expenses incurred as a result of the injury or disease **up to the date of the settlement**. The product is deemed to be the amount of WC settlement intended as payment for medical and hospital expenses. It applies the latter amount to the medical and hospital expenses incurred due to the work-related injury. (See §40.3.4.)

Generally, the FI or carrier bases the determination of the "total amount that would have been payable under WC had the claim not been settled by compromise" on information furnished by the beneficiary's attorney. If there is reason to question the attorney's estimate, it bases the determination on information from other sources such as the State WC agency.

The FI or carrier requests the attorney to furnish a statement of the amounts that would have been payable for disability and medical care if the beneficiary were awarded full benefits under the WC law. The attorney's estimate should include an amount for disability based on the anticipated number of months of total disability and an amount for partial disability. Each amount should be based on the specific amounts which the law states are payable for each type of disability. The estimate should include an amount for medical care based on actual and anticipated medical expenses related to the work injury. The information provided by the attorney should be consistent with the beneficiary's medical condition and the provisions of the applicable WC law. (WC laws require that employers pay all work-related medical expenses, and designate amounts for temporary and permanent disability.)

If there is a discrepancy between the attorney's estimate and the beneficiary's medical situation and the provisions of the law, the FI or carrier asks the attorney for additional information and/or an explanation of how the amount was determined. It may find it helpful to consult with the State WC agency to obtain confirmation that the attorney's estimate is consistent with the medical facts and with the law.

The FI or carrier contacts the WC agency for the above information if the attorney does not cooperate.

If the FI or carrier believes that the attorney has overstated the amount that would have been paid if the claim were not settled by compromise, it bases a determination of overpayment on a lower amount that is considered reasonable based on all the facts. It sends the attorney a full explanation of how the estimate was determined with particular attention to the aspects that differ from the attorney's.

EXAMPLE 4

Mr. A. suffered a work injury resulting in loss of income and expenses for hospital and medical services for which the total WC payment would have been $24,000 had the case not been compromised. The expenses totaled $18,000 and included $10,200 in hospital services, which in the absence of WC, would be paid for under Part A; $6,300 in expenses for medical and other health services for which payment would be made under Part B on a reasonable charge basis, and $1,500 in expenses for services not reimbursable under Part A or Part B but reimbursable under WC. The WC carrier made a settlement with the beneficiary under which it paid a total of $8,000. A separate award was made for legal fees.

Since the settlement was for one-third of the amount which would have been payable under WC had the case not been compromised ($8,000/$24,000 = 1/3) the settlement is deemed to have paid for one-third of the total medical and hospital expenses (1/3 x $18,000 = $6,000).

To determine the amount of Medicare benefits payable, the contractor applies the $6,000 of the compromise WC settlement considered as payment for hospital and medical expenses, first to the $1,500 in noncovered expenses. It applies the remaining $4,500 to the $6,300 in Part B covered expenses (without deducting the deductible and coinsurance). The remaining $1,800 of Part B expenses and all of the $10,200 in expenses for services covered under Part A would be reimbursable under Medicare.

EXAMPLE 5

Mr. B worked for a florist. On May 18, 2002, while making a delivery, he fell and broke his hip. He was admitted to the hospital, where it was discovered that, in addition to his fracture, he had a severe infection. He was hospitalized until August 20, 2002. Medicare paid a total of $60,000 toward the medical and hospital expenses.

Mr. B settled his WC claim by accepting a lump sum compromise payment of $50,000, $10,000 of which represented attorney's fees. Medicare submitted a claim to Mr. B's attorney requesting reimbursement for the amount it had paid. The WC lump sum represented a compromise settlement of Mr. B's present and future disability benefits, estimated at $35,000, and past medical expenses (including $48,000 paid under Part A, $12,000 covered under Part B, and $5,000 for expenses not covered under Medicare). Had Mr. B not compromised, the total amount that would have been payable for disability and medical expenses would have been $100,000 ($35,000 for disability and

$65,000 for medical). There did not appear to be an attempt to shift the WC liability to Medicare.

The award ($50,000), less attorney fees ($10,000), is 40 percent of what would have been paid if Mr. B had been awarded full benefits ($100,000). Under the lump sum apportionment formula, 40 percent of $65,000 in total medical expenses, or $26,000, is deemed to have been paid by the WC compromise settlement.

As Mr. B had $5,000 medical expenses for noncovered Medicare services, that amount is deducted from the $26,000, leaving $21,000 to be applied to Mr. B's Medicare covered expenses. The entire $12,000 of Mr. B's Part B expenses (including the deductible and coinsurance) is considered to have been paid by the WC award and $9,000 of the $48,000 in Part A expenses are considered paid by the WC award. Medicare's claim is the amount it paid toward the $12,000 in Part B services and $9,000 of the Part A payment. These payments were duplicated by the WC payment.

40.3.5 - Workers' Compensation: Commutation of Future Benefits

(Rev. 1, 10-01-03)

Memorandum to All Associate Regional Office Administrators dated July 23, 2001 inserted based on CMS comments.

Medicare's regulations (42 CFR 411.46) make a distinction between lump sum settlements that are commutations of future benefits and those that are due to a compromise between the Workers' Compensation (WC) carrier and the injured individual. This section clarifies how the ROs should evaluate and approve WC lump sum settlements to help ensure that Medicare's interests are properly considered.

Regional Office staff may choose to consult with the Regional Office's Office of the General Counsel (OGC) on WC cases because these cases may entail many legal questions. OGC should become involved in WC cases if there are legal issues that need to be evaluated or if there is a request to compromise Medicare's recovery claim or if the Federal Claims Collection Act (FCCA) delegations require such consultation. Because most WC carriers typically dispute liability in WC compromise cases, it is very common that Medicare later finds that it has already made conditional payments. (A conditional payment means a Medicare payment for which another payer is responsible.) If Medicare's conditional payments are more than $100,000 and the beneficiary also wishes Medicare to compromise its recovery under FCCA (31 U.S.C.3711), the case must be referred to Central Office and then forwarded to the Department of Justice. It is important to note in all WC compromise cases that all pre-settlement and post-settlement requests to compromise **any** Medicare recovery claim amounts must be submitted to the RO for appropriate action. Regional Offices must comply with general CMS rules regarding collection of debts.

Medicare is secondary payer to WC; therefore, it is in Medicare's best interests to learn the existence of WC situations as soon as possible in order to avoid making mistaken

payments. The use of administrative mechanisms sometimes referred to by attorneys as Medicare Set-Aside Trusts (hereafter referred to as "set-aside arrangements") in WC commutation cases enables Medicare to identify WC situations that would otherwise go unnoticed, which in turn prevents Medicare from making mistaken payments.

Although 42 CFR 411.46 requires that all WC settlements must adequately consider Medicare's interests, 42 CFR 411.46 does not mandate what particular type of administrative mechanism should be used to set-aside monies for Medicare including a self-administered arrangement (State law permitting). Of course, if an arrangement is self-administered, then the injured individual/beneficiary must adhere to the same rules/requirements as any other administrator of a set-aside arrangement.

Set-aside arrangements are used in WC commutation cases, where an injured individual is disabled by the event for which WC is making payment, but the individual will not become entitled to Medicare until some time after the WC settlement is made. Medicare learns of the existence of a primary payer (WC) as soon as possible when Medicare reviews a proposed set-aside arrangement at or about the time of WC settlement. In such cases, Medicare greatly increases the likelihood that no Medicare payment is made until the set-aside arrangement's funds are depleted. These set-aside arrangements provide both Medicare and its beneficiaries security with regard to the amount that is to be used to pay for an individual's disability related expenses. It is important to note that set-aside arrangements are **only** used in WC cases that possess a commutation aspect; they are not used in WC cases that are strictly or solely compromise cases.

Lump sum compromise settlements represent an agreement between the WC carrier and the injured individual to accept less than the injured individual would have received if he or she had received full reimbursement for lost wages and life long medical treatment for the injury or illness. In a typical lump sum compromise cases between a WC carrier and an injured individual, the WC carrier strongly disputes liability and usually will not have voluntarily paid for all the medical bills relating to the accident. Generally, settlement offers in these cases are relatively low and allocations for income replacement and medical costs may not be disaggregated. Such agreements, rather than being based on a purely mathematical computation, are based on other factors. These may include whether there was a preexisting condition, whether the accident was really work related, or whether the individual was acting as an employee, or performing work-related duties at the time the accident occurred.

One of the distinctions that Medicare's regulations and manuals make between compromise and commutation cases is the absence of controversy over whether a WC carrier is liable to make payments. A significant number of WC lump sum cases are commutations of future WC benefits where typically there is no controversy between the injured individual and the WC carrier over whether the WC carrier is actually liable to make payments. An absence of controversy over whether a WC carrier is liable to make payments is not the only distinction that Medicare's manuals and regulations make between compromise and commutation cases. Thus, lump sum settlements should not automatically be considered as compromise cases simply because a WC carrier does not admit to being liable in the settlement agreement. Conversely, lump sum settlements

should not automatically be considered as commutation cases simply because a WC carrier does admit to being liable in a settlement agreement. Therefore, an admission of liability by the WC carrier is not the sole determining factor of whether or not a case is considered a compromise or commutation.

Workers' Compensation commutation cases are settlement awards intended to compensate individuals for **future** medical expenses required because of a work-related injury or disease. In contrast, WC compromise cases are settlement awards for an individual's current or past medical expenses that were incurred because of a work-related injury or disease. Therefore, settlement awards or agreements that intend to compensate an individual for any medical expenses after the date of settlement (i.e., future medical expenses) are commutation cases.

It is important to note that a single WC lump sum settlement agreement can possess both WC compromise and commutation aspects. That is, some single lump sum settlement agreements can designate part of a settlement for an injured individual's future medical expenses and simultaneously designate another part of the settlement for all of the injured individual's medical expenses up to the date of settlement. This means that a commutation case may possess a compromise aspect to it when a settlement agreement also stipulates to pay for all medical expenses up to the date of settlement. Conversely, a compromise case may possess a commutation aspect to it when a settlement agreement also stipulates to pay for future medical expenses. Therefore, it is possible for a single WC lump sum settlement agreement to be both a WC compromise case and a WC commutation case.

Generally, parties to WC commutation cases agree on a lump sum amount in exchange for giving up the usual continuing payments by WC for lost wages and for lifetime medical care related to the injuries. Such lump sum amounts are usually requested because the beneficiary wishes to use the funds for some specific purpose. For example, the individual's home may need to be remodeled to accommodate a wheelchair or, more typically, he or she is so disabled that lifetime attendant care is needed. In these latter cases, the injured individual seeks a lump sum payment so that such care can be arranged with certainty in the future. The amount of the lump sum is typically established by using a life care plan and actuarial methods to determine the individual's life expectancy. When WC has accepted full liability in a case prior to the creation of a set-aside arrangement, the likelihood of any Medicare conditional payments being made is reduced.

If a life care plan is not used to justify the injured individual's future medical expenses, then the injured individual or his/her representative **must** present other alternative evidence that sufficiently justifies the amounts set-aside for Medicare.

Set-aside arrangements are most often used in those cases in which the beneficiary is comparatively young and has an impairment that seriously restricts his or her daily living activity. These set-aside arrangements are typically not created until the individual's condition has stabilized so that it can be determined, based on past experience, what the future medical expenses may be.

Medicare regulations at 42 CFR 411.46 state that:

> If a lump sum compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury or disease, Medicare payments for such services are excluded until medical expenses related to the injury or disease equal the amount of the lump sum payment.

In addition, §40.3.4 of this chapter states:

> When a beneficiary accepts a lump sum payment that represents a commutation of **all** future medical expenses and disability benefits, and the lump sum amount is reasonable considering the future medical services that can be anticipated for the condition, Medicare does not pay for any items or services directly related to the injury or illness for which the commutation lump sum is made, until the beneficiary presents medical bills related to the injury equal to the total amount of the lump sum settlement allocated to medical treatment.

40.3.5.1 - Questions and Answers Concerning WC Commutation of Future Benefits

(Rev. 1, 10-01-03)

Memorandum to All Associate Regional Office Administrators dated July 23, 2001 inserted based on CMS comments.

Question 1

a. Does the Medicare program have a claim against a lump sum WC payment before an individual's Medicare entitlement?

b. If not, can the Medicare program give a written opinion on the sufficiency of a set-side arrangement even if the individual is not as yet entitled to Medicare?

c. In WC cases involving injured individuals who are not yet Medicare beneficiaries, when must Medicare's interests be considered before the parties can settle the case?

Answer 1

These questions have been raised by attorneys who wish to devise set-aside arrangements, which represent amounts for medical items, and services that would ordinarily be covered by Medicare and are specified for future medical treatment for work-related illness or injuries. The attorneys are concerned that Medicare will not pay once the individual becomes entitled to Medicare, because the lump sum included payment for future medical treatment.

The answer to Question 1(a) is no, Medicare cannot make a formal determination until the individual actually becomes entitled to Medicare. However, the attorneys are correct that once the individual becomes entitled, Medicare payment may not be made to the extent of Medicare's interests in the lump sum payment per 42 CFR 411.46 or a set-aside arrangement that adequately considers Medicare's interests in the lump sum payment.

The answer to Question 1(b) is that the RO (with consultation from the Regional OGC, if necessary) can review a proposed settlement including a set-aside arrangement and can give a written opinion on which the potential beneficiary and the attorney can rely, regarding whether the WC settlement has adequately considered Medicare's interests per 42 CFR 411.46. These settlements should all be handled on a case-by-case basis, as each situation is different. If there are several years prior to Medicare entitlement, the RO should use its best judgement regarding what Medicare utilization might be once there is Medicare entitlement. This decision should be based on the documentation obtained as stated in the answer to Question 10. Once the RO has given written assurance that the set-aside arrangement is sufficient to satisfy the requirements at 42 CFR 411.46, when the set-aside arrangement is established and the settlement is approved, the RO, should then set up a procedure to follow the case.

The answer to question 1(c) is, it is not in Medicare's best interests to review every WC settlement nationwide in order to protect Medicare's interests per 42 CFR 411.46. Injured individuals (who are not yet Medicare beneficiaries) should only consider Medicare's interests when the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date, **and** the anticipated **total** settlement amount for future medical expenses **and** disability/lost wages over the life or duration of the settlement agreement is expected to be greater than $250,000.

Note that the review thresholds (i.e., 30 months and $250,000) will be subject to adjustment once CMS has experience reviewing these matters under these instructions.

For example, if the injured individual is designated by WC as a Permanent Total disabled individual, has filed for Social Security disability, and the settlement apportions $25,000 per year (combined for both future medical expenses and disability/lost wages) for the next 20 years, then the RO should review that WC settlement because the total settlement amount over the life of the settlement agreement is greater than $250,000 ($25,000 x 20 years = $500,000) and the injured individual has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date. If the injured individual in this example fails to consider Medicare's interests, then Medicare may preclude its payments pursuant to 42 CFR 411.46 once the injured individual actually becomes entitled to Medicare.

NOTE: Injured individuals who are already Medicare beneficiaries **must** always consider Medicare's interests prior to settling their WC claim regardless of whether or not the total settlement amount exceeds $250,000. That is, **ALL WC PAYMENTS** regardless of amount **must** be considered for current Medicare beneficiaries.

Question 2

Should a "system of records" be established for the documentation that the RO and contractors receive/collect concerning these set-aside arrangements?

Answer 2

Yes. The CMS Division of Benefit Coordination is in the process of establishing a "system of records" via the Federal Register process, which will provide legal authority to maintain records on individuals that are not enrolled in Medicare. The RO will be responsible for maintaining or "housing" the records for every arrangement on which the RO provides a written opinion. Please note that these records are not subject to Freedom of Information Act requests and may not be disseminated to the public.

Question 3

Once the set-aside arrangement has been approved by the RO (with consultation from the Regional OGC, if necessary), what is the subsequent role of the ROs and contractors?

Answer 3

When the RO approves a set-aside arrangement (with consultation from the regional OGC, if necessary), the RO will check on a monthly basis the National Medicare Enrollment database in order to determine when an injured individual actually becomes enrolled in Medicare. Once the RO verifies that the injured individual has actually been enrolled in Medicare, the RO will assign a contractor responsible for monitoring the individual's case. The RO will assign the contractor based on the injured individual's State of residence.

When the injured individual has actually been enrolled in Medicare, the RO **mus**t provide the Coordination of Benefits Contractor (COBC) with identifying information to add a WC record to Common Working File. The RO must exercise one of the following options:

- FAX the information to the COBC; or
- Submit through an Electronic Correspondence Referral System (ECRS) inquiry.

At a minimum, the RO must indicate that this is a WC set-aside arrangement case, and include the following information:

- Beneficiary Name;
- Beneficiary HIC;
- Date of Incident;

- DX code(s): If you do not have dx codes readily available, you must include a description of the illness/injury. Note: Do not forward to COB without a dx or description.

- Administrator of Trust, and

- Claimant Attorney Information.

The administrator of the set-aside arrangement must forward annual accounting summaries concerning the expenditures of the arrangement to the contractor responsible for monitoring the individual's case. The contractor responsible for monitoring the individual's case is then responsible for insuring/verifying that the funds allocated to the set-aside arrangement were expended on medical services for Medicare covered services only. Additionally, the contractor responsible for monitoring the individual's case will be responsible for ensuring that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been exhausted.

Question 4

What types of measures should the RO and the contractors take to ensure that Medicare makes no payments related to the illness or accident until the set-aside arrangement has been depleted?

Answer 4

Generally, set-aside arrangements that are designed as lump sums (i.e., the arrangement is funded by the WC settlement all at once) present less of a problem to monitor than structured arrangements. Medicare would not make any payments for individuals that possess lump sum arrangements until all of the funds within the arrangement have been depleted. For example, if a set-aside arrangement were established for $90,000, Medicare would not make any payments until the entire $90,000 (plus interest, if applicable) were exhausted on the individual's medical care (for Medicare covered services only).

Structured set-aside arrangements generally apportion settlement monies over fixed or defined period of time. For example, a structured arrangement may be designed to disburse $20,000 per year over the next ten years for an individual's medical care (for Medicare covered services only). If the $20,000 allocated on January 1 for Year 1 were fully exhausted on August 31, Medicare may make payments for the services performed after August 31 once the contractor responsible for monitoring the individual's case can verify that the entire $20,000 (plus interest, if applicable) is exhausted. However, when the structured arrangement allocates money for the start of Year 2 (i.e., on January 1) Medicare would not make any payments for services performed until Year 2's allocation was completely exhausted.

In every set-aside arrangement case, the contractor responsible for monitoring the individual's case (with assistance from the RO, if necessary) should ensure that Medicare

does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the arrangement have truly been exhausted.

NOTE: Until the individual actually becomes entitled to Medicare, the set-aside arrangement fund must **not** be used to pay the individual's expenses. That is, an individual's medical expenses must be paid from some other source besides the set-aside arrangement when the individual is not a Medicare beneficiary. Once the individual actually becomes entitled to Medicare, then the administrator of the arrangement is permitted to make payments for the individual's medical care (for Medicare-covered services only) from the arrangement.

If the contractor monitoring the individual's case discovers that payments from the set-aside arrangement have been used to pay for services that are not covered by Medicare or for administrative expenses that exceed those approved by the RO (see Question 11), then the contractor will not pay the Medicare claims. The contractor must provide the evidence of the unauthorized expenditures to the RO for investigation. If the RO determines that the expenditures were contrary to the RO's written opinion on the sufficiency of the arrangement, then the RO will notify the administrator of the arrangement that the RO's informal approval of the arrangement is withdrawn until such time as the funds used for non-Medicare expenses and/or unapproved administrative expenses are restored to the set-aside arrangement.

Question 5

What are the criteria that Medicare uses to determine whether the amount of a lump sum or structured settlement has sufficiently taken its interests into account?

Answer 5

The following criteria should be used in evaluating the amount of a proposed settlement to determine whether there has been an attempt to shift liability for the cost of a work-related injury or illness to Medicare. Specifically, is the amount allocated for future medical expenses reasonable? If Medicare has already made conditional payments their repayment also has to be taken into account.

Evaluation criteria:

1 - Date of entitlement to Medicare.

2 - Basis for Medicare entitlement (disability, ESRD or age). If the beneficiary has entitlement based on disability and would also be eligible on the basis of ESRD, this should be noted since the medical expenses would be higher. This would also be true for beneficiaries who are over 65 but had been entitled prior to attaining that age.

3 - Type and severity of injury or illness. Obtain diagnosis codes so injury or illness related expenses can be identified. Is full or partial recovery expected? What is

the projected time frame if partial or full recovery is anticipated? As a result of the accident is the individual an amputee, paraplegic or quadriplegic? Is the beneficiary's condition stable or is there a possibility of medical deterioration?

4 - Age of beneficiary. Acquire an evaluation of whether his/her condition would shorten the life span.

5 - WC classification of beneficiary (e.g., permanent partial, permanent total disability, or a combination of both).

6 - Prior medical expenses paid by WC due to the injury or illness in the 1 or 2 year period after the condition has stabilized. If Medicare has paid any amounts, they must be recovered. Also, this would indicate that the case may not purely be a commutation case, but may also entail some compromise aspects, e.g., the WC carrier or agency may have take the position that the services were not covered by WC.

7 - Amount of lump sum or amount of structured settlement. Obtain as much information as possible regarding the allocation between income replacement, loss of limb or function, and medical benefits.

8 - Is the commutation for the beneficiary's lifetime or for a specific time period? If not for lifetime, what is the basis? Medicare must insist that there is a reasonable relationship between the respective allocation for services covered by Medicare and services not covered by Medicare. For example, is it reasonable for the settlement agreement's allocation for services not covered by Medicare to be based on the beneficiary's life time while the agreement's allocation for services covered by Medicare is based on a lesser time period? What is the State law regarding how long WC is obligated to cover the items or services related to the accident or illness?

9 - Is the beneficiary living at home, in a nursing home, or receiving assisted living care, etc.? If the beneficiary is living in a nursing home, or receiving assisted living care, it should be determined who is expected to pay for such care, e.g., WC (for life time or a specified period) from the medical benefits allocation of lump sum settlement, Medicaid, etc.

10 - Are the expected expenses for Medicare covered items and services appropriate in light of the beneficiary's condition? Estimated medical expenses should include an amount for hospital and/or SNF care during the time period for the commutation of the WC benefit. (Just one hospital stay that is related tot he accident could cost $20,000.) For example, a quadriplegic may develop decubitus ulcers requiring possible surgery, urinary tract infections, kidney stones, pneumonia and/or thrombophlebitis. Although each case must be evaluated on its own merits, it may be helpful to ascertain for comparison purposes the average annual amounts of Part A and Part B spending for a disabled person in the appropriate State of residence. Keep in mind that these Fee-for-Service amounts

are for all Medicare covered services, while our focus here only deals with services related to the WC accident or illness. Therefore, the RO should use appropriate judgment and seek input from a medical consultant when determining whether the amount of the lump sum or structured settlement has sufficiently considered Medicare's interests.

The attorney for the individual for whom the arrangement is set-up should be advised that Medicare applies a set of criteria to any WC settlement on a case-by case basis in order to determine whether Medicare has an obligation for services provided after the settlement that originally were the responsibility of WC.

NOTE: Before evaluating whether an arrangement reasonably covers/considers Medicare's interests, **the RO must know** whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts.

Question 6

Some attorneys have indicated that a set-aside arrangement should only contemplate three to five years of estimated Medicare covered items or services. Would this be reasonable?

Answer 6

No. To protect the Medicare Trust Fund, a set-side arrangement should be funded based on the expected life expectancy of the individual unless the State law specifically limits the length of time that WC covers work related conditions. If an estimate of the beneficiary's estimated longevity was not submitted, one must be obtained.

Question 7

What other issues should be considered?

Answer 7

The lump sum amount should be interest bearing and indexed to account for inflation consistent with how Medicare calculates its growth in spending. Provision should also be made in the settlement agreement to provide for a mechanism so that items or services that were not covered by Medicare at the time, but later become covered, are transferred from the commutation specified for non-Medicare covered items and services to the set-aside arrangement. (For example, if outpatient prescription drugs become more widely covered.) If the beneficiary belongs to a Health Maintenance Organization that may not be coordinating benefits based on WC entitlement, the settlement should still set-aside funds for Medicare covered services in case the beneficiary converts to a fee for service plan.

Question 8

Is it permissible for Medicare to accept an up-front cash settlement instead of a set-aside arrangement?

Answer 8

An up-front cash settlement is only appropriate in certain instances when Medicare agrees to a compromise in order to recover conditional payments made when WC did not pay promptly. Thus, when future benefits are included in a WC settlement agreement, Medicare cannot pay until the medical expenses related to the injury or disease equal the amount of the settlement allocated to future medical expenses or the amount included for medical expenses in the set-aside arrangement has been exhausted.

Question 9

How do providers and suppliers obtain payment for the services covered by the set-aside arrangement?

Answer 9

There are two distinct methods for providers, physicians and other suppliers to obtain payment for WC covered services when funds are held in a set-aside arrangement. Determining which distinct payment method applies depends on two factors:

- How the set-aside arrangement is constructed, and
- Whether the arrangement was constructed by contemplating full actual charges or WC fee schedule amounts (i.e., were the injured individual's medical expenses determined based on full actual charge estimates or WC fee schedule estimates).

When a set-aside arrangement's settlement agreement contains specific provisions establishing that the WC carrier will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan, and when the RO reviews and approves the sufficiency of the arrangement based on the WC plan's WC fee schedules, then, providers, physicians and other suppliers will be paid based on what would normally be payable under the WC plan (i.e., under the WC fee schedule). Therefore, providers, physicians and other suppliers would not be permitted to bill the arrangement more than the WC fee schedule rate. For example, if a provider's full charge for a particular service is $100 and the WC carrier normally pays $65 for that particular service, then the arrangement should only pay $65. However, when an arrangement's settlement agreement does **not** contain specific provisions ensuring that the arrangement cannot be charged more than what would normally be payable under the WC plan, then providers, physicians and other suppliers are permitted to bill the arrangement their full charges. It is important to note that when an arrangement's settlement agreement does not contain specific provisions ensuring that providers, physicians and other suppliers cannot bill the arrangement more than the WC fee schedule amounts, then the RO must

review the sufficiency of that particular arrangement based upon full actual charge estimates.

Before evaluating whether an arrangement reasonably covers/considers Medicare's interests, **the RO must know** whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts. If the arrangement is based upon WC fee schedule amounts, then, the RO cannot provide a written opinion on the sufficiency of an arrangement until the arrangement's settlement agreement contains specific provisions that establish that the WC carrier can and will ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan. The WC carrier must require all entities and individuals that accept WC payments to agree not to charge the arrangement more than what the WC plan would normally pay.

If a WC carrier is unable to enforce the requirement that the arrangement can only be charged the WC fee schedule rates, then the RO will evaluate whether an arrangement reasonably covers/considers Medicare's interest based on whether the future medical expenses billed to the arrangement are enough to cover the actual expenses for the services at issue. If State WC laws do not provide a particular WC carrier with the legal authority to enforce that requirement, then the RO can still provide a written opinion on the sufficiency of the arrangement so long as future medical expenses are evaluated by the RO using full actual charge estimates, not WC fee schedule amounts.

If the arrangement is constructed based upon full actual charge estimates, then the RO must determine whether the proposed amount to be placed in the arrangement for future medical expenses and administrative costs (see Question 11) is sufficient to cover the actual charges for the services at issue (rather than an amount equal to what would have been the Medicare approved amount for a particular service).

Once the arrangement has been depleted because of payments for otherwise Medicare covered services, a complete accounting must be provided to the contractor responsible for monitoring the individual's case and if the payments have been properly made Medicare can then be billed.

Question 10

Are there documentation requirements that must be satisfied before the RO can provide a written opinion on the sufficiency of a set-aside arrangement?

Answer 10

Yes. At a minimum, the following documentation must be obtained by the RO prior to the approval of any arrangement:

> A copy of the settlement agreement, or proposed settlement agreement, a copy of the life care plan (if there is one), and, if the life care plan does not contain an estimate of the injured individual's estimated life span, then a "rate age" may be obtainable from life insurance companies for injuries/illnesses sustained by other similarly situated individuals. In

addition, documentation that gives the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the necessity of continued care).

The RO may require additional documentation, if necessary and approved by CO.

Question 11

How does the RO determine whether or not the administrative fees and expenses charged to the arrangement are reasonable?

Answer 11

Before a proposed arrangement can be approved, the RO must determine whether the administrative fees and expenses to be charged to the arrangement are reasonable. The RO must be notified (in writing) of all proposed administrative fees prior to the RO providing its written assurance that the set-aside arrangement is sufficient to satisfy the requirements of 42 CFR 411.46. If the administrative fees are determined to be unreasonable, the RO must withhold its approval of the set-aside arrangement. The amount of the approved arrangement must include both the estimated medical expenses plus the amount of administrative fees found to be reasonable.

Question 12

What impact will arrangements have on Medicare payment systems and procedures?

Answer 12

Because an arrangement's purpose is to pay for all services related to the individual's work-related injury or disease, Medicare will not make any payments (as a primary, secondary or tertiary payer) for any services related to the work-related injury or disease until nothing remains in the set-aside arrangement. Arrangements are established in order to pay for all medical expenses resulting from work-related injuries or diseases; arrangements are not designed to simply pay portions of medical expenses for work-related injuries or diseases.

When arrangements are designed as lump sum commutations (i.e., the arrangement is designed in a manner that the WC settlement is paid into the arrangement all at once, (see Question 4 above), Medicare would not make any payments for that individual's medical expenses (for work-related injuries or diseases) until all the funds (including interest) within the arrangement have been completely exhausted. These same basic principles also apply to structured commutations (see Question 4 above).

When providers, physicians and other suppliers submit claims to Medicare related to the individual's work-related injury or disease, claims processing contractors should deny those claims and instruct the entity or individual to seek payment from the administrator of the arrangement. Since the injured individual will be a Medicare beneficiary at the

time when the provider, physician, or other supplier submits the claim to Medicare, the contractor responsible for monitoring the individual's case will have already updated the Common Working File to indicate that the injured individual's claims should be denied. However, when a provider, physician or other supplier submits any claims that are for injuries or diseases that are not work-related, then contractors should process those claims like they would any other claim for Medicare payment.

When the administrator of an arrangement refuses to make payment on a provider's, physician's, or other supplier's claim because the administrator of the arrangement asserts the services are for injuries or diseases that are not work-related (or when the administrator of the arrangement denies the claim for any other reason), and the provider, physician or other supplier, subsequent to the administrator's denial, submits the claim to Medicare, then the contractor should consult the RO in order to determine whether Medicare should pay the claim. If a determination to deny the claim is made, then Medicare's regular administrative appeals process for claim denials would apply to the claim.

50 - Recoveries From Liability Insurance Including No-Fault Insurance, Uninsured, or Under-Insured Motorist Insurance

(Rev. 1, 10-01-03)

50.1 - General Operational Instructions

(Rev. 1, 10-01-03)

A3-3418, B3-3340.6

These instructions address the operational aspects of reimbursement to the Medicare program in situations involving settlements to beneficiaries paid by liability insurance, auto liability insurance, no-fault insurance and uninsured, or under-insured motorist insurance. Liability insurance means insurance (including a self-insurance plan) that provides payment based on legal liability for injury or illness or damage to property, homeowners' liability insurance, malpractice insurance, product liability insurance and general casualty insurance. Since recovering Medicare secondary payer (MSP) liability overpayments involves procedures which vary somewhat from those used for general overpayments, the following recovery instructions are to be used in place of the general overpayment instructions found in the Financial Manual, Chapter 3, **except where specific references to those sections are provided.** Overpayments arising from benefits paid by employer group health plans should be resolved using procedures applicable to general Medicare overpayments, as described in Chapter 3 of the Medicare Financial Management Manual.

Section 1862(b) of the Act grants Medicare a priority right of recovery. Section 1862(b) also gives the Medicare program the right of subrogation for any amounts payable to the program under §1962 of the Act. In order to recover the conditional payment, Medicare may bring direct action in its own right against the entity responsible or required to pay

Medicare, or against any other entity that has received payment. In addition, Medicare has, under subrogation law, a right to recover its payment from an individual or other entity that received payment from a third party payer.

Previously, situations and recoveries involving liability settlement claims were referred to generically as "subrogation." This term has caused confusion in the legal community and implies that Medicare has only a subrogated right when, in fact, Medicare has a priority right of recovery. This priority right of recovery is much stronger than the subrogated right. Medicare's right to recover its benefits takes precedence over the claims of any other party, including Medicaid. (See §10.1.) The FI or carrier refers to these situations as liability cases or situations, and focuses on Medicare's statutory priority right of recovery when corresponding with the beneficiary and/or the beneficiary's attorney.

The CMS may employ various statutory authorities to waive, compromise, terminate, or suspend its right of recovery. Section 1862(b)(2)(B)(iv) of the Act provides for waiver of an MSP overpayment when it is in the best interests of the Medicare program. Section 1870(c) of the Act also permits CMS to waive its right to recovery when the beneficiary meets certain criteria. The Federal Claims Collection Act (FCCA) of 1966 (31 U.S.C. 3711) gives CMS the right to compromise claims for less than the full amount on behalf of the Government of the United States, or to suspend or terminate collection action. Contractors have authority to resolve claims under §1870(c) of the Act, but not under FCCA nor §1862(b). Each of these authorities is discussed §50.6.3 - 50.7.2.

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

If a negligent party who carries liability insurance decides to pay a liability claim with his/her own funds rather than submit the claim to the liability insurer, Medicare recovers its benefits for such a payment because it is deemed to be a liability insurance payment. Medicare benefits are also subject to recovery from payments by a self-insured party.

50.2 - Provider's and Beneficiary's Responsibility With Respect to No-Fault Insurance

(Rev. 1, 10-01-03)

A3-3489.8

The provider and beneficiary (or the beneficiary's representative) are responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under no-fault insurance. Therefore, unless conditional payments can be made under §50.2.2, the FI or carrier shall not make any Medicare payments until the provider

or the beneficiary has exhausted the entire claims process under no-fault insurance. Conditional benefits are not payable if payment cannot be made under no-fault insurance because the provider or the beneficiary failed to file a proper claim. (See Chapter 1, §20 for definition.)

Exception: When failure to file a proper claim is due to mental or physical incapacity of the beneficiary, and the provider could not have known that a no-fault claim was involved, this rule does not apply.

50.2.1 - Claimant's Right to Take Legal Action Against a GHP

(Rev. 1, 10-01-03)

A3-3489.9, A3-3491.16, B3-3329.12

The OBRA of 1986 provides that any claimant has the right to take legal action against, and to collect double damages from, a no-fault insurer or any GHP that fails to pay primary benefits for services covered by the no-fault insurer or GHP where required to do so under §1862(b) of the Act.

50.2.2 - Conditional Primary Medicare Benefits

(Rev. 1, 10-01-03)

A3-3489.3.F, B3-3338.3

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

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

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

When such conditional Medicare payments are made, they are made on condition that the beneficiary will reimburse the program to the extent that the liability/no-fault insurer subsequently makes payment. When making such payments, the FI or carrier notifies the beneficiary and the insurer of the requirement for repayment. (However, failure to do so does not relieve the beneficiary or insurer of the obligation to refund the payments.) The FI or carrier asks the insurer to notify the Medicare contractor when it is prepared to pay the claim, so that direct refund can be arranged, in accordance with §50.5.

The Medicare contractor flags **all** cases for possible follow-up action to recover the conditional payments.

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

50.2.3 - Services Covered Under No-Fault Insurance and Liability Claim Also Filed

(Rev. 1, 10-01-03)

A3-3489.6, B3-3340.7

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

50.3 - Action if a Liability Insurance Payment Has Been Made to the Provider or Physician Who Accepted Medicare Assignment

(Rev. 1, 10-01-03)

A3-3489.3.C.1, A3-3489.3.B.2, B3-3338.2.C, A3-3489.3.C.2(a), B3-3338.2.C.2(a)

If a FI or carrier discovers that Medicare paid primary benefits and payment was also made by a liability/no-fault insurer, it recovers the excess Medicare benefits in accordance with Chapter 3 of the Medicare Financial Management Manual. Section 120.2 of that manual states when a provider is liable for refunding the primary Medicare payments and §210 of the same manual states when a physician is liable for refunding the primary Medicare payments. The beneficiary is liable in all other situations.

Upon receipt of information that a liability/no-fault insurer paid a provider or physician for services previously paid for by Medicare, the FI or carrier determines the amount of Medicare secondary benefits payable on the claim. It recoups from the provider or physician any portion of the amount Medicare paid in excess of the amount of Medicare secondary benefits payable, subject to the overpayment recovery tolerance in The Medicare Financial Management Manual. Where no Medicare secondary benefits are payable, the FI or carrier recovers the amount of the Medicare payment. The provider or physician may keep the full liability/no-fault insurance payment but may not charge the

beneficiary any amount for the services and must return any deductible and coinsurance amounts paid by or on behalf of the beneficiary. (See Chapter 3, §30.2.1.3, where the provider did not file a proper claim.)

50.3.1 - Insurance Pays Service Benefits

(Rev. 1, 10-01-03)

A3-3489.3.E.1

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

According to 42 CFR 411.32(b), Medicare does not make a secondary payment if the provider or supplier is either obligated to accept, or voluntarily accepts, as full payment, a third party payment that is less than its charges.

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

(Rev. 1, 10-01-03)

A3-3489.4

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

Example: Beneficiary receives outpatient hospital services covered by no-fault insurance. Total charges are $200. The no-fault insurer is billed but makes no payment because of $1000 deductible in policy. Hospital bills Medicare for $200, following the procedures set forth in the Medicare Claims Processing Manual for billing for secondary Medicare benefits.

50.3.3 - Other Situations

(Rev. 1, 10-01-03)

A3-3489.3.E.2

In other cases, no-fault insurance may not pay the provider's or physician's charges because the beneficiary's total medical expenses exceed the dollar limit of the coverage, or because of some other coverage limit, deductible or coinsurance applicable to all policyholders. (See §50.3.2.)

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

If a FI or carrier has reason to question the correctness of the amount shown on the Medicare claim as having been paid by no-fault insurance, it confirms the amount with the insurer or beneficiary. A copy of a no-fault insurer's explanation of benefits is the best evidence. If the beneficiary does not submit this or other satisfactory evidence, the FI or carrier contacts the insurer by phone or letter to ascertain what payments have been made.

50.4 - Pre-Settlement Issues

(Rev. 1, 10-01-03)

A3-3418.6

50.4.1 - Existence of Overpayment

(Rev. 1, 10-01-03)

A3-3418.6.A

In MSP liability situations, before a settlement is reached between the beneficiary and the liable party or a court renders a judgment, there is no overpayment. Medicare's claim comes into existence by operation of law (42 U.S.C. 1395y(b)(2)(B)(i)) when payment for medical expenses that Medicare conditionally paid for has been made by a third party payer. Consequently, while Medicare may alert beneficiaries and their attorneys of Medicare's right to recover settlement proceeds in pre-settlement correspondence, no demand for recovery may be made until a settlement has been reached. However, the FI or carrier should send a letter to the beneficiary and attorney giving notice of possible recovery by Medicare. This letter also notifies the beneficiary and attorney that settlement proceeds should not be disbursed until Medicare's claim has been satisfied.

Note that the Coordination of Benefit contractor (COBC) is responsible for initiating MSP development and making MSP determinations. It is the responsibility of the carrier or FI to forward any information identified, in Pre-Pay MSP or other FI/carrier functions to the COBC for further development. Once the COBC has established the MSP record on CWF, the FI, and carrier will continue to be responsible for all activities related to identification and recovery of MSP-related debts.

50.4.2 - Pre-Settlement Negotiations, Compromises, and Discussions With Beneficiaries/Attorneys

(Rev. 1, 10-01-03)

A3-3418.6.E

The Federal Claims Collection Act grants Medicare the right to compromise its claims, or to suspend or terminate its recovery action. However, only CMS claims collection officers may take this action. Consequently, contractors may **not**, under any circumstances, enter into negotiations (either pre- or post-settlement) with beneficiaries, or their attorneys or representatives, to compromise Medicare's claim. If beneficiaries, or their attorneys or representatives, wish to discuss arrangements by which Medicare's claim might be reduced (outside of a formal request for Medicare to waive its claim), the contractor either

- Instructs the party to either make its request for compromise in writing, in which case the contractor forwards the request to its RO, or

- Refers the party directly to the appropriate RO staff person to handle the negotiation.

Contractors may advise an attorney and a beneficiary that Medicare's conditional payment must be considered during settlement negotiations with any third party. Federal law authorizes Medicare's priority right of recovery from liability settlement or judgment proceeds. (See Chapter 2, §40.)

50.4.3 - Pre-Settlement Communications

(Rev. 1, 10-01-03)

A3-3418.6.F

In many instances liability settlements are reached without resorting to litigation, or before trial commences. The FI or carrier initially determines if the beneficiary has had any contact with an insurance company with respect to filing a claim, or has engaged an attorney.

If the beneficiary is pursuing the claim, the FI or carrier advises the beneficiary of Medicare's interest in the matter. In addition, it advises the liability insurer directly that Medicare is a party to any settlement. If the beneficiary has engaged counsel, the FI or

carrier notifies both the beneficiary and the beneficiary's attorney. It retains copies for the file. If the beneficiary has not engaged counsel, there will probably be no procurement costs to subtract from Medicare's claim. As with beneficiaries and their attorneys, contractors are not permitted to conduct negotiations with liability insurers.

50.4.4 - Designations in Settlements

(Rev. 1, 10-01-03)

A3-3418.7

In general, Medicare policy requires recovering payments from liability awards or settlements, whether the settlement arises from a personal injury action or a survivor action, without regard to how the settlement agreement stipulates disbursement should be made. That includes situations in which the settlements do not expressly include damages for medical expenses. Since liability payments are usually based on the injured or deceased person's medical expenses, liability payments are considered to have been made "with respect to" medical services related to the injury even when the settlement does not expressly include an amount for medical expenses. To the extent that Medicare has paid for such services, the law obligates Medicare to seek recovery of its payments. The only situation in which Medicare recognizes allocations of liability payments to nonmedical losses is when payment is based on a court order on the merits of the case. If the court or other adjudicator of the merits specifically designate amounts that are for payment of pain and suffering or other amounts not related to medical services, Medicare will accept the Court's designation. Medicare does not seek recovery from portions of court awards that are designated as payment for losses other than medical services.

50.4.5 - Allegation of Preexisting Conditions

(Rev. 1, 10-01-03)

A3-3418.8.A

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

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

50.5 - Contractor Action if a Liability Claim Is Pending and Medicare Benefits Were Paid

(Rev. 1, 10-01-03)

1998 Budget and Performance Requirements (BPRs) B3-3340.5, B3-3340.6.A, A3-3489.3.B.2, B3-3340.6.A, A3-3418.6.B, A3-3418.6.C

If the contractor has specific information from a third party payer, beneficiary or attorney that an insurer had primary payment responsibility for a particular MSP situation, the contractor must search all applicable claims history, identify primary payments related to the MSP situation, coordinate with other contractors and recover the mistaken primary payments. There is no recovery dollar threshold on such recoveries.

The COBC develops all cases where there is no specific information that a MSP situation does exist but there is evidence that a MSP situation may exist to determine if a MSP situation does exist. If COBC development establishes that a MSP situation does exist and that there are primary payments to be recovered, the contractor must recover the identified mistaken primary payments. There is no development dollar threshold in such cases. There is no recovery dollar threshold on such recoveries.

If a Medicare claim has been paid and there is indication that a liability claim is pending, the contractor takes steps to assure that, in the event a liability insurance payment is made, any conditional primary Medicare payments are refunded for services related to the injury. If the services were **not** related to the accident, but **were** used to procure the settlement, the contractor recovers Medicare's payments. If the services were unrelated to the accident, but **not** used to procure the settlement amount, the Medicare payments are not recoverable. There should be no recovery of benefits paid for services rendered after the date of a liability insurance settlement. However, the entire amount of a settlement is subject to recovery, whether the liability payment is made at the time of settlement, or over a period of time agreed to by the parties in a structured settlement. The contractor notifies the beneficiary of Medicare's right to reimbursement. If the beneficiary has an attorney, the contractor also notifies the attorney and retains a copy of the notification in its files.

If disbursement has not yet been made to the beneficiary (e.g., beneficiary's attorney is holding monies in an escrow account, or a multiple party check is yet unsigned), the contractor attempts to recover Medicare's portion of the settlement **immediately** by sending a recovery letter (see Exhibit 2), as described in §50.2.1. It is very important that the file reflect that Medicare's right to reimbursement was asserted before the beneficiary had an opportunity to dispose of the funds. This information is especially important if a future request for waiver or compromise is submitted.

When a liability claim is pending, and Medicare made conditional payments for **services rendered before settlement**, and Medicare is billed **after** the settlement has been reached, the FI or carrier may recover Medicare's payment for the additional claims if Medicare did not have knowledge of them at the time of settlement.

If services are covered by liability insurance, the FI or carrier asks the insurer to pay Medicare an amount equal to Medicare's payments (up to the policy limits). If the insurer refuses to reimburse Medicare even though its contract covers the services, the FI or carrier informs the insurer of Medicare's Right to Recovery. If the insurer still refuses, the FI or carrier refers the case to the RO with full documentation.

50.5.1 - Contractor Coordination Responsibilities

(Rev. 1, 10-01-03)

A3-3489.3.B.4, B3-3338.2.B.4

Contractors must coordinate determinations regarding liability insurance coverage and/or recovery efforts with other contractors. When there is information that other contractors may have received claims for expenses related to the same injury, the lead contractor will pursue the overpayment in recovery actions. Other contractors provide information to the lead contractors as needed. See §50.5.1.1.

50.5.1.1 - Lead Contractor Responsibilities

(Rev. 1, 10-01-03)

A3-3418.22, A3-3418.22.A, A3-3418.23, A3-3418.22.B

The lead contractor is assigned by the COBC effective January 8, 2001. Once a lead contractor has been established, that contractor remains the "lead" contractor until the MSP issue is concluded.

The primary function of the lead contractor is coordination. It coordinates Medicare's activities with all parties, including the Medicare contractors, the beneficiary and the beneficiary's representative(s), the liability insurer, and the RO to insure that Medicare receives a settlement in accordance with CMS guidelines. To accomplish this, the lead contractor shall:

- Maintain a log of all charges related to the liability settlement claim which have been, or will be, paid by any Medicare contractor on behalf of the beneficiary. Compile the documentation necessary for the accurate and efficient identification and adjudication of the liability settlement claim;

- Keep the RO informed of all developments in the liability settlement process;

- Notify all involved contractors of its position as the lead contractor;

- Act as the contact point for any communications directed to Medicare from any party involved in the liability settlement situation and, where necessary, pass the information along to the appropriate Medicare contractor and RO;

- Act as the conduit for any communications from other Medicare contractors and/or the RO to the beneficiary, the beneficiary's representative or any other concerned party to the liability settlement situation;
- Refer all requests to negotiate/compromise Medicare's claim to the RO;
- Within the guidelines of these instructions, notify the involved Medicare contractors of any savings they may claim after the liability situation is resolved;
- Notify the RO of every MSP liability case handled; and
- Process requests for appeals of overpayment determinations.

A - Lead Contractor's Responsibility to Notify Beneficiary/Attorney and Liability Insurer of Medicare's Interest

When a claim is identified in which litigation either has been or may be undertaken by the beneficiary, the Medicare lead contractor should contact the beneficiary and the beneficiary's attorney and advise them of Medicare's interest **as soon as possible**, to protect Medicare's claim. The lead contractor must also notify the liability insurer, or alleged liable party, of Medicare's interest in the litigation. If a settlement has not been reached, it forwards Exhibit 10 and Exhibit 12, Standard Notice of Potential Medicare Recovery, to the beneficiary and attorney. Use of one of these letters, not a substitute, is mandatory. Once a settlement is reached, the lead contractor should forward Exhibit 2, Standard Recovery/Initial Determination Letter. It retains copies of all correspondence for the file.

If the alleged wrongdoer, or their representative or insurer, makes inquiries about the details of Medicare's claim, such as asking for an itemization of the services paid for, the contractor shall refer them to the beneficiary's attorney.

B - Documenting a MSP Liability Case By Lead Contractor (Exhibit 9)

A3-3418.27

When a MSP liability claim is identified, the lead contractor must compile a liability case file including:

- Name of lead contractor;
- Name(s) of other Medicare contractors involved;
- Beneficiary's name;
- HICN;
- Date of the accident and/or illness;
- Name of liability insurer;

- Address of liability insurer;
- Name and address of liability insurer's agent/attorney;
- Name and address of beneficiary's lawyer/ representative;
- Specific information about the benefits paid on behalf of the beneficiary, broken out by contractor;
- A brief narrative of the circumstances giving rise to the claim;
- Letter of initial determination, containing notification of waiver and appeal rights;
- Any written request from the beneficiary or the beneficiary's representative requesting that Medicare reduce its claim, with reason for request;
- Any stated amount being offered to the Medicare program by beneficiary/attorney, if provided (this is information which the RO is ultimately responsible for retaining, since RO conducts negotiation);
- A copy of the settlement agreement or documentation of the settlement reached;
- A statement of the procurement costs incurred;
- Where waiver is requested, documentation supporting claims of financial hardship or equity and good conscience; and
- Itemization of out-of-pocket expenses incurred as a result of the accident, including dates and places of medical services, the nature of those services and the identification of providers, physicians, and suppliers.

The case documentation checklist worksheet (Exhibit 9) should be used to ensure that the appropriate documentation is gathered.

MSP liability files are to be maintained on the premises of the lead contractor. The lead contractor should maintain the actual liability settlement case files in its records for a period of not less than 5 years from the date of initial correspondence with the beneficiary concerning Medicare's potential claim (i.e., the date of Exhibit 10 or Exhibit 12).

C - Exhibit 9 - MSP Liability Case Documentation Checklist

A3-3418.30

MSP LIABILITY CASE DOCUMENTATION CHECKLIST

- Management control document to RO _____;

- Written request from beneficiary/beneficiary's agent for a reduction in Medicare's recovery, with reason for request _____;
- A statement of the total settlement offered by the liability insurer, or ordered by the court _____;
- Amount the beneficiary/attorney believes Medicare should accept in satisfaction of its claim _____;
- Accounting of procurement costs incurred in the claim settlement _____;
- Dates and types of medical services and names and addresses of providers, physicians, and suppliers _____;
- Accounting of beneficiary's out-of-pocket expenses _____;
- Amount of benefits paid on behalf of the beneficiary, broken out by contractor _____;
- Documentation of nature of accident, including dates _____.

50.5.1.2 - Non-Lead Contractor Responsibilities

(Rev. 1, 10-01-03)

A3-3418.24

Contractors involved in an MSP liability case but not as the lead contractor, have the following responsibilities:

- Upon identifying a liability situation in which it is obvious another contractor will be the lead, confirm that the contractor is aware that a liability settlement situation exists and that it apparently will be the responsible lead contractor;
- Notify the lead contractor of all benefits paid on behalf of the beneficiary involved in the liability situation. This should be done no matter what the dollar amount of the payments total; and
- Forward to the lead contractor all inquiries received from the beneficiary, the beneficiary's agent(s) or other parties involved in the liability situation for a response. When necessary, provide the lead contractor with the information required for it to make an appropriate response.

50.5.2 - Contractor Settlement Communications/Correspondence

(Rev. 1, 10-01-03)

A3-3418.9

The contractor notifies the beneficiary when writing to the beneficiary's attorney. Also, when Medicare conditional payments are requested from an insurance company paying a settlement amount owed to the beneficiary, it notifies the beneficiary and the beneficiary's attorney by sending them a copy of the letter sent to the insurance company.

50.5.2.1 - Issuance of Recovery Letter

(Rev. 1, 10-01-03)

A3-3418.9A

The contractor initiates recovery from the beneficiary by sending the letter shown in Exhibit 2 - Standard Recovery/Initial Determination Letter to Beneficiary. Use of this letter, not a substitute, is mandatory. The letter contains all pertinent information:

- Medicare's right to recover;
- The amount of the mistaken payment;
- Notice of the beneficiary's right to request a waiver and/or appeal;
- Notice of Medicare's right to collect interest on the debt;
- Notice of the beneficiary's right to request free legal services; and,
- How and when to repay Medicare.

The contractor keeps a dated copy of all correspondence and exhibits forwarded to the beneficiary and the attorney.

Exhibit 2 - Standard Recovery/Initial Determination Letter to Beneficiary

(Rev. 1, 10-01-03)

Dear Mr./Ms. _____

This letter follows our (date of initial letter to beneficiary/attorney) letter in which we advised you that you would have to pay Medicare back if you received money from a third party due to your (date of accident) accident which caused medical expenses for which Medicare conditionally paid. We have now been advised that you have received such proceeds. This means that Medicare now has a claim against these proceeds in the amount of $_____, which represents Medicare's claim after reduction for procurement costs, in accordance with 42 CFR 411.37.

The Medicare Secondary payer provisions of the statute, 42 CFR 1395y(b)(2), preclude Medicare from paying for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made promptly under an automobile or liability insurance policy or plan (including a self-insured plan) or under no-fault insurance." However, Medicare will pay for a beneficiary's covered medical expenses when the third party payer does not pay promptly, conditioned on reimbursement to Medicare from proceeds received from a third party liability settlement, award, judgment or recovery. In your case, Medicare made a conditional payment in the amount of $_____. A list of the claims used to arrive at this total is enclosed.

Medicare's regulations require that you pay Medicare back within 60 days of your receipt of settlement or insurance proceeds. It is our understanding that 60 days have passed since you received the insurance proceeds. Therefore, please send a check or money order in the amount of $_____, made payable to (name of contractor) in the enclosed envelope.

Exercising common law authority and consistent with the Federal Claims Collection Act and 45 CFR 30.13, we will assess interest if this debt is not repaid in full within 60 days of the date of this letter. Additionally, 45 CFR 30.14(a) provides that a debtor may either pay the debt, or be liable for interest on the un-collectable debt while a waiver determination, appeal, or a formal or informal review of the debt is pending. Therefore, assessment of interest may not be suspended solely because further review may be requested. Interest will be assessed at the rate of _____. It should be noted, however, that you may repay the debt to avoid accruing charges, but retain your right to dispute, appeal, or request waiver of the debt. If you succeed in your appeal or waiver request, Medicare will refund your money.

If you do not repay this overpayment, Medicare has the authority to refer it to the Social Security Administration or Railroad Retirement Board for further recovery action, which

may result in the overpayment being deducted from any monthly Social Security or Railroad Retirement benefits to which you may be entitled.

If you are unable to refund this amount in one payment, you may ask us to consider whether to allow you to pay in regular installments.

The law requires that you must repay an overpayment to Medicare unless both of the following conditions are met:

1. This overpayment was not your fault, because the information you gave us with your claim was correct and complete as far as you knew, and, when the Medicare payment was made, you thought that it was the right payment for your claim,

AND

2. Paying back this money would cause financial hardship **OR** would be unfair for some other reason.

If you believe that **BOTH** of the conditions above apply in your case, please let us know, giving a brief statement of your reasons. You will be sent a form asking for information about your income, assets, and expenses, and requesting that you explain why you believe you are entitled to waiver of the overpayment. We will notify you if recovery of this overpayment can be waived.

You may appeal our decision if: you disagree that you received an overpayment; or you disagree with the amount of overpayment; or you disagree with our decision not to waive your repayment of the overpayment.

For Part A services, you must appeal within 60 days from the date of your receipt of this determination. For Part B services, you must file an appeal within 6 months of the date of this determination. However, we recommend that you file appeals of Part A and Part B claims within 60 days of receiving this notice so that both appeals may be resolved efficiently. Appeals should be requested in writing to _____.

If you decide to appeal this determination further, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will provide free legal services if you qualify.

If you have any questions about this letter, you may contact either this office or any Social Security office.

Sincerely,

ABC Contractor

Attachments: List of claims
Pre-addressed Envelope

50.5.2.2 - Exhibit 1 - Calculating Medicare's Share of Procurement Costs

(Rev. 1, 10-01-03)

A3-3418.8.B, A3-3489.3.D, B3-3338.2, B3-3338.3, B3-3340.7, B3-3328.13, 42 CFR 411.37

The Medicare recovery is reduced when procurement costs are incurred to obtain a third party payment as a result of a judgment or settlement.

If the reimbursement is not made, CMS:

- May bring legal action against any entity required to make or responsible for payment and collect double damages;
- May take legal action to recover its benefits from any entity that has received primary payment from the GHP for items and services furnished to an individual for whom Medicare is the secondary payer;
- May join or intervene in any legal action against the GHP related to the events that gave rise to the need for the items or services; and
- Is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from a GHP.

Title 42 CFR 411.37(c) stipulates that Medicare will recognize a proportionate share of the necessary procurement costs incurred in obtaining the settlement. Procurement costs are those costs incurred in obtaining a judgment or settlement (e.g. court costs, attorney fees). If a liability insurer pays a beneficiary, the contractor recovers Medicare's payment from the beneficiary, reduced by a proportionate share of the beneficiary's procurement costs, if any.

If, under the Prospective Payment System (PPS), Medicare pays a provider more than its charges, the contractor does not recover more than the charges from a beneficiary's liability settlement. (Under Medicare regulations, a beneficiary who must refund a Medicare payment made to a provider is liable only to the extent that the beneficiary benefited from the payment. Since the beneficiary would have had to pay only the provider's charges in the absence of Medicare, the beneficiary is not liable for refunding more than the charges.) The provider is not required to refund the excess of the Medicare payment rate over the provider's charges.

To determine procurement costs, the contractor asks the attorney to furnish (in writing) the costs, including attorney fees, incurred by the individual to procure the settlement/judgment. If these costs appear in excess of the prevailing costs in the area for similar claims, it asks for an itemized statement of costs or copy of a contingency agreement, if applicable, or other appropriate documentation. If the procurement costs are

documented, the contractor allows them. Should a contractor need advice on what constitutes procurement costs in a particular case, it consults contractor legal counsel or the RO. (Also, see definition of procurement costs in §50.5.2.2.)

It uses the following formula to determine the amount of Medicare's claim when there are procurement costs:

Step 1 - Determine the ratio of the procurement costs to the total amount of the liability insurance payment, judgment or settlement payment;

Step 2 - Apply this ratio to the Medicare payment. The product is the Medicare share of procurement costs; and

Step 3 - Subtract the Medicare share of procurement costs determined in step 2 from the lesser of the total conditional payments or the providers' charges. The remainder is the amount to be refunded to the Medicare program. (This amount may be rounded to the nearest dollar.)

NOTE: If Medicare payments equal or exceed the amount of the liability insurance payment, judgment or settlement amount, the contractor recovers the entire liability insurance payment, total judgment or settlement payment up to the providers' charges, minus the **total** procurement costs.

A - CMS Incurs Procurement Costs

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

- The Medicare payment; and
- The total judgment or settlement amount, minus the party's total procurement cost.

B - Medicare Liability Settlement Claim Reimbursement Summary (Exhibit 1)

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

MEDICARE LIABILITY SETTLEMENT CLAIM REIMBURSEMENT SUMMARY

Beneficiary: _____ HICN: _____

1. Amount of settlement $_____

2. Medicare payments

(contractor) $_____

(contractor) $_____

(contractor) $_____

3. Total Medicare payments $_____

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

5. Other procurement costs incurred (per attorney) $_____

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

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

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

9. Total Providers' Charges $_____

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

PLEASE PREPARE THE CHECK EXACTLY AS SPECIFIED BELOW

NAME OF CONTRACTOR $ AMOUNT

If any questions arise, please call: (Name and telephone number of appropriate contractor staff person.)

50.5.2.3 - Collecting Interest on the Liability Claim

(Rev. 1, 10-01-03)

A3-3418.28

A - Medicare's Right to Collect Interest

Medicare assesses interest on MSP debts by exercising common law authority that is consistent with the Federal Claims Collection Act (FCCA) and implementing regulations. (See 45 CFR 30.13.) CMS requires that a beneficiary or other entity repay CMS within 60 days of receiving insurance proceeds from a third party payer. (See 42 CFR 411.24(h).) If CMS does not receive a full refund, or adequate proof that no overpayment exists, within 60 days of notifying the beneficiary of CMS' demand, the contractor begins assessing interest as of the date of the mailing of the demand letter.

If the beneficiary requests a waiver or an appeal of the overpayment determination, the beneficiary will be held responsible for the interest on the debt if the agency prevails and a refund is later collected. (See 45 CFR 30.14(a).)

In cases of joint and several liability among two or more debtors, Federal regulations at 42 CFR 401.623 prohibit CMS from allocating the burden of claims payment among the debtors. The CMS will proceed with collection action against one debtor even if other liable debtors have not paid their proportionate shares. Therefore, if one of the joint debtors owes Medicare, contractors may assess interest on the debt.

Regulations at 45 CFR 30.13(a) provide for assessing the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate of interest on overpayments and underpayments.

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

B - How to Calculate Interest

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

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

- Interest cannot be assessed on deductible and coinsurance amounts; and

- Even though contractors will be requesting repayment of the **gross** Medicare payment, interest can be charged only on the **actual** Medicare payment or the

provider’s charges, if less. Therefore, these amounts must be separated to determine the amount on which interest will be charged.

50.5.2.4 - Release Agreement Form

(Rev. 1, 10-01-03)

A3-3418.10

Once the beneficiary agrees to pay Medicare the amount that Medicare will accept in satisfaction of its claim (full amount, or amount remaining after an appeal or waiver determination), it is the lead contractor’s responsibility to obtain the appropriate signatures on a general release after the settlement. A general release as applied to Medicare is an agreement which waives Medicare’s right to change the amount of money it is accepting in satisfaction of its claim, and precludes Medicare from later asserting a claim against any outstanding amount not included in the satisfaction, e.g., monies remaining in the case of a partial waiver (See Exhibit 7 - Release Agreement Form.) The beneficiary agrees to the amount in question and is released from further obligation to repay. **Medicare has no obligation to pay for any services related to the injury furnished before the date of the settlement that were not brought to Medicare’s attention in writing before the settlement was reached.**

This form should be signed either a) when the beneficiary agrees to remit in full, or b) after final disposition of a waiver/appeal request. The RO is responsible for securing a release for claims compromised under FCCA.

50.5.2.4.1 - Release Agreement Form (Exhibit 7)

(Rev. 1, 10-01-03)

A3-3418.30

(Name, title and name of contractor) , as a Medicare intermediary or carrier authorized to make the following statements and assurances on behalf of Medicare. The undersigned beneficiary, (name of beneficiary) , is the claimant in an action resulting from an accident which occurred on or about (Date of accident) .

Medicare has been advised of a (proposed) settlement in the above action in the amount of $_____. In accordance with Federal Regulations at 42 CFR 411.37, the amount of funds to be recovered by Medicare pursuant to §1862(b)(2) of the Social Security Act (42 U.S.C. 1395y(b)(2)) has been determined to be $_____. Medicare and the undersigned beneficiary have agreed that Medicare will accept $_____ in full satisfaction of its claim.

(Name, title and name of contractor) , on behalf of Medicare, does forever discharge (name of beneficiary) , his/her agents, successors, executors, administrators and assigns from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses, and compensation whatsoever, which Medicare now has or which may hereafter accrue related to the incident above.

(Name of beneficiary) does forever discharge Medicare, its agents, successors and assigns from any liability for payment for claims related to the incident above and does specifically waive any and all rights to appeal, waiver or [further] compromise of Medicare's interest in claims for items or services related to the incident above.

Medicare has no liability or obligation to pay for any services related to the injury that were furnished before the date of the settlement and that the beneficiary did not specifically identify to Medicare in writing before the release was executed.

Each of the undersigned has read the foregoing release and fully understands it and its terms.

Date: _____

_____ _____

(Witness) (Name & Title)

_____ Medicare

(Witness)

Date: _____

_____ _____

(Witness) (Name of Beneficiary)

_____ Beneficiary/Claimant

(Witness)

50.5.3 - Recovery From Liability Insurers

(Rev. 1, 10-01-03)

A3-3418.21, B3-3340.6.B

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

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

Contractors will always try to recover any Medicare payments directly from the insurer before the proceeds of an award or settlement are disbursed.

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

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

50.5.4 - Recovery From the Beneficiary

(Rev. 1, 10-01-03)

A3-3489.3C.2(b), B3-3338.2C.2(b), B3 3340.6.C

If a liability or no-fault insurance payment was made to the beneficiary, the contractor recovers the amount of primary benefits Medicare paid in excess of any secondary Medicare benefits payable. Regulations permit reducing that amount to allow for the beneficiary's costs in procuring liability or no-fault benefits only in cases where the claim was in dispute (i.e., the no-fault insurer at first would not pay and only after an attorney intervened was payment made). If the beneficiary claims procurement costs to obtain liability insurance payments, the contractor secures a breakdown between the two.

If a beneficiary is paid by a liability insurer, contractors recover from the beneficiary, Medicare's primary payment, reduced by a proportionate share of the individual's

procurement costs, if any. **The contractor uses the formula in §50.5.2.2 to determine the amount of Medicare's claim when there are procurement costs.**

If a negligent party who carries liability insurance decides to pay a liability claim with their own funds rather than submit the claim to the liability insurer, Medicare recovers its benefits from such a payment because it is deemed to be a liability insurance payment. Medicare benefits are also subject to recovery from payments by a self-insured party. (See Chapter 1, §20.)

50.5.4.1 - Recovery From Estate of Deceased Beneficiary

(Rev. 1, 10-01-03)

A3-3418.20

A beneficiary's death does not materially change Medicare's interest in recovering its payments made on behalf of the beneficiary while alive. Upon death, the estate of the beneficiary comes into existence by operation of law. An executor or administrator whose sole purpose is to conclude all business and financial matters that still remained at death manages it. Medicare's interest in the outcome of a third party liability claim is one of these matters. Therefore, Medicare's claim is properly asserted against the estate.

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

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

- If a settlement has been reached, a letter (Exhibit 2, "Standard Recovery/Initial Determination Letter") containing an initial determination should have been sent. The rights to request waiver and/or appeal that are expressed in this letter apply equally to the estate, **if there is a surviving spouse or dependent that is entitled under Title II or XVIII**. Where neither of these parties exists, waiver under §1870(c) may not be granted. (However, relief may still be available under §1862(b) or FCCA.); and

- The contractor will ensure that the executor or administrator understands Medicare's priority right to satisfaction of its claim by re-emphasizing that fact in conversations. The contractor employee should also attempt to end each conversation with a specific action that the administrator should take within a specific time period. If this time limit passes and the action has not occurred, the

contractor contacts the administrator again. The most important thing is the prevention of settlement of the estate prior to satisfaction of Medicare's claim.

50.5.4.1.1 - Wrongful Death Statutes

(Rev. 1, 10-01-03)

A3-3418.20.B

Wrongful death statutes are State laws that permit a person's survivors to assert the claims and rights that the decedent had at the time of death. These laws may include recovering for the deceased's medical expenses. When a liability insurance payment is made pursuant to a wrongful death action, Medicare may recover from the payment only if the State statute permits recovery of these medical expenses. Generally, if the statute permits recovery of the deceased's medical expenses, Medicare may pursue its payments, even if the action fails to explicitly request damages to cover medical expenses. Thus, in that event, even if the **entire** cause of action sets forth only the relatives and/or heirs damages and losses, then Medicare may still recover its payments.

When State law permits a full recovery of medical damages but limits the amount of the recovery which is payable to creditors as a result of past medical expenses, Medicare may recover against the entire tort recovery, up to the full amount of past Medicare payments. However, when State law limits the amount of the past medical expenses that may be recovered from the tort feasor and responsible insurer, Medicare may recover only up to that amount (or the amount of the settlement, if the settlement is less than or equal to Medicare's claim.)

NOTE: If a wrongful death statute does not permit recovering medical damages, Medicare has no claim to the wrongful death payments.

50.5.4.2 - Beneficiary Fails to Respond to Requests for Payment

(Rev. 1, 10-01-03)

A3-3418.19

These instructions for MSP liability cases supersede instructions found in The Medicare Financial Management Manual, Chapter 3, regarding offset of uncollectible overpayments.

The contractor sends the entire MSP liability overpayment case to the RO when efforts to collect the MSP overpayment are unsuccessful e.g. after it has made two written requests. The RO follows instruction in §60, "Debt Collection Improvement Act of 1996 (DCIA)."

50.5.4.3 - Beneficiary Refunds to Medicare

(Rev. 1, 10-01-03)

A3-3418.10

A - Installment Payments

If the beneficiary wishes to refund in installments, the contractor follows the instructions found in the Medicare Financial Management Manual, Chapter 3.

B - Multiple-Party Settlement Checks

If a liability insurer sends the Medicare contractor a check intended to repay Medicare benefits paid on the beneficiary's behalf, but which is made out jointly to the contractor (or Medicare) and to other parties, such as the beneficiary or representing attorney, the contractor sends a note to the other payee(s) asking them to endorse the check and return it to the Medicare contractor. It does not endorse the check before endorsement of the other payee(s) is received. It tells the other payees that Medicare will deposit the check in an interest bearing account.

Non-lead contractors must refer the check to the lead contractor. If the lead contractor determines the check amount is **not** for the full amount of Medicare's claim, or the other payee(s) refuses to endorse the check and return it to Medicare, the contractor refers the check to the RO.

50.5.4.4 - Beneficiary Requests Reduction or Waiver of Medicare's Claim

(Rev. 1, 10-01-03)

A3-3418.11

Beneficiaries must be informed that they have the right to request waiver of adjustment or recovery of the overpayment and/or to appeal the existence of an overpayment, the amount of the mistaken payment, or the denial of waiver of conditional payment. This notice (right to request appeal and/or waiver of recovery) must be given at the time repayment is requested from the beneficiary. (See Exhibit 2, "Mandatory Recovery/Initial Determination Letter.")

50.5.4.4.1 - Beneficiary Must Submit Waiver Request

(Rev. 1, 10-01-03)

A3-3418.12.A

The beneficiary must request a waiver in writing. Once the waiver request has been received, the contractor sends the beneficiary and attorney the Standard Letter

Acknowledging Waiver Request (Exhibit 11). Use of this letter, not a substitute, is mandatory. The letter provides the beneficiary with a Form SSA 632-BK - Request for Waiver of Overpayment - form, and acknowledges that the waiver request has been received. It also informs the beneficiary that a determination will be sent once it is reached.

The Social Security Administration Request for Waiver of Overpayment Recovery (Form SSA-632-BK) can be viewed and downloaded at the following internet address: http://www.ssa.gov/online/ssa-632.pdf

50.5.4.4.2 - Standard Letter Acknowledging Waiver Request (Exhibit 11)

(Rev. 1, 10-01-03)

A3-3418.30

Exhibit 11 - Standard Letter Acknowledging Waiver Request

Dear Beneficiary/Attorney:

This letter acknowledges your/your client's request for waiver of recovery of a Medicare overpayment resulting from the liability settlement you received.

In order to help us evaluate your/your client's request under §1870(c) of the Social Security Act (42 U.S.C. 1395gg(c)), please complete and return the enclosed Form SSA-632-BK, Request for Waiver of Overpayment Recovery. Also, please provide an explanation of your reasons for requesting a waiver. You/Your client are/is responsible for providing complete documentation substantiating your request, including documentation of procurement costs and out-of-pocket expenses incurred, if any. If you claim that repaying Medicare will create a financial hardship you should provide evidence to demonstrate such hardship.

If you/your client are/is able to refund a portion of the overpayment, please let us know how much you are able to repay, with an explanation of why you are unable to refund the entire amount. Please refer to our (**date of recovery/initial determination**) letter, in which we explained the criteria that control our determination of whether waiver may be granted.

Any person who makes or causes to be made a false statement of representation of material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law and/or State law. In submitting the enclosed SSA-632-BK form and any material documentation, you are deemed to affirm that all information you have given is true.

Any questions you have may be directed to _____at (area code) XXX-XXXX.

Sincerely,

ABC Contractor

Enclosure: SSA-632-BK Form

50.5.4.4. 3 - Timely Processing of Waiver Determinations

(Rev. 1, 10-01-03)

A3-3418.18

Waiver determinations should be completed within 120 days from the date a waiver request is received (and date stamped) in the contractor mailroom.

50.6 - Contractor Criteria for Waiver Determinations

(Rev. 1, 10-01-03)

A3-3418.11

There are three statutory authorities under which Medicare may accept less than the full amount of its claim:

- §1870(c) of the Social Security Act;
- §1862(b) of the Social Security Act; and
- The Federal Claims Collection Act (FCCA).

Each statute contains different criteria upon which decisions to compromise, waive, suspend, or terminate Medicare's claim may be made. Likewise, the exercise of each authority is limited to specific entities.

Medicare contractors have authority to consider beneficiary requests for waivers under §1870(c) of the Act. Authority to waive Medicare claims under §1862(b) and to compromise claims, or to suspend or terminate recovery action under FCCA, is reserved exclusively to CMS CO and/or RO staffs.

However, FCCA and §1862(b) provisions are described at §50.7.2 and 50.7.1, to assist the contractor in identifying the types of inquiries/circumstances in which the RO must be involved, and to assist the contractor in understanding the terms which apply to each authority. Distinctions between waiver, partial waiver and compromise are important and are found at Chapter 1, §20, where each term is defined.

50.6.1 - Waiver Determination Under §1870(c): Step 1 Collect All Pertinent Data

(Rev. 1, 10-01-03)

A3-3418.12

The contractor sends the beneficiary a Form SSA-632-BK, (obtained from the following Social Security Administration (SSA) internet address:

http://www.ssa.gov/online/ssa-632.pdf), with appropriate supporting documentation. Enclose this form with Exhibit 11. The beneficiary does **not** need to complete Section 1 - "Without Fault" - of the SSA-632-BK, since at this time, beneficiaries are deemed to be without fault. At the time the Form SSA-632-BK - Request for Waiver of Overpayment is submitted, the beneficiary must also provide supporting documentation for:

- Procurement costs;
- Accident-related out-of-pocket medical expenses incurred; and
- Expenses and income information that demonstrate financial hardship (if the beneficiary is alleging financial hardship).

50.6.2 - Waiver Determination Under §1870(c): Step 2 - Apply Waiver Criteria

(Rev. 1, 10-01-03)

A3-3418.13

The contractor determines whether the beneficiary meets the criteria for waiver determinations under §1870(c) of the Act (42 CFR 405.355 and 20 CFR 404.506-512). Section 1870(c) of the Act provides that CMS may waive all or part of its recovery in any case where an overpayment under title XVIII has been made with respect to a beneficiary:

a. Who is without fault, **and**

b. When adjustment or recovery would either:

   1. Defeat the purpose of title II or title XVIII of the Act, **or**

   2. Be against equity and good conscience.

50.6.3 - Factors to Consider in Determining if a Full or Partial Waiver is Warranted: Step 3

(Rev. 1, 10-01-03)

A3-3418.14

50.6.3.1 - Allowing Out-of-Pocket Expenses in Waiver Determinations

(Rev. 1, 10-01-03)

Out-of-pocket expenses should be considered in determining if a full or partial waiver is warranted. Out-of-pocket expenses are defined as those medical expenses for which a beneficiary has paid or is responsible to pay incurred for injuries directly related to the

accident and that are **not** covered by insurance (including Medicare), settlement proceeds, or court-awarded damages.

A waiver of all or part of the out-of-pocket expenses may be granted only if the following criteria have been met. In determining the amount of out-of-pocket expenses to be waived, each case must be considered on its own merits.

A - Beneficiary Documents Out-of-Pocket Expenses.

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

- Notarized/sworn statement which attests to the validity of the expenses;
- Canceled checks (which correlate to bills received);
- Receipts for services furnished; and
- Copies of bills demonstrating services furnished.

B - Beneficiary's Assets Insufficient to Repay Medicare

The contractor must not automatically assume that out-of-pockets should be waived. Using assets reported on the Form SSA-632-BK - Request for Waiver of Overpayment, it determines whether the beneficiary was actually able to afford the out-of-pocket expenses.

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

- Housing renovation - beneficiary's residence had to be modified to accommodate beneficiary because of an accident-related injury e.g., addition of a ramp to accommodate a wheel chair;
- Adult diapers - where the accident caused loss of bladder use;
- Prescriptions for medication needed as a result of an accident-related injury;
- Private duty nursing or custodial care not covered by Medicare;
- Coinsurance and deductibles not covered by supplemental insurance; and
- Expenses for dental work caused by the accident.
- Contractors should not consider:
- Funeral expenses; or
- Travel for relatives (even if accident-related).

50.6.3.2 - Other factual data in Determining if a Full or Partial Waiver is Warranted

(Rev. 1, 10-01-03)

A3-3418.14.B

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

- Age of beneficiary;
- Beneficiary's assets;
- Beneficiary's monthly income and expenses; and
- Physical or mental impairments.

50.6.4 - Determining Beneficiary Fault

(Rev. 1, 10-01-03)

A3-3418.13.A

Based on the CMS application of the SSA definition of fault, found at 20 CFR 404.507, CMS deems that beneficiaries are without fault.

50.6.5 - When Recovery Would Defeat the Purpose of Title II or Title XVIII

(Rev. 1, 10-01-03)

A3-3418.13.B

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

- Fixed living expenses, such as food and clothing, rent, mortgage payments, utilities, maintenance, insurance (e.g., life, accident, and health insurance, including premiums for supplementary medical insurance benefits under title XVIII), taxes, installment payments, etc.;
- Medical, hospitalization, and other similar expenses not covered by Medicare or any other insurer;

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

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

50.6.5.1 - Examples of Financial Hardship

(Rev. 1, 10-01-03)

A3-3418.13.B

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

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

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

- An unforeseen severe financial circumstance existing at the time Medicare's claim comes into existence can also constitute financial hardship. If a beneficiary has become legally financially responsible for an unforeseen obligation, has acted in good faith at all times with respect to Medicare's claim, **and** has no other financial resources to meet this legal obligation, waiver may be warranted. For example, waiver would be appropriate if a beneficiary's grandchildren became the legal responsibility under a will or trust that came into existence upon the sudden death of the beneficiary's child (the parent of the grandchildren).

NOTE: The contractor should assume in **all** waiver examples that the attorney has already taken attorney fees from the settlement proceeds, and the beneficiary does not have to pay the attorney from the settlement figure shown. Also, it should assume that the settlement proceeds are being retained in an escrow account by the attorney and have not been spent. In cases where the funds have already been spent by the beneficiary, the

beneficiary's monthly financial situation and the likelihood of recouping the monies will be significant factors.

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

A - Example 1

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

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

Action: Grant full waiver.

B - Example 2

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

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

Action: Grant a partial waiver of the amount owed.

50.6.5.2 - Recovery Would Be Against Equity and Good Conscience

(Rev. 1, 10-01-03)

A3-3418.13.C

"Equity and good conscience" is applied to Medicare overpayment recoveries when required, based on the totality of the circumstances in a particular case. In applying the standard of "equity and good conscience," factors to consider include, but are not limited to, the following:

- The degree to which the beneficiary contributed to causing the overpayment;
- The degree to which Medicare and/or its contractors contributed to causing the overpayment;
- The degree to which recovery or adjustment would cause undue hardship for the beneficiary;
- Whether the beneficiary would be unjustly enriched by a waiver or adjustment of recovery; and
- Whether the beneficiary changed their position to their material detriment as a result of receiving the overpayment or as a result of relying on erroneous information supplied to the beneficiary by Medicare.

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

- The beneficiary made a personal financial decision, based on written information from an official CMS source, that the overpayment was correct, and recovery would change the beneficiary's position for the worse; or
- Recovery of the full overpayment amount is contraindicated by especially compelling mitigating facts and circumstances of the beneficiary's case.

Below are examples where it would be against equity and good conscience for Medicare to recover its total payments.

A - Example 1

Facts: The beneficiary sustained injuries in an automobile accident. Medicare made conditional payments in the amount of $7,500 on the beneficiary's behalf. The beneficiary later filed suit for the injuries and damages suffered as a result of the accident and received a $5,000 settlement. There were no attorneys fees, thus Medicare's claim is $5,000. The beneficiary requested a waiver of the overpayment. The beneficiary

submitted documentation demonstrating that the money received was used to replace the automobile that was totaled in the accident.

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

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

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

B - Example 2

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

Analysis: Since the beneficiary is now unable to work, the ability to absorb the out-of-pocket medical expenses has greatly diminished. Since a valuable right, i.e., the right to be gainfully employed, is a change in one's position, it would be against equity and good conscience for Medicare to recoup its entire recovery. In accordance with §50.7.1, since Medicare stands to recover 100 percent of the settlement amount, it may waive 100 percent of the out-of-pocket costs. It would not be feasible to pursue recovery of the remaining $500.

Action: Grant full waiver.

50.6.5.3 - When the Beneficiary Fails to Meet Either Waiver Criterion Under §1870(c)

(Rev. 1, 10-01-03)

A3-3418.13.D

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

A - Example 1

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

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

Action: Waiver request is denied.

B - Example 2

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

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

Action: Waiver request is denied**.**

50.6.5.4 - Waiver Indicators

(Rev. 1, 10-01-03)

A3-3418.13.E

Waiver decisions are rarely, if ever, straightforward and uncomplicated. However, there are a few indicators to consider. The following are just examples and are in no way conclusive determinations of whether waiver should or should not be granted. Every waiver decision must be made on the merits of the facts in the case in question.

A - Indicators that support granting full or partial waiver include:

- Medicare's recovery exceeds settlement amount (this is often true with small settlements);
- Beneficiary sustained the type of permanent injuries, or has documented lost wages, or became unemployed;
- There are noncovered out-of-pocket accident related expenses; and
- Beneficiary's living expenses are equal to or higher than income.

B - Indicators that support denying waiver (where financial hardship is alleged) include:

- Medicare asserted its right to recover before the settlement proceeds were disbursed (and there is correspondence in the case file which provides documentation of Medicare's timely assertion);
- Beneficiary receives a large settlement;
- Beneficiary's income exceeds ordinary living expenses;
- After repaying Medicare and allowing for out-of-pocket medical costs (if such allowances are necessary), the beneficiary will be left with a substantial amount of the settlement proceeds; and
- Beneficiary has substantial assets.

In order to make proper use of these indicators it is imperative to carefully collect information from the beneficiary. Consistent use of the Form SSA-632-BK form is essential.

50.6.5.4.1 - Letter for Granting a Full Waiver (Exhibit 4)

(Rev. 1, 10-01-03)

A3-3418.12.D

Exhibit 4 - Letter for Granting a Full Waiver

If granting a full waiver, the contractor sends the Standard Letter Granting Full Waiver shown below. Use of this letter is mandatory. Substitutes may **not** be used. The contractor retains copies for the file.

STANDARD LETTER GRANTING FULL WAIVER

Re: Name of Beneficiary HIC #

Dear Beneficiary/Attorney:

We have reviewed your/your client's request to waive the amount owed to Medicare and have determined that you qualify for a full waiver.

This qualification is based upon the requirements of §1870(c) of the Act (42 U.S.C. 1395gg(c)), and the regulations found at 42 CFR 405.355-405.356, and 20 CFR 404.506 et seq. These regulations provide that a beneficiary's overpayment may be waived if the beneficiary is without fault in causing the overpayment, **and** if recovery would either defeat the purpose of the Social Security Act or Medicare program, **or** if recovery would be against equity and good conscience. Because you/your client meet(s) these qualifications, we are granting a full waiver.

You have shown [include explanation of the reasons the qualifications for waiver have been met].

The Medicare conditional payment in this case was $_____. You (Your client) received a settlement of $_____. The procurement costs in this case, including attorney fees were $_____. After allowing $_____ as Medicare's share of procurement costs, the amount which would have been due to Medicare is $_____.

However, for the reasons stated above, Medicare is waiving recovery of this amount.

Please sign the enclosed release agreement form within 10 days and return it to this office. Should you/your client have any questions concerning this letter, please contact _____ on _____.

Medicare Contractor

Enclosure(s): Release Agreement

50.6.5.4.2 - Letter for Granting A Partial Waiver (Exhibit 5)

(Rev. 1, 10-01-03)

A3-3418.12.D

Exhibit 5 - Letter for Granting a Partial Waiver

If granting a partial waiver, the contractor sends the Standard Letter Granting Partial Waiver shown below. Use of this letter is mandatory. Substitutes may **not** be used. The contractor retains copies for the file.

STANDARD LETTER GRANTING PARTIAL WAIVER

Re: Name of Beneficiary HIC #

Dear Beneficiary/Attorney:

We have completed our review of your/your client's request to waive monies owed to Medicare. It is our decision to partially waive Medicare's claim.

The authority to waive recovery of a Medicare overpayment is found in §1870(c) of the Social Security Act (42 U.S.C. 1395gg(c)). Under this provision, and the regulations found at 42 CFR 405.355-405.356, if a beneficiary is without fault in causing the overpayment **and** recovery would either defeat the purpose of the Social Security Act or Medicare program, **or** would be against equity and good conscience, recovery may be waived. In making these decisions, Medicare applies the rules found in Social Security regulations at 20 CFR 404.506-404.509, 404.510a, and 404.512.

In applying these rules, we found the following:

The contractor enters reasons for partial deductions:

Example

This partial waiver is granted because it would be against equity and good conscience to recover the full amount of the claim. The settlement proceeds in this particular case were very small considering the injuries suffered; therefore, it would be against equity and good conscience for Medicare to take the entire settlement.

OR

Example

You have documented financial hardship and we have determined that it would defeat the purpose of the Social Security Act to request repayment of the entire claim. Therefore, we are granting a partial waiver in the amount of _____, and _____must be repaid to Medicare.

Medicare's conditional payment in this case was _____. You (your client) received a settlement of $_____. The procurement costs in this case, including attorney fees were $_____. After allowing $_____ as Medicare's share of procurement costs per 42 CFR 411.37, Medicare's net conditional claim was $_____.

However, in accordance with this determination, we are granting a partial waiver in the amount of _____. The total amount now due to Medicare is $(principle and interest).

In accordance with this determination, a check in the amount of $_____, made payable to Medicare, should be sent to:

Medicare contractor

Address

Your/the beneficiary's name and health insurance claim number should be included on the check made payable to Medicare.

On (date that exhibit 2 was sent)_____, we notified you that interest would be assessed on any debt not repaid in full within 60 days of that date, regardless of whether you chose to appeal or to seek waiver of the debt. We advised you that repaying the debt would not affect your right to dispute, appeal, or request waiver of the debt. Because you did not repay the debt within 60 days of (the date that exhibit 2 was sent), you owe Medicare $_____, in interest charges.

Please sign the enclosed release agreement form within 10 days and return it to this office.

If you disagree with the decision not to grant a full waiver of recovery of this overpayment, you have 60 days from the date you receive this letter to request a reconsideration. The request can be submitted directly to the address above.

If you decide to exercise your appeal rights, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. There are groups, such as lawyer referral services and public interest advocacy groups that can help you find a lawyer.

There are also groups, such as legal aide services, who provide free legal services if you meet eligibility requirements. Should you/your client have any questions concerning this letter, please contact _____ on _____.

Medicare Contractor

Enclosure(s): Release Agreement Form

Pre-addressed envelope

50.6.5.4.3 - Letter if Waiver Criteria Are Not Met (Exhibit 6)

(Rev. 1, 10-01-03)

A3-3418.12.E

Exhibit 6 - Letter if Waiver Criteria Are Not Met

The contractor sends the Standard Letter Denying Waiver Request shown below, providing a full explanation of the reasons for the denial. Use of this letter is mandatory. Substitutes may **not** be used. The contractor retains copies for the file.

STANDARD LETTER DENYING WAIVER REQUEST

Medicare Beneficiary

HIC # XXX-XX-XXXD

We have completed our review of your request for waiver of the outstanding Medicare claim against the settlement or recovery proceeds you have received with respect to your accident. It is our determination that your circumstances do not fall within the criteria used to grant waiver, as set forth in our letter to you dated . These circumstances are:

[Insert substantive and fact-driven reasoning, applying the waiver criteria and explaining how particular expenses were or were not accident-related. Be sure to address or rebut the beneficiary's reasons for requesting a waiver, including if no reason was given.] For these reasons, we are denying your request that Medicare waive its recovery.

Medicare's conditional payment in this case was $_____. The liability settlement received was $_____. The procurement costs totaled $_____. After allowing $_____ as Medicare's share of procurement costs under 42 CFR 411.37(c), Medicare has a claim in the amount of $_____ against your settlement or recovery proceeds. Also, on (date that exhibit 2 was sent)_____, we notified you that interest would be assessed on any debt not repaid in full within 60 days of that date, regardless of

whether you chose to appeal or to seek waiver of the debt. We advised you that repaying the debt would not have affect your right to dispute, appeal, or request waiver of the debt.

Because you did not repay the debt within 60 days of (date that exhibit 2 was sent), you owe Medicare $_____ in interest charges.

Therefore, in accordance with this determination, the amount which must be repaid to Medicare is $_____. A check in the amount of $_____, made payable to Medicare, should be sent within 30 days of your receipt of this determination in the enclosed envelope to:

Medicare contractor

Address

Your/the beneficiary's name and health insurance claim number should be included on the check made payable to Medicare.

If you disagree with the decision not to grant waiver of recovery of this overpayment, you have 60 days from the date you receive this letter to request a reconsideration. The request can be submitted directly to the address above.

If you decide to exercise your appeal rights, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. There are groups, such as lawyer referral services and public interest advocacy groups, that can help you find a lawyer.

There are also groups, such as legal aide services, who provide free legal services if you meet eligibility requirements. Should you/your client have any questions concerning this letter, please contact _____ on _____.

Medicare Contractor

Enclosure(s)

50.7 - Waiver and/or Compromise Exercised Only by CMS

(Rev. 1, 10-01-03)

50.7.1 - Waiver Under §1862(b) of the Social Security Act

(Rev. 1, 10-01-03)

A3-3418.15

This section of the Act grants the Secretary the right to waive MSP liability recoveries if doing so would be "in the best interests of the program." Authority to grant waivers under this section of the Act may be exercised only by CMS CO or RO staff. Waivers granted under this authority may not be appealed because they are granted at CMS' discretion. (See 42 CFR 405.705(d).)

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

(Rev. 1, 10-01-03)

A3-3418.16

This statutory provision gives Federal agencies the authority to compromise where:

- The cost of collection does not justify the enforced collection of the full amount of the claim;
- There is an inability to pay within a reasonable time on the part of the individual against whom the claim is made; or
- The chances of successful litigation are questionable, making it advisable to seek a compromise settlement.

These criteria are provided here for contractor information, since only RO or CO staff, not Medicare contractors, are permitted to compromise Medicare claims. If a beneficiary, attorney, or beneficiary's representative offers to pay Medicare less than the full amount of its claim, the contractor informs the inquiring party of their rights to request waiver, appeal, or compromise of the claim. It advises them that while contractors may assist them in securing a waiver or appeal, contractors are not permitted to compromise claims on behalf of the United States Government. Then, it follows the instructions at §50.4.2, which provide that a resolution through the FCCA is available **through the RO** at any time after the contractor is aware that Medicare has made conditional payments in a liability situation.

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

50.7.3 - Documentation Necessary for Liability Cases Forwarded to CMS Where Waiver or Compromise is Requested

(Rev. 1, 10-01-03)

Regional Medicare Letter Part A 92-168/Part B 92-350 sent via Profs 12/15/92

The Lead contractor determines waiver in liability cases. Contractors must develop and prepare MSP liability overpayment cases that are to be referred to CMS RO for a determination on request for compromise. Complete development and preparation is necessary to provide the sufficient information to make a compromise decision. If a contractor receives a request for a waiver of a Medicare overpayment that meets the cited criteria, the attorney's written request must be forwarded to the Lead Contractor. If a contractor receives a request for a compromise of a Medicare overpayment that meets the cited criteria, the attorney's written request for compromise and the case file should be immediately forwarded to the RO. No action can be taken on telephone requests, even for pre-settlement compromise.

50.8 - Appeals Procedures for MSP Liability Overpayments

(Rev. 1, 10-01-03)

A3-3418.17, A3-3419

These instructions prescribe procedures to be used in processing appeals of MSP liability overpayment and waiver determinations. Since recovering MSP liability overpayments involves procedures which vary somewhat from those used for general overpayments, the following recovery instructions are to be used in place of the general overpayment instructions found in the Medicare Customer Service Manual, Chapter 1, **except where specific references to those sections are provided**. These instructions supersede any conflicts in the procedures.

50.8.1 - Initial Determinations

(Rev. 1, 10-01-03)

A3-3419.1

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

- The existence of the overpayment;
- The amount of the overpayment; and
- A less than fully favorable determination of §1870(c) waiver request.

Negotiation of a compromise, or suspension or termination of collection action under the Federal Claims Collection Act by the RO, is **not** an initial determination, and, therefore generates no appeal rights. (See 42 CFR 405.705(d).) A waiver granted under §1862(b) of the Social Security Act also generates no appeal rights.

50.8.2 - Notification of the Right to Appeal

(Rev. 1, 10-01-03)

A3-3419.2

The beneficiary must be given notice of appeal rights within the document reflecting the initial determination. If the beneficiary continues to follow through with the appeal process, notice of the next sequential appeal right must be given with each new determination. (See §50.5.4.3 and Exhibit 14, "Standard Reconsideration of Waiver Determination.")

50.8.3 - Part A and Part B Appeals of MSP Liability Overpayments

(Rev. 1, 10-01-03)

A3-3419.3

MSP liability determinations that may be appealed are listed at §50.8.1. Medicare contractors are responsible for processing appeals of these determinations. When processing a Part A appeal, the contractor uses the Part A appeal process set forth in the Medicare Customer Service Manual Chapter 1, Section 4. Part B appeals should be processed using the Part B appeal procedures in the Medicare Customer Service Manual, Chapter 1, Section 5. The first level of the Part A appeal process is a reconsideration. The first level of the Part B appeal process is a review.

A - Requests for Appeal

(Rev. 1, 10-01-03)

A3-3419.3.A

Any writing that the contractor receives indicating dissatisfaction with the initial determination constitutes a request for an appeal. Any language about a review, reexamination, investigation or the like is deemed an implied request for an appeal. (See 42 CFR 405.710.)

B - Combined Requests for Waiver and Appeal

(Rev. 1, 10-01-03)

A3-3419.3.B

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

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

If the initial overpayment determination is affirmed, then the contractor proceeds with evaluation of the waiver request in accordance with the instructions found at §50.6.2. It issues the waiver determination. (See Exhibits 4, Exhibit 5, and Exhibit 6 for standard waiver determination letters to use.)

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

C - Combined Part A and Part B Appeals

(Rev. 1, 10-01-03)

A3-3419.3.C

When an appeal request is made which involves both Part A and Part B payments, the lead contractor is responsible for ensuring that payments under Part A are processed using the reconsideration process, and that Part B payments are processed under the review process. These are two separate and distinct processes. Contractors are responsible for ensuring that Part A and B appeals are conducted according to their respective processes. To do so, the contractor separates the Part A payments from those made under Part B.

Contractors are also responsible for all aspects of conducting the appeal, including evaluation of the record, issuance of the appeal decision and workload reporting. The contractor processes all subsequent appeal activities, e.g., ALJ hearing requests and ALJ hearing determination effectuation. Also, it provides the other contractors involved with final appeal dispositions and MSP program savings, if any.

D - Steps in Deciding an Appeal

(Rev. 1, 10-01-03)

A3-3419.3.D

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

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

- Check all mathematical computations for accuracy;
- Determine whether any new evidence has been produced since the time the initial determination was made; if so, that information must be considered;
- If the beneficiary is appealing a denial of a waiver request, use the criteria found in §50.6.3 to determine whether the initial determination is correct;
- Once the determination has been made, send the beneficiary/attorney the standard letter found at either Exhibit 13 or 14, depending upon whether the beneficiary is appealing the overpayment or a waiver determination. **the contractor's letter must include a clear rationale for its determination**; and
- The determination contains notification of the second appeal right This appeal right automatically comes into effect when the beneficiary is dissatisfied with the reconsideration, or review determination and makes a written request for such an appeal. See the Medicare Customer Service Manual, Chapters 4 and 5, for the next level of appeal and the time limits for filing for the various levels of appeal. The intermediary uses Exhibit 13, "Standard Reconsideration of Overpayment Determination/Computation," or Exhibit 14, "Standard Reconsideration of Waiver Determination." Use of these letters is mandatory; substitutes may not be used.

50.8.3.1 - Standard Reconsideration of Overpayment Determination/ Computation (Exhibit 13)

(Rev. 1, 10-01-03)

A3-3419.3.D

Exhibit 13 - Standard Reconsideration of Overpayment Determination/Computation

Dear Beneficiary:

As a result of your (**date**) request for reconsideration of our initial determination of the amount/existence of Medicare's claim against settlement proceeds you received from a third party due to the [**type of]** accident which gave rise to medical expenses for which Medicare conditionally paid, we hereby (affirm, modify, reverse) our initial determination. This new determination was made by individuals who were not involved in making the initial determination. The latest reviewer(s) examined all the information that was previously available and all additional information that you submitted with respect to this reconsideration.

In your request for reconsideration, you stated . . . (give summary of why a reconsideration was requested).

You provided additional information in the forms of . . . which we fully considered in making this reconsidered determination, **OR** you provided no new or additional information.

[Insert application of the facts to the existence of the claim or how particular expenses were or were not accident-related. Be sure to address or rebut the beneficiary's reasons for requesting a reconsideration, including if none were given.]

If the determination reverses Medicare's claim, provide explanation for the new determination.

The Medicare conditional payment in this case was $_____.

You received a settlement of $_____.

The procurement costs, including attorney fees, were $_____.

After allowing $_____ as Medicare's share of procurement costs, the amount which would have been due is $____.

However, for the reasons stated above Medicare will not seek recovery of this amount.

Please sign the enclosed release form within 10 days and return it to this office.

Should you have any questions concerning this letter, please contact _____ on _____.

If Medicare's claim is affirmed or modified, in accordance with this determination, we are granting a partial waiver in the amount of $_____.

The total amount now due to Medicare is $_____.

In accordance with this determination, a check in the amount of $_____, made payable to Medicare, should be sent to:

Medicare Contractor

Address

If you disagree with this reconsidered determination and the amount remaining in question is $100.00 or more, you have a right to request a hearing before an Administrative Law Judge (ALJ) in the Office of Hearing and Appeals of the Social Security Administration.

If you want to have an ALJ consider your case at a hearing,

1. You have 60 days to request an ALJ hearing;

2. The 60 days starts when you receive this reconsideration determination;

3. If you waited longer than 60 days to request a hearing, your appeal will be dismissed, unless you provide a good explanation as to why your request was late; and,

4. You must ask for a hearing in writing. Write a letter saying you want a hearing to either this office or your local Social Security office. They will provide you with the necessary forms.

If you decide to appeal this determination, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. There are groups, such as lawyer referral services and public interest advocacy groups, that can help you find a lawyer. There are also groups, such as legal aide services, who will provide free legal services if you meet eligibility requirements.

Copies of the law, regulations and guidelines upon which we based this determination are available upon request. If you have any questions about this reconsideration determination and/or the request for hearing, please contact:

Medicare Contractor

50.8.3.2 - Standard Reconsideration of Waiver Determination (Exhibit 14)

(Rev. 1, 10-01-03)

A3-3419.3.D

Exhibit 14 - Standard Reconsideration of Waiver Determination

Medicare Beneficiary

HIC # XXX-XX-XXXD

Dear Beneficiary:

We have reconsidered our initial determination **(dated)** in which we denied your request for waiver of Medicare's claim against the proceeds you realized from your **(date)** accident. This new determination was made by individuals who were not involved in making the initial determination. These latest reviewer(s) examined all the information that was available, and any additional information that you may have submitted. We **(affirm, modify, reverse)** our initial determination.

[**Following paragraph inserted only if no new evidence submitted**]

In your **(date)** request for reconsideration, you submitted no new or additional evidence. After examining all the facts and evidence, we find no basis for setting aside or amending our initial determination on your waiver request. Accordingly, Medicare's claim of $_____ against your settlement proceeds is affirmed.

The Medicare law 42 U.S.C. 1395gg(c) gives us the authority to grant a full or partial waiver of its recovery when certain conditions are met. This authority creates a beneficiary's right to **request** waiver; it does not grant an automatic right to receive a waiver. This statute permits granting a waiver when repaying Medicare would either create a demonstrated financial hardship, or if repayment would be against principles of equity and good conscience.

Medicare incurred $_____ for your medical expenses. This amount was reduced by Medicare's share of the procurement costs which reduced Medicare's claim to $_____. You requested that Medicare waive this amount. You requested a waiver on **(date)** on the basis of _____ because:

(Insert reasoning which shows an application of the facts to the claim or how particular expenses were or were not accident-related. Be sure to address or rebut the beneficiary's reasons for requesting a reconsideration, including if none were given.)

If the determination does not reverse Medicare's claim, provide explanation for the new determination and conclude by stating: for the reasons stated above, Medicare is waiving recovery of this amount. Please sign the enclosed release agreement...."

If Medicare's claim is affirmed, insert the remaining paragraphs.

For all of these reasons, Medicare's claim against your settlement or recovery proceeds $_____. Please remit this amount in the form of a check or money order payable to _____ in the enclosed envelope within 30 days of receipt of this notice of your reconsidered determination.

Medicare assesses interest on MSP debts by exercising common law authority that is consistent with the Federal Claims Collection Act (FCCA) and implementing regulations. The CMS requires that a beneficiary or other entity repay CMS within 60 days of receiving insurance proceeds from a third party payer. If CMS does not receive a full refund, or adequate proof that no overpayment exists, within 60 days of notifying the beneficiary of CMS' demand, begin assessing interest as of the date of the mailing of the demand letter.

If you disagree with this reconsidered determination and the remaining amount in question is $100.00 or more, you have a right to request a hearing before an Administrative Law Judge (ALJ) in the Office of Hearing and Appeals of the Social Security Administration.

If you want to have an ALJ consider your case at a hearing,

1. You have 60 days to request an ALJ hearing;

2. The 60 days starts when you receive this reconsideration determination;

3. If you waited longer than 60 days to request a hearing, your appeal will be dismissed, unless you provide a good explanation as to why your request was late; and

4. You must ask for a hearing in writing. Write a letter saying you want a hearing to either this office or your local Social Security office. They will provide you with the necessary forms.

If you decide to appeal this determination, and if you want help with your appeal, you can have a friend, lawyer, or someone else help you. There are groups, such as lawyer referral services and public interest advocacy groups, that can help you find a lawyer. There are also groups, such as legal aide services, who will provide free legal services if you meet eligibility requirements.

Copies of the law, regulations and guidelines upon which we based this determination are available upon request. If you have any questions about this reconsideration determination and/or the request for hearing, please contact: [name of contact person].

Medicare Contractor

50.8.3.3 - Role of Carriers in MSP Liability Appeals Process

(Rev. 1, 10-01-03)

A3-3419.4

Lead Contractors conduct appeals therefore. when a contractor receives an appeal of one of the determinations listed at §50.8.1 pertaining to a liability situation, the appeal should be forwarded to the Lead Contractor. The Lead Contractor should request assistance from non-lead contractors to review disputed claims.

There are statutory appeal processing timeliness requirements which require prompt action on the part of the Lead Contractor. Upon receipt of an MSP liability appeal request, a carrier or FI must transfer the request to the Lead Contractor within 10 calendar days. The Lead Contractor should acknowledge the request for appeal within normal time frames. For processing timeliness, the Lead Contractor uses the date of receipt in the mailroom as the date of receipt. The date the beneficiary filed the request with a carrier or intermediary is used to determine if the beneficiary filed timely.

50.9 - MSP Liability Case Tracking Report for Waiver Cases (Exhibit 8)

(Rev. 1, 10-01-03)

A3-3418.26, A3-3418.30

The intermediary or carrier sends the Liability Settlement Tracking Report (Exhibit 8) to the RO no later than 30 days after the end of each quarter, i.e., January 30, April 30, July 30, and October 30. It reports only cases where either a settlement has been reached or a liability payment has been received, and where a final disposition has been reached, including either: waiver, compromise, suspension, termination, offset, or receipt of final payment.

The FI or carrier completes the report as follows:

- Fill in the contractor name, contractor number, the quarter and fiscal year;
- List each beneficiary and HICN for cases settled, and reimbursement to the Medicare program received during the quarter;

- List Medicare's proportionate share of the procurement costs;
- If the total amount of conditional payments minus Medicare's share of the procurement costs is less than the final amount collected, enter a brief explanation for accepting the lesser amount in the comment section.

Use the following definitions to complete the report:

Date of Injury	The date of the initial injury or accident.
Date Settled	The date final settlement was reached or date liability policy payment was made.
Total Amount of Conditional Payments	Total amounts (Parts A and B) of all Medicare payment for which the other insurer is liable.
Final Amount Collected	Amount refunded to Medicare.

Exhibit 8 - MSP Liability Case Tracking Report

Contractor Name_____ Contractor Number_____

Quarter Ended _____ Fiscal Year _____

Beneficiary Name	HIC	Date of Injury	Date of Settlement	Cond. Payment	Procurmt Costs	Amt. Collected	Remarks

50.10 - Allocation of Recovered Medicare Payments

(Rev. 1, 10-01-03)

A3-3489.7

If the amount recovered is less than the amount claimed, the contractor applies the refund so that available Part A benefits are restored, in the following order:

- Inpatient hospital days first;
- SNF days second; and

- Other Part A benefits third.

If payments were made for both Part A and Part B services, the contractor applies the refund first to Part A expenses in the same order.

60 - Medicare Secondary Payer (MSP) Debt Referral, "Write-Off - Closed" Instructions and Debt Collection Improvement Act of 1996 (DCIA) Activities

(Rev. 1, 10-01-03)

AB-02-102 (CR2145), AB-03-103 (2749)

MSP DCIA activities include all GHP-based debts, including those where the debtor is the provider, physician, other supplier, or beneficiary. MSP DCIA activities also include liability and no-fault-based debts of all types for all debtors, as well as workers' compensation-based debts for all debtors.

60.1 - Background

(Rev. 1, 10-01-03)

The DCIA requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center (DCC) for cross servicing and/or offset. The CMS is mandated to refer all eligible debt, over 180 days delinquent, for cross-servicing, including the Treasury Offset Program (TOP).

The CMS has the option of referring such debt before it is 181 days delinquent, but is required to refer all eligible debt that is over 181 days delinquent. Over 181 days delinquent means 181 days or more after the payment due date stated in the recovery demand letter.

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

The DCIA states that certain debts such as those in bankruptcy or in litigation in which the United States is a party are not eligible for referral. See §60.2 for a more detailed listing of the exclusions that Medicare contractors will use.

The DCIA process for MSP debts involves:

1. Selecting debts based on specific criteria;

2. Certifying these debts as valid;

3. Updating interest accruals;

4. Sending an “intent to refer” letter which contains specific language regarding the DCIA;

5. Dealing with inquiries and replies related to these activities;

6. Inputting debt information into the Debt Collection System (DCS) for electronic transmission to the PSC, as appropriate;

7. Coordination with CO, RO, and any other entity, as appropriate; and

8. Related reporting activities, including all financial statement and debt management activities.

Additionally, Medicare contractors remain responsible for all other associated systems updates and associated accounts receivable activity.

The ultimate goal is that on or before any MSP debt is 181 days delinquent, it will have been referred for further collection activity. This means that as Medicare contractors’ DCIA related workload becomes current, the “intent to refer” letter will be a standard letter that they will issue after the initial demand letter. Once all backlogs are eliminated, the “intent to refer” letter will routinely be issued as soon as a debt is delinquent. The DCIA process has been phased in at Medicare contractors in order to address both the backlog as well as new debts so that a new backlog is not created.

60.2 - Debt Selection, Verification of Debt, and Updating of Interest

(Rev. 1, 10-01-03)

Medicare contractors will select debts from their existing debt inventories for DCIA debt referral. The referral process for MSP debts involves selecting debts based on specific criteria, in order to certify these debts as valid.

For purposes of debt selection and referral, any dollar threshold includes both outstanding principal and outstanding interest. Also, because some Medicare contractors record their accounts receivable (AR) at the claim level (Example: 5 claims in a demand = 5 ARs) and others record them at the demand level (Example: all claims for a particular beneficiary = 1 AR), it is important that Medicare contractors have a common understanding of how the term “debt” is used in this instruction.

- For Group Health Plan (GHP) based debt where the demand was issued to the employer, insurer, third party administrator, GHP, or other plan sponsor, the debt includes all of the claims in a demand letter to a debtor for a particular beneficiary even if a single cover letter has been issued to the debtor for multiple beneficiaries' claims.

- For duplicate primary payment recovery demands to a provider or supplier (including physicians), the debt includes all claims in the recovery demand letter regardless of the number of beneficiaries involved.

- For GHP-based recovery demands to a beneficiary, the debt includes all claims in the recovery demand letter. (Medicare may only make such recoveries when Medicare made its payment directly to the beneficiary and the insurer paid the beneficiary.)

- For liability, no-fault, and workers' compensation, the debt includes all claims in the recovery demand letter.

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

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

Current debt selection criteria are as follows:

- Debts may be for Part A and/or Part B services.

- Debts must be delinquent. (Medicare contractors should select from both old delinquent debt and newly delinquent debt)

- Debts may be Data Match (DM) or non-DM GHP-based debts regardless of who the debtor is.(Previous instructions limited the DCIA referral process to GHP based debts where the demand was issued to the employer, insurer, third party administrator, GHP, or other plan sponsor.); and

- Debts may be liability, no-fault, or workers' compensation based regardless of who the debtor is. Although debts may be liability, no-fault, or workers' compensation based, contractors should place their highest priority on GHP-based debt until the backlog of GHP-based debt is eliminated. Where MSP liability, no-

fault and workers' compensation staff are not assisting with the GHP-based debt DCIA referral activities, selection of liability, no-fault, and workers' compensation based debt should begin immediately. (Previous instructions did not include liability, no-fault or workers' compensation based debts. Contractors should remember that liability and no-fault insurance include automobile liability insurance and automobile no-fault insurance as well as other types of liability and no-fault insurance.)

In addition to the above selection criteria, once a single debt for a particular debtor has been selected, all debt for a particular debtor that does not fall under a specific exclusion may be selected and referred. **CO encourages Medicare contractors to at least select all of the debt for a particular debtor that was included in a particular demand letter regardless of the dollar amount involved.** (For example, if a single demand letter was issued for 5 DM Report IDs, the contractor should select all 5 debts.) This will be less confusing to the debtor and decrease the number of "intent to refer" packages which are issued to the same debtor. Medicare contractors should routinely consider this issue for GHP-based debts; however it is less likely to be an issue for liability, no-fault or workers' compensation-based debts. See §60.3 for a more detailed discussion of this situation. However, a $25.00 threshold must be met for each debt as debts of less than $25.00 (principal and interest) are excluded from referral (see exclusion below).

Debts always excluded from referral include:

- Debts in appeal status (pending at any level),
- Debts where the debtor is in bankruptcy,
- Debts under a fraud and abuse investigation, if the contractor has received specific instructions from the investigating unit (i.e., Office of Inspector General or Office of Genera Counsel, etc.) not to attempt collection,
- Debts in litigation,
- Debts where the only entity which received the last demand letter is the employer and the employer is a Federal agency,
- Debts where the debtor is deceased and the estate is closed, or
- Debts where CMS has identified a specific debt or group of debtors as excluded from DCIA referral.
- Debts where there is a pending request for a waiver or compromise; and
- Debts less than $25.00 (principal and interest). (This threshold was used as a debt selection criterion (vs. an exclusion). As debts under $25.00 dollars are excluded from referral, CMS has changed this aspect of the instructions.) See Section 70.7 for additional discussion of debts that are less than $25.00 (principal and interest).

For purposes of excluding a debt from referral, the term "litigation" is limited to legal actions involving the United States (on behalf of CMS) and another entity. "Litigation" does **not** include litigation between the beneficiary and the insurer.

Debts currently subject to exclusion as "in litigation" include:

- To ensure that no debts involved in the Aetna or Cigna litigation are being referred, Medicare contractors should exclude all Aetna or Cigna debts that include any date of service on or before December 17, 1996. The CMS will provide further instructions for Aetna or Cigna debts/demands that involve dates of services with overlapping periods at a later date. Aetna or Cigna debts where all dates of service are subsequent to December 17, 1996, must be considered eligible for referral (absent meeting some other exclusion criteria such as "debts less than $25.00 (principal and interest)"). The Aetna and Cigna litigation includes the following entities:

  Connecticut General Life Insurance Company;

  Equitable Life Assurance Society of the U.S.;

  Equicor Life Insurance Company;

  Cigna Employee Benefits Services (as successor to Equicor, Inc.); and

  Aetna Life Insurance Company.

  NOTE: New York Life (including all known affiliates and subsidiaries) is no longer an exclusion under the DCIA referral process. The New York Life litigation has been concluded. New York Life debt (including associated interest) involving dates of service through June 15, 1998, should be recommended for "write-off - closed." The reason code used on the quarterly recommendation report to the RO should be "NYL." Where a NYL debt involves services on or before June 15, 1998, **and** after this date, only that part of the debt (principal and interest) for services on or before June 15, 1998, should be recommended for "write-off - closed." Any part of the debt that involves dates of service after June 15, 1998, must be considered eligible for referral, as should all such debts where all dates of service are after June 15, 1998. "Intent to refer" letters for debts where New York Life rather than NYLC or NYLCare Health Plans is listed as the debtor should be sent to NYLCare Health Plans because NYLCare Health Plans was the health business unit of New York Life and was acquired by Aetna in July 1998. See §§70.3 and 70.7 for further information about MSP "write-off - closed."

Debts currently subject to exclusion as a "CMS identified exclusion" include:

- Debts where a Federal agency is involved as the employer but the last demand was issued to the insurer (other than the Federal agency itself), third party administrator, GHP, or other plan sponsor, are currently excluded from referral as a "CMS identified exclusion." (Absent this specific CMS identified exclusion, debts involving a Federal agency would be referred if the last demand letter prior

to the “intent to refer” letter was sent to the insurer (other than the Federal agency itself), third party administrator, GHP, or other plan sponsor.) Because of this exclusion, Medicare contractors must routinely check the identity of the employer before an “intent to refer” letter is issued. If there is a situation where the employer is unknown, the Medicare contractor should assume the employer is not a Federal agency, absent proof to the contrary.

- Debts where Amalgamated (including known affiliates and subsidiaries) is involved as the union plan/insurer are excluded, regardless of whether the demand was issued to the employer or to Amalgamated. Associated names/entities for Amalgamated include, but are not limited to: Amalgamated Life Insurance Company, ALICO, Amalgamated Insurance Fund, and Amalgamated Cotton Garment Fund. (Because Amalgamated is a union plan, the lack of a CWF record for such debts is not enough to invalidate the debt. See further discussion of this issue below.)

Medicare contractors must check the Common Working File (CWF) for any status changes prior to sending the “intent to refer” letter and include a screen print of the CWF information in their case file. This review is to enable contractors to close debt, where appropriate, if the MSP record has been updated or terminated. For liability, no-fault, and worker’s compensation debts, Medicare contractors must verify that a demand was properly issued (there was a settlement, judgment, or award), but they do not need to check CWF before sending the “intent to refer” letter. Additionally, where a provider, physician, or other supplier overpayment is the result of a duplicate primary payment, it is not necessary to check CWF. The demand should not have been issued unless insurer information has already confirmed the existence of a duplicate payment. For all types of debts, contractors must also check to see if any correspondence and/or adjustments have come in that will change/alter the debt owed to Medicare before issuing the “intent to refer” letter. This includes ensuring that all associated payments/checks have been posted.

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

Additionally, contractors must check their internal systems for an updated address before sending the DCIA “intent to refer” letter. This information must be reviewed and the case file updated before an “intent to refer” letter can be issued. Contractors are reminded that MSP periods for beneficiaries enrolled in “union plans” are not routinely placed on CWF. If the GHP on the original demand has a “union plan,” the lack of CWF information for the debt would not be sufficient to invalidate the debt.

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

Any changes to status codes should be updated in **all** associated systems and interest accruals should be brought up to date while performing the debt validation process. This includes updates to internal systems and/or spreadsheets so that Medicare contractors can easily ascertain from their systems and/or spreadsheets what stage of the DCIA referral process a particular debt is at.

On DM debts, Medicare contractors will change the status code of the debt on the Mistaken Payment Recovery Tracking System (MPaRTS) at the time the "intent to refer" letter is sent, as well as when the debt is referred to the PSC. The status code on MPaRTS when the "intent to refer" letter is sent is "IL." The status code on MPaRTS when the debt is referred to the PSC is "PS."

The parameters for debt selection will be updated each year in the Budget Performance Requirements (BPRs), if appropriate, and any interim change will be communicated through a formal instruction to contractors.

60.3 - "Intent to Refer" Letter and Inquiries/Replies Related to DCIA Activities

(Rev. 1, 10-01-03)

Previous instructions contained a "200/500" minimum monthly standard for contractors for the issuance of "intent to refer" letters and/or the resolution of selected debts. Medicare contractors were required to resolve at least 500 selected debts or issue 200 "intent to refer" letters each month, whichever occurred first. Contractors must now issue "intent to refer" letters and/or resolve selected debts in sufficient numbers each month to eliminate all backlogs of unreferred eligible delinquent debt before the end of FY 2002; even if this requires them to meet a standard beyond the existing "200/500" standard. All debts which became 181 days delinquent on or before September 30, 2002, must have been resolved or have had the applicable "intent to refer" letter issued. Debts which will become 181 days delinquent on or after October 1, 2002, must be resolved or have the applicable "intent to refer" letter issued early enough that the debt will be referred, where appropriate, by the date the debt becomes 181 days delinquent. (Medicare contractors were previously advised in the amended MSP BPRs for fiscal year 2002, of the focus on DCIA debt referral and the need to eliminate all DCIA backlogs by the end of fiscal year 2002.)

Debt that qualifies for a Medicare contractor recommendation for "write-off - closed" should be recommended for "write-off - closed," not selected for the DCIA process. (See §70.) Debts for which an "intent to refer" letter has already been issued will not be removed from the DCIA process solely because they now meet the criteria for recommending "write-off - closed." However, once such a debt has been referred for cross-servicing/TOP, it may be recommended for "write-off - closed" if it meets such criteria and there has been no collection, payment, recoupment, offset, or adjustment activity for 12 months from the date of referral. Once the contractor receives approval for " write-off – closed" for such a debt, the debt must be pulled back from cross-servicing/TOP. Contractors should review any debt for "write-off - closed" before

spending time/resources on validation efforts or updating interest accruals for the DCIA process.

The DCIA requires agencies to inform the debtor of the agency's intent to refer the debt, and to provide the debtor with information regarding the referral process. Medicare contractors will send "intent to refer" letters via certified mail, return receipt requested, containing DCIA specific language, to the "current debtor." For liability, no-fault, and worker's compensation cases, the "intent to refer" letter should be addressed to the beneficiary where the beneficiary is the debtor, with a copy to the beneficiary's attorney or other representative (if applicable). See the definition of "debtor" in §60.2 above.

Use of the "intent to refer" letter is mandatory (including a copy of the last demand letter and all attachments to the demand letter) (See Exhibit 1, "DCIA 'Intent to Refer' Letter" and Exhibit 1E, "Enclosure for "DCIA 'Intent to Refer' Letters for GHP-based employer, insurer, third party administrator, GHP or other plan sponsor debts.")

The "intent to refer" letter explains the referral process and the debtor's rights. Exhibit 1E explains the proper way for an employer, insurer, third party administrator, GHP, or other plan sponsor to document a valid defense for a GHP-based debt. The additional information in this enclosure will assist both the debtor and Medicare contractors by reducing the need for discussion and inquiries regarding what an employer, insurer, third party administrator, GHP, or other plan sponsor must submit to establish a valid documented defense for a GHP-based debt. (The "intent to refer" letter and the enclosure in Exhibit 1E must be generated without standard system changes. For most Medicare contractors this would mean PC-based generated letters.)

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

If a Medicare contractor receives a response to the "intent to refer" letter which challenges the amount of the debt, it must reply using the letter in Exhibit 1B, 1C, or 1D, as appropriate. (These letters must be generated without systems changes. For most Medicare contractors this would mean PC based generated letters.) Where a debtor establishes that the debt or part of the debt should not be referred to the PSC due to one of the exclusions such as a pending appeal, the Medicare contractor must inform the debtor of the amount that remains subject to referral. (The response should indicate what amount will be excluded from referral at this time and what amount continues to be subject to referral.) These response letters must be issued within 15 days of receipt of the debtor's reply.

If the "intent to refer" letter is returned stamped "Undeliverable Mail," Medicare contractors should make one effort to locate a better address (for example; by calling directory assistance to obtain a phone number for the debtor). Once the better/new address is obtained, contractors must re-issue the "intent to refer" letter with a new

issuance date and must ensure that CWF is updated, including any necessary ECRS transmission. If this limited development effort does not result in a new address, Medicare contractors must document this development in the case file. Next, they must staple the envelope to the returned "intent to refer" letter and file it in the case. The debt can then be referred to the PSC/Treasury immediately for further collection activity.

If the certified mail delivery is refused, the contractor must re-mail the "intent to refer" letter, by regular mail, within seven calendar days of receiving the refusal. The contractor must re-mail the existing letter (vs. reissuing the letter with a new date) by regular mail and proceed with the referral process based upon the date in the letter as originally issued. Contractors should retain documentation of the refusal and annotate the file to show the date the letter was re-mailed. If the certified mail delivery is returned as unclaimed, contractors will follow the same procedures as they would for refused mail.

As stated in §60.2, once a single debt for a particular debtor has been selected, all debt for that debtor that does not fall under a specific exclusion may be selected and referred. Additionally, Medicare contractors are encouraged to at least select all of the debt for a particular debtor that was included in a particular demand letter without regard to the amount involved in the other debts (other than the $25.00 minimum threshold for referral.) There must be a separate "intent to refer" letter for each debt as well as an instructional cover sheet **for each package** of "intent to refer" letters when multiple "intent to refer" letters are sent to the same debtor at the same time. (See Exhibit 1A for the instructional cover sheet. This sheet must be generated without standard system changes. For most Medicare contractors this would mean a PC based generated document.) Multiple debts may **not** be aggregated or otherwise combined in a single "intent to refer" letter. "Intent to refer" letters must be debt specific. Input into the DCS must also be debt specific. (See §60.2 for the definition of "debt" for purposes of these instructions.)

Medicare contractors will answer any inquiries as a result of the DCIA "intent to refer" letter. These inquiries should be handled in the same manner as any DM, non-DM, liability, no-fault, or workers compensation inquiry.

60.4 - DCS System, DCS Input, Debt Transmission, Documentation to PSC

(Rev. 1, 10-01-03)

NOTE: Effective January 21, 2002, the PSC is no longer a designated DCC for MSP debts 181 or more days delinquent. However, MSP debts will continue to be referred to the PSC, as the PSC is still responsible for completing the referral process to Treasury for cross-servicing and TOP. Medicare contractors may still have some contact/interaction with the PSC (or its contractor, OSI) with respect to debts previously referred to the PSC.

Generally, this change has no effect on contractor processes, including DCS input and/or updating. However, Medicare contractors will now interact directly with Treasury and Treasury's contractors (private collection agencies) as well as the PSC. Consequently, the

paragraphs below may continue to reference the PSC even where Treasury is the responsible entity for newly referred debts. Further instructions will be issued once more detail is available and/or if there are any changes contractors need to make in their activities (including reporting).

NOTE: It is important to remember that all instructions in this section to update applicable systems include Medicare contractors' internal systems, databases and spreadsheets, as well as the standard contractor systems, because many aspects of MSP recoveries/debts are not tracked on the standard systems. This is especially true for liability, no-fault, and workers' compensation-based debts.

If the Medicare contractor receives a response to the "intent to refer" letter, the contractor must work this response within 15 calendar days of receipt of the correspondence at any contractor location. Where a response establishes a valid documented defense for part of the debt and/or there is partial payment, the balance of the debt is still eligible for referral to the PSC. Once the correspondence is worked, debt eligible for referral to the PSC must be input into the DCS within 10 calendar days or the 61st day after the "intent to refer" letter is issued, **whichever is later**. Debts may **not** be referred to the PSC until the 61st day after the "intent to refer" letter is issued, except for undeliverable "intent to refer" letters where the Medicare contractor is unable to locate a better address. Consequently, there will be some instances where the Medicare contractor has worked the incoming correspondence but must hold the debt/delay input to the DCS system until the 61st day. Debts that are returned as undeliverable may be entered into the DCS system as soon as the Medicare contractor has followed the appropriate procedures for trying to locate a better address and has been unable to do so. Medicare contractors must also update all other systems, as appropriate, within 10 calendar days of working the correspondence and/or posting any checks received (this includes MPaRTS, where applicable).

If there is no response to the "intent to refer" letter within 60 days, Medicare contractors will input the debt information into the DCS and update all other systems, as appropriate, within 10 calendar days.

NOTE: Once a Medicare contractor is current with its DCIA workload, it may use the 45-day correspondence time frame set forth in the FY 2003 BPRs to work its DCIA correspondence workload. "Current" means that all eligible delinquent debt is routinely referred on or before the date it becomes 181 days delinquent. Contractors using this 45-day standard must complete all associated systems updates (other than DCS input) within 45 days or 10 days of resolving the correspondence, whichever is earlier.

The DCS is used to refer debts to the PSC/Treasury for cross servicing of individual debts, including TOP. It is also used to track debts pending action at the PSC/Treasury. Input into the DCS certifies the debt as valid, legally enforceable, and ready for referral to the PSC/Treasury.

The DCS database is accessed through the CMS Data Center and is limited to authorized users. The DCS system is made up of four (4) screens: (1) the Search Screen, (2) the Data Entry Screen, (3) Comments Screen, and (4) the Collection Screen.

- The Search Screen enables the user to look for a debt by Tax Identification Number (TIN), Company Name (Comp Name), and Debt Number (Debt #).

- The Data Entry Screen provides for detailed information on a debt as well as the ability to enter a debt into the system.

- The Comments Screen allows the entry of comments in order to provide for a complete audit trail.

- All collections must be entered into the Collection Screen for a proper audit trail. Additionally, Medicare contractors must view the Collection Screen in order to see the current balance of the debt **shown in the DCS**. (The amounts shown on the Collection Screen will not include interest accrued subsequent to the initial input of the debt into the DCS unless that additional interest has actually been collected and posted as part of a collection.)

Instructions for DCS access and data entry are included in the DCS Manual, which has already been provided to Medicare contractors. These instructions:

- Provide step-by-step guidance on entering a debt into the system;

- Define each field in the system;

- Provide directions on how to handle and enter various situations which may occur during the DCIA process; and

- Provide directions for weekly Medicare contractor reports for debts pulled back/recalled from the PSC.

Medicare contractors have access to the DCS and input certified debts directly to the database. When inputting the debt into the DCS system the contractor uses status code “UU” except for debts where the “intent to refer” letter was undeliverable which is input with a status code of “UN” (“UU"= initial entry of the debt for referral; “UN” = undeliverable Status Code letter).

Once the debt has been input into the system for referral, a copy of the “intent to refer” letter with all attachments and/or enclosures, must be forwarded to the Treasury in Birmingham, Alabama within 7 calendar days from the date of input. The address for debtors to mail information to Treasury is contained in Exhibit 3. If not already received, contractors must obtain the address contractors are to use in mailing information to Treasury from their ROs.

When a Medicare contractor receives information from a government entity responsible for some aspect of the referral process for cross-servicing/TOP (or from another entity under contract for these purposes) that conflicts with what it has in-house, it checks CWF for current MSP Auxiliary File information. If the information the Medicare contractor receives from the PSC and/or an entity under contract to the PSC is consistent with the information on CWF, then no further action is required. If the information the Medicare

contractor receives from the PSC and/or entity under contract to the PSC conflicts with the CWF MSP Auxiliary File data and it is not within the Medicare contractor's authority to resolve, the contractor sends an Electronic Control Response System (ECRS) inquiry to the Coordination of Benefits (COB) Contractor. The COBC investigates the query to resolution and updates the MSP record, as appropriate. (Please note that the entity currently under contract to the PSC to perform various collection activities is Outsourcing Solutions Incorporated (OSI). Medicare contractors will be notified if the PSC changes the entity it contracts with for these activities.) Additionally, contractors should be aware that Treasury also contracts with outside entities for cross-servicing activities. Contractors received notification from their ROs of the private collection agencies currently under contract to Treasury.)

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

60.5 - Actions Subsequent to DCS Input

(Rev. 1, 10-01-03)

AB-03-103

NOTE: As indicated in §60.4, the fact that the PSC will only be the referral point for debts being sent to Treasury for cross-servicing and TOP rather than the entity responsible for actual cross-servicing should have no impact on contractor activities at this time other then the fact that supporting documentation is now mailed to Treasury rather than the PSC. Consequently, the paragraphs below may continue to refer to the PSC even where Treasury is the responsible entity for newly referred debts. Further instructions will be issued when there is more detail available and/or if there are any changes contractors need to make in their activities (including reporting).

Once a debt is referred to the PSC/Treasury, collection efforts by the Medicare contractor, the RO, and/or CMS must cease. However, referred debts must still be maintained in the Medicare contractors' internal systems and interest must continue to accrue.

As stated, the Medicare contractor inputs/enters the debt into the DCS database using "UU" or "UN." Once CO changes the status code to "UJ," the debt has been referred to the PSC for referral to Treasury for further collection efforts (including referral to TOP). (Status code "UJ" means that responsibility for pursuing the debt is at the PSC.) CO, via the RO, furnishes Medicare contractors with routine reports of debt transmitted to the PSC.

Cross-servicing activities will include sending letters to the debtor. If the PSC recovers on a debt, they notify the Medicare contractor via CO and the RO.

If Treasury or an entity on its behalf recovers on an MSP debt, Treasury will notify the PSC who notifies the Medicare contractor via CO and the RO. If a debt is returned due to a lack of collection subsequent to referral, CO will need to make a determination concerning any future/further action on the debt. (Until that decision is made, the debt remains on the Medicare contractors' internal records, remains on contractor systems, and is reported on Form CMS-750 (Statement of Financial Position"), Form CMS-751 (Status of Accounts Receivable), and Form CMS-M751 (Status of MSP Accounts Receivable") (Form CMS 750/751 reports).)

Medicare contractors may receive telephone inquiries/questions on debts that have already been referred to the PSC. Medicare contractors identify which letter (PSC, PSC contractor, Treasury, Treasury contractor, or Medicare contractor) the caller has and help the caller. If the caller/debtor wants to pay Medicare back or send correspondence and they have received letter from an entity responsible for cross-servicing, then the Medicare contractor instructs the caller to send the check or correspondence to the entity which issued the letter, not the Medicare contractor. In addition, if an inquiry from a government entity responsible for some aspect of the referral process (or from another entity under contract for these purposes) calls for assistance on the debt, the Medicare contractor shall help them.

The general rule once a debt has been referred to the PSC/Treasury is as follows:

- In all instances where a debt is eliminated or reduced by collection and/or the establishment of a valid documented defense, the Medicare contractor is responsible for updating the DCS.

- If the Medicare contractor discovers an error, collects (by check or internal offset), receives information establishing a valid documented defense, or receives information that would exclude all or part of a debt from DCIA referral, they are responsible for the appropriate recall report. This recall report is used to pull back a debt that was previously referred or adjust the amount remaining at the PSC, as appropriate. Medicare contractors update the DCS Data Entry Screen, as appropriate, document the reason for the recall along with the date of the action prompting the recall; i.e. date of collection on the Comment Screen, and complete the weekly report on recall and send it to the PSC in Rockville, Maryland. If a collection is received, the contractor updates the Collection Screen. DCS updates must be done within 15 calendar days.

- If a cross-servicing entity discovers an error, receives information that establishes a valid documented defense, or receives information that would exclude all or part of a debt from DCIA referral, the Medicare contractor will be notified by central office (CO) and/or the regional office (RO) via The Treasury Debt Management Services Action Form (Action Form). The Action Form, along with supporting documentation, is sent to CMS by Treasury for verification. The CMS then

forwards the Action Form on to the appropriate Medicare contractor. The Action Form is not a resolution of a debt by Treasury, it is a request for the Medicare contractor to review the documentation and provide a decision. Therefore, it is the Medicare contractor's responsibility, after review of the Action Form and supporting documentation, to initiate all required actions including total debt recalls or adjustments due to valid documented defenses. Medicare contractors are responsible for updating all systems, including Debt Collection System (DCS) and CFO tracking systems, if the decision so warrants within 30 calendar days. Medicare contractors will notify Treasury of their decision and must include the Debt Management Service Center Number in their response. This number is located at the top left of the Action Form. The contractor should provide a copy of Action Form decisions to their Medicare Secondary Payer RO Coordinator to assist the RO in their oversight role.

If a cross-servicing entity receives any partial or full collections for debts that have been referred, PSC will notify CO via an IPAC report. (The IPAC report was previously known as the OPAC report.) The notification when furnished to the Medicare contractor will detail how the collection was applied

Specific instructions for DCS input and recalls are included in the DCS Manual and are updated on a continuing basis.

NOTE: Once a debt is recalled/returned from the PSC due to bankruptcy, the Medicare contractor follows normal procedures for bankruptcies

60.6 - MSP DCIA Tracking Report for Referral/Collection

(Rev. 1, 10-01-03)

The CMS developed a revised MSP DCIA Tracking Report for Referral/Collection to assist contractors in monitoring and tracking the debts selected for potential/actual referral and for CMS oversight of the DCIA referral process (see Exhibit 2 - MSP DCIA Tracking Report for Referral/Collection). Medicare contractors submit this report by the 21st of each month for the previous month's activity. This report is a manual report. All Medicare contractors forward the completed report to their RO MSP Coordinator and to CO at a special mailbox that CO has designated for these reports. Contractors send their monthly MSP DCIA Tracking Report to: MSPDCIARPT@cms.hhs.gov. This mailbox is only for the submission of CO's copy of the monthly report. This report must be received by the RO and CO by the 21st of each month.

The required format and instructions for the completion of the Monthly MSP DCIA Tracking Report (including the required CFO certification) are contained in Exhibit 2. However, contractors will also be receiving a copy of the required format by disc, and they must use this disc for their report to CO. DO NOT CHANGE THE FORMAT OF THIS REPORT. Each contractor's information will feed into a spreadsheet of summary information for all contractors for each month, for CO's use.

Medicare contractors must be able to readily access the records for, and identify all debts selected for the DCIA process that are included on this report. Contractors are also reminded that they must have a proper audit trail; they must maintain (and furnish to their RO upon request) debt specific detail supporting their monthly MSP DCIA Tracking Report. ROs will use this information in the course of their oversight activities for the DCIA process. Remember that where an RO requests detailed support for the information in the contractor's monthly report, this must be sent by disc or hardcopy due to privacy considerations.

60.6.1 - Monitoring Debts Excluded From the DCIA Referral Process

(Rev. 1, 10-01-03)

Medicare contractors monitor and report on debts that were selected for potential referral but met one of the exclusions to the DCIA referral process. Contractors monitor and determine any change in the status of such debts, which would lift the exclusion and make the debt subject to referral (for example, if a debtor loses an appeal and still refuses to make payment or if CMS eliminates a litigation exclusion or a CMS-identified exclusion).

60.7 - Financial Reporting

(Rev. 1, 10-01-03)

Medicare contractors are responsible for the financial reporting of all Accounts Receivables (AR) throughout the DCIA process. The AR for debts referred to the PSC remain on Medicare contractors' internal records, remain on contractor systems, and are reported on Form CMS-750 ("Statement of Financial Position"), Form CMS-751 (Status of Accounts Receivable), and Form CMS-M751 ("Status of MSP Accounts Receivable") and Form CMS-MC751 for MSP "Write-Off - Currently Not Collectible Debt" (collectively known as Form CMS-750/751 reports).

NOTE: Medicare Contractors must refer to Chapter 5 of the Medicare Financial Management Manual (concerning the preparation and submission of Contractor Financial Reports (Form CMS-750 and 751) and follow the instructions contained therein when doing any financial reporting for DCIA activities.

Medicare contractors continue to accrue interest on a debt after the debt is entered into the DCS system. Although the DCS does not reflect this additional interest unless/until DCS is updated in connection with a collection, the PSC takes the continuing accrued interest into account in its recovery effort. Also, although the private collection agencies under contract to Treasury do not take additional interest into account, contractors must continue to accrue interest regardless of the referral location of the debt.

Where the PSC or Treasury receives payment, CMS is notified and receives payment through IPAC. Medicare contractors are responsible for all associated AR actions once they receive collection information from CO via the RO. Medicare contractors must

complete all associated AR actions within the same quarter that they receive notification of an IPAC payment.

Upon contractor determination of an Action Form, contractors must update all financial reporting systems to reflect appropriate adjustments (CFO reported actions) due to approved valid documented defenses. Contractors should await CO notification prior to reporting collections received by the PSC or Treasury.

Medicare contractors must maintain detailed support for all information reported on the Monthly MSP DCIA Tracking Report.

60.8 - Compromise Requests and Extended Repayment Agreement Requests, and Waiver of Interest Requests

(Rev. 1, 10-01-03)

Compromise requests should be rare. Additionally, third party payer debts are unlikely to meet the regulatory criteria for consideration of a compromise. Any compromise requests must be in writing and must state the reason why the debtor believes a compromise should be agreed to. If a verbal request or a written request which does not state a reason for the requested compromise is received, the Medicare contractor should inform the requestor of these requirements, state that no action will be taken on the compromise request until these requirements are met, and refer them to the compromise criteria set forth in 42 CFR 401.613. Written compromise requests that state the reason for the requested compromise must be forwarded to the RO, within 15 days of receipt by the Medicare contractor. The Medicare contractor must send a copy of the case file and must include any supplemental information or documents furnished by the debtor. The RO will make compromise decisions within its Federal Claims Collection Act (FCCA) authority. ROs do not have the authority to compromise debts where the principal amount exceeds $100,000 or any third party payer debt (debtor is the insurer, employer, third party administrator, plan, or other plan sponsor) regardless of the amount. For debts exceeding $100,000 or any third party payer debt regardless of the amount, the RO reviews each case individually, writes a recommendation, and forwards a complete case file including a Claims Collection Litigation Report (CCLR), together with their recommendation to CO to the Deputy Chief Financial Officer (through the Medicare Secondary Payer Operations Chief) for approval. Once the RO or CO, where appropriate, makes a decision, the RO communicates the decision in writing to the debtor, with a copy to the Medicare contractor.

If the Medicare contractor receives a request from the debtor for an extended repayment agreement from a third party payer (insurer, employer, third party payer, GHP, or other plan sponsor), it must contact the RO. The RO, with the assistance and input of CO, handles these requests on an individual basis. Medicare contractors will handle extended repayment agreements for providers/suppliers (including physicians) or beneficiaries under existing procedures.

Medicare contractors have the authority to make waiver determinations under §1870 of the Act (a decision whether or not a provider, physician or other supplier is "without fault" with respect to an overpayment; a decision whether or not a beneficiary is "without fault" and recovery would either cause financial hardship or be against equity and good conscience). Where a partial or full waiver is granted, **no interest is due for the waived amount,** and the contractor must make a manual downward adjustment for the interest associated with the waived principal amount if this is not done automatically by the contractor's system. It is important to understand that this action is not a "waiver of interest" and that interest is **not** subject to waiver under §1870 of the Act. (Similarly, other situations where the contractor must adjust interest due to an error (for example, a debtor establishes that their liability settlement payment was actually received after the recovery demand letter was issued) do not involve a waiver of interest.) Contractors are also reminded that waiver under §1870 of the Act does not apply to MSP debtors other than providers, physicians and other suppliers, or beneficiaries.

In some instances, contractors have received a request for a waiver of interest rather than a request for compromise. This issue is not within the Medicare contractor jurisdiction. Any such request must be in writing, and must explain why the debtor believes that the interest should be waived. Such requests must be forwarded to the RO with a copy of the case file. ROs must review any such requests and make a recommendation to CO. Once CO makes a decision, it will communicate the decision in writing to the debtor, with a copy to the RO and to the Medicare contractor**.**

MSP compromise requests, extended repayment agreement requests, and requests to waive interest sent to the RO should be sent to the attention of the RO MSP Coordinator.

60.9 – Miscellaneous Questions and Answers

(Rev. 1, 10-01-03)

Q1. If we have an unprocessed Data Match (DM) case, is this part of the backlog that we should be working on with respect to the DCIA referral process? (We have not issued demand letters for these cases yet.)

A1. No. The DCIA referral process is used only for delinquent, established debt. A recovery demand letter must have been issued in order to establish the debt.

Q2. Do these instructions include liability, no-fault, and workers' compensation debts? Do these instructions include credit balance debts we make a demand on?

A2. Yes, the instructions now include liability, no-fault and workers' compensation based debts. The instructions also include MSP credit balance debts for which a demand has been made.

Q3. The language for the "intent to refer" letter indicates that a case ID number is part of the "debt identification number" and must be included on the letter for non-DM debts. Our non-DM debts do not have a case ID number. Do we need to assign case ID numbers to these cases or can we leave this information out of the "intent to refer" letter for non-DM debts? (We identify our non-DM cases by the Medicare HIC number.)

A3. No, you may not leave this information out. From the information in your question, the Medicare HIC number is what **you** use as a "case ID number" for non-DM cases. Therefore, you would use the HIC number as the case ID number in the "intent to refer" letter. Case ID numbers are how you identify a case (i.e., HICN, Report IDs, etc.).

Q4. Assume that: (1) We have a DM debt that is delinquent and has not yet been selected for the DCIA referral process/has not had an "intent to refer" letter issued; and (2) We receive a new DM tape which has another report ID for the same beneficiary. Do we keep the two cases separate for DCIA purposes (separate "intent to refer" letters, etc.) or do we somehow lump them together?

A4. You may not group them together in any manner. The information on the new DM tape is not a debt until a recovery demand letter is issued. Additionally, as stated in the instructions, multiple debts may not be aggregated or otherwise combined in a single "intent to refer" letter (see section III.). However, as further discussed in §60.3, Medicare contractors are encouraged to bulk mail all of the "intent to refer" letters for a particular debtor at one time, where possible.

Q5. Is assessment of interest/additional interest appropriate if the debt only had one demand sent, with no follow up demand letter?

A5. Yes, interest continues to accrue on the debt. As stated in the PM, the accrued interest amount needs to be updated (manually, if necessary) before the "intent to refer" letter is issued. The applicable interest rate is the rate in effect on the date the demand letter was issued.

Q6. Should the beneficiary be copied on the "intent to refer" letter?

A6. The only situation in which the beneficiary would be involved with an "intent to refer" letter is when the beneficiary is the debtor in question. In most instances this will involve a liability, no-fault or workers' compensation-based debt although it could involve a GHP-based debt. As stated in §60.3 above, for liability, no-fault, and workers' compensation debts, the "intent to refer" letter should be addressed to the beneficiary where the beneficiary is the debtor, with a copy sent to the beneficiary's attorney or other representative (if applicable). One reason for sending the "intent to refer" letter directly to the beneficiary (where the beneficiary is the debtor) is that the beneficiary may have no ongoing relationship with the individual who was their attorney by the time the "intent to refer" letter is issued. It is crucial that the beneficiary realize that there is an outstanding matter against him/her as any further collection action or Treasury offset action will be taken against the beneficiary. See also, the discussion of the terms "debtor" and "current debtor" in §60.2.

Q7. If an "intent to refer" letter is issued and a partial payment or other response is received, does the time frame start over again?

A7. No. Any balance still owed is to be referred.

Q8. How is the Medicare contractor to determine if the debtor is in bankruptcy for potential referral where no response is received to the "intent to refer" letter? Similarly, how is the Medicare contractor to determine that a debtor is deceased if there is no response to the "intent to refer" letter?

A8. Absent proof to the contrary, assume that a debtor is not in bankruptcy and is alive.

Q9. (a) Why does the "intent to refer" letter include the amount of interest as of 30 days after the date of the "intent to refer" letter? Is this necessary since the debtor has 60 days to respond to the "intent to refer" letter? (b) When the "intent to refer" letters are sent, the interest is calculated to show the amount due 30 days and then 60 days from the date of the "intent to refer" letter. This does not always run true with the required accrual of interest because interest accrues from the date of the original demand letter to the debtor (and is due and payable as of the first day of each 30 day period). This means that there are instances where even if the debtor pays the amount specified in the letter, including interest, the amount paid is insufficient. How should the contractor handle this situation?

A9. Medicare contractors must keep in mind that interest runs from the date of the original demand letter to the debtor. Although a particular debt will not be referred to Treasury or a designated DCC until the 60 day period in the "intent to refer" letter has expired, interest continues to accrue from the date of the original demand letter to the debtor during this period. The additional information about interest accrual is included in the letter so that the debtor will know how much they should repay if they do not make repayment immediately upon receipt of the "intent to refer" letter.

However, as indicated in (b) in the above question, the interest language in the "intent to refer" letter, as issued in PM AB-01-83, is problematic. It does result in some situations where payment of the amount specified in the "intent to refer" letter, including interest, is insufficient. As an example:

- The date of last interest accrual was March 1 (amount due, including interest = $120);

- The date of the intent to refer letter is March 10;

- The intent to refer letter **as set forth in PM AB-01-83** would include the amount due as of March 1st (last accrual date; $120, including interest), as of April 9 (30 days from the date of the "intent to refer" letter; $130, including interest), and as of May 9 (60 days from the "intent to refer" letter; $140, including interest); and

- If the debtor paid on April 6, the debtor would assume that $120 was due and repay that amount. However as the next accrual date was March 31(30 days from the March 1 accrual date), they actually owed the $130 at the time they repaid. (Remember that interest is due and payable on the first day of each 30-day period.)

To correct this, the revised "intent to refer" letter now requires Medicare contractors to tie the amount due back to the existing interest accrual dates rather than to the date of the "intent to refer" letter. This means that the debtor will have accurate information as to when the amount due changes/will change due to the accrual of additional interest. If a Medicare contractor has a situation where the debtor has paid the amount specified in the "intent to refer" letter, but this amount is insufficient solely because of the problem explained above, the contractor should adjust the interest downward by the additional amount accrued as of the date of repayment but not specified in the "intent to refer letter." This adjustment must be done before the check is posted to the account receivable because payment is applied to interest first and principal second. In the example given above, the contractor would need to adjust the interest due, downward, by $10.

Q10. What will we do if the insurer or employer responds to the "intent to refer" letter stating that they have already paid the provider, physician, or other supplier?

A10. Ask for proof of payment. The insurer or employer still owes any interest that accrued up until the date they paid the provider, physician, or other supplier. If they paid the provider, physician, or other supplier before Medicare issued its demand, then proof of such payment is a valid documented defense for the entire debt. However, if the insurer or employer paid the provider, physician, or other supplier after Medicare issued its demand letter, the employer or insurer still owes any interest which had accrued and was due at the time of the payment to the provider, physician, or other supplier. (Proof of payment may include a remittance advice, an EOB (explanation of benefits), cancelled checks and/or spreadsheets/computer print-outs on the insurer's letterhead that establish that the insurer in fact paid the provider, physician, or other supplier.)

Q11. The requirement that Medicare contractors select debts of $5,000 or more during the first part of the fiscal year, and $250 or more during the latter part of the fiscal year could result in contractors sorting the same debts twice.

A11. In PM AB-01-83, CMS answered: If this is true for a particular contractor, they should consider doing the sort a single time and then simply working the larger debts first. With the commitment to refer all eligible delinquent debt by the end this fiscal year and to thereafter remain current with the referral of eligible delinquent debt, this requirement has been eliminated from the debt selection criteria.

Q12. On the Debt Collection System (DCS) there is a field for the Taxpayer Identification Number (TIN). Is this a required field? What do we enter if a TIN is not available? When do we enter a Social Security Number (SSN) as a TIN?

A12. Yes, this is a required field if the TIN information is available. If the TIN is not available, the field must be left blank; a pseudo-number should **not** be entered. The TIN for a corporate entity is the Employer Identification Number (EIN). The TIN for an individual is an SSN.

Q13. How would a Medicare contractor enter a debt into the DCS system to be referred to the PSC/Treasury for the following scenario: The employer/insurer paid the provider/physician/supplier after Medicare issued its original demand letter, the employer/insurer still owes interest which had accrued and was due at the time of the payment to the provider/physician/supplier?

A13. This type of scenario/debt would be entered into the DCS following the DCS manual instructions with the following exceptions. On the Data Entry Screen the contractor would enter in the Principal Referred Amount field, a penny (.01) and in the Interest Referred amount field the amount of interest still due and owed by the debtor. The contractor will enter a comment on the Comments Screen explaining that the debtor has paid the provider all the principal due, but still owes interest on this debt to the Medicare Program.

Q14. Contractors must annotate the demand package "appropriately" when the amount of the debt has been reduced from the amount in the original demand letter. Please explain what is meant by the term "appropriate"?

A14. The original demand package needs to be marked up to show the new amount owed and note on the packet why the amount has changed (due to a partial payment, adjustment, partial defense, Medicare primary for some, etc.) and note what claims are paid and what claims are still due. This annotated/marked up demand packet must be included with the "intent to refer" letter so that the debtor can see exactly what has occurred on their debt owed to the Medicare program. A copy of this annotated/marked up packet must be included in the contractor's case file as an audit trail for the case file. Internal notes to the file or notes on a comment screen are insufficient because they do not clarify matters for the debtor.

60.10 - Exhibits

(Rev. 1, 10-01-03)

60.10.1 - Exhibit 1 - DCIA "Intent to Refer" Letter

(Rev. 15, 4-30-04)

DCIA "Intent to Refer" Letter

[Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

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

Date debt became past-due: **[insert:the 31st or 61st day after demand letter date depending on the type of debt and whether the demand letter set a 30-day time frame for repayment or a 60-day time frame for repayment]**

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

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

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

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

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

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

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

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

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

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

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

Challenging the Indebtedness:

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

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

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

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

[insert: name of Medicare Contractor – MSP Unit], include a copy of this notice and forward both to the address below.]

[insert & instructions: beneficiary GHP-based debt - If the debtor is the beneficiary and the debt is GHP-based debt, CMS does not charge interest to the beneficiary. In these situations, the contractor must delete the standard paragraph which includes information about interest (that is starting with "The past due debt owed....") and insert the following paragraph in its place: The past-due debt owed to CMS is [insert: amount of outstanding debt]. Please make your check or money order payable to [insert: name of Medicare Contractor - MSP Unit], include a copy of this notice and forward both to the address below.]

[insert: Name of Medicare Contractor - MSP Unit

Attention: Manager's Name

Address of Medicare Contractor]

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

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

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

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

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

[insert: Name of Contractor's Contact Person

Telephone Number of Contact Person]

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

Sincerely,

[insert: Name

Title

Contractor's Name - MSP Unit]

Enclosures:

Demand Letter

Claims Summary/Claims Facsimiles

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

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

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

(Rev. 1, 10-01-03)

Cover Instruction Sheet When Contractor Sends Multiple "Intent to Refer" Letters to the Same Debtor in One Package

Date: [Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

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

The Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) has determined that you are indebted to the Medicare program and that the amounts due are delinquent.

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

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

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

(Rev. 1, 10-01-03)

Valid Documented Defense for All Claims Included In the Intent to Refer Letter-- Reply

Date: [Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

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

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

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

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

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

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

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

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

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

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

[insert: Name of Medicare Contractor - MSP Unit

Attention: Contact Person's Name

Address of Medicare Contractor

Telephone Number of Contact Person]

Sincerely,

[insert: Name

Title

Contractor's Name - MSP Unit]

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

(Rev. 1, 10-01-03)

Unacceptable Defense for All Claims in the Intent to Refer Letter - Reply

Date: [Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

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

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

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

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

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

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

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

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

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

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

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

[insert: Name of Medicare Contractor - MSP Unit

Attention: Contact Person's Name

Address of Medicare Contractor

Telephone Number of Contact Person]

Sincerely,

[insert: Name

Title

Contractor's Name - MSP Unit]

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

(Rev. 1, 10-01-03)

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

Date: [Insert: Date]

[Insert: Debtor Name

Debtor Address

Debtor City/State/Zip]

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

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

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

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

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

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

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

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

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

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

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

Please refer to the Demand Letter dated **[insert: date]** for a summary of your obligation and Medicare's rights regarding collection of this debt. Additionally, we are enclosing an updated copy of the summary of claims data sheet that was included with the Intent to Refer letter dated **[insert: date]**. This summary has been annotated to indicate the claims that have been subtracted from our demand because of the rebuttal and/or payment you submitted. The interest due has also been recalculated to take this reduction into consideration.

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

[insert: Name of Medicare Contractor -MSP Unit

Attention: Contact Person's Name

Address of Medicare Contractor

Telephone Number of Contact Person]

Sincerely,

[insert: Name

Title

Contractor's Name - MSP Unit]

Enclosure

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

(Rev. 1, 10-01-03)

Supplemental Guidance on Resolving MSP Debts for Employers, Insurers, Third Party Administrators, Group Health Plans (GHP's), and Other Plan Sponsors

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

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

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

Number 1

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

Number 2

The health plan information that Medicare provided in the original demand letters was, in almost all cases provided by the employer in response to Internal Revenue Service (IRS)/Social Security Administration (SSA)/CMS Data Match questionnaires. In other cases, the health plan information was obtained from the beneficiary, the insurer, or the provider/physician/other supplier that furnished services to the beneficiary. Thus, the information is presumed to be accurate as of the time it was provided. Many employers offer employees the opportunity periodically to choose among several available group health plans. Because CMS was not advised of changes in employees' group health plan choices, the group health plan Medicare identified as providing the health insurance may not be correct as of the date particular services were provided to an identified beneficiary.

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

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

- A copy of the individual claim;
- Date of the original demand letter containing the claim;
- Associated report identification number for that claim as provided in the demand letter;
- Explanation of how the principal payment was determined; and
- Explanation of how applicable interest was computed.

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

Number 3

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

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

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

Number 4

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

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

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

Number 5

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

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

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

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

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

Number 6

Most group health plans (GHPs) have established time limits during which claims must be submitted in order to qualify for payment. If a GHP or any entity responsible for payment under the plan (employer, insurer, third party administrator (TPA), or other plan sponsor ("responsible entities")) does not receive a claim within those time limits, the plan is not obligated to make payment (even if it would be obligated to make payment if

the claim had been submitted prior to the expiration of the time limit). These time limits are typically called "timely filing" requirements. Applicable Federal law limits the ability of any responsible entity (including the employer/insurer/TPA/GHP/other plan sponsor) that received a demand letter to assert a timely filing defense to an MSP-based debt.

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

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

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

The second rule applies to services provided on or after August 5, 1997, and further restricts the use of a timely filing defense. The Balanced Budget Act of 1997 eliminated timely filing defenses for <u>at least</u> 3 years from the date of the service. For services on or after August 5, 1997, there is no timely filing defense if Medicare's original demand letter is dated within 3 years of the date of the service. This rule applies even if the plan's timely filing period is less than 3 years. (<u>If the services were on or after August 5, 1997, and Medicare's original demand letter is not dated within 3 years from the date of the service, then the first rule applies.</u>)

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

- A copy of the individual Medicare claim supplied with the demand letter with the services for which the defense is offered annotated by the entity asserting the defense;

- The date of the original Medicare demand letter containing the claim (and the associated report identification number for Data Match recoveries);

- A copy of plan documents that establish the timely filing period with the applicable provisions annotated; and

- A written statement by or behalf of the recipient of the demand letter that claims records of all responsible entities exist for the time period when the services were provided, were searched, and no record of the services being provided to the beneficiary were found.

Medicare considers all claims for which such a documented defense is provided to be fully resolved, subject to Medicare's subrogated appeal rights described in Step 7.

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

Number 7

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

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

Number 8

As explained in the original demand letter, in addition to its statutory recovery rights, Medicare also has subrogation rights. Medicare utilizes its subrogated rights to appeal a denial of payment due to a timely filing defense and/or seek waiver of the timely filing requirements to the same extent that the patient could appeal and/or seek such a waiver. Where there is a denial of payment based upon a timely filing defense, Medicare's original demand letter must be treated as a request for appeal of that denial. Similarly, if the right to seek a waiver of the plan's requirement exists, Medicare's original demand letter must be treated as a request for waiver. If such rights do not exist, a copy of the plan's documents that explain that such rights do not exist must be provided.

When a patient's rights to appeal a timely filing denial and/or to seek a waiver of the plan's timely filing requirements exist(s), the employer/insurer/TPA/GHP/other plan sponsor must apply the same criteria to Medicare's appeal and request for waiver as they would have had the appeal or waiver request been made by the patient. For example, if the timely filing requirement is always waived for the patient if the claim was not filed timely through no-fault of the patient, the employer/insurer/TPA/GHP/other plan sponsor

must waive the timely filing requirements for Medicare. Accordingly, before a case can be closed with respect to a particular service (or services) due to presentation of a valid fully documented timely filing defense, the employer/insurer/TPA/GHP/other plan sponsor must furnish to the contractor a notification that the appeal and waiver requests have been denied and provide copies of any provision upon which the denial is based. (This documentation is in addition to the information previously described as necessary for a timely filing defense.)

60.10.2 - Exhibit 2 - Instructions for the Required Format and Content of the Monthly MSP DCIA Status Report for Referral/Collection

(Rev. 1, 10-01-03)

Instructions for the required format and content of the Monthly MSP DCIA Status Report for Referral/Collection

NOTE: Both the format and the content of this report have been revised.

The CMS has designed the MSP DCIA Tracking Report to assist in the monitoring and tracking of debts eligible for referral to the Department of Treasury and/or a designated Debt Collection Center (DCC). Medicare contractors **must** complete the MSP DCIA Tracking Report by the 21st of each month for the previous month's activity. The purpose of this report is to provide CMS with a monthly summary of debt selection, debt referral, and collection activity. Entries of the total number and dollar amounts must be included in each column. **The dollar amount column should include both principal and interest combined**. Posted entries are not cumulative from month to month. Each month's debt activity is shown separately. For example:

	Number Selected	**Dollars**
June 2002	800 debts	$100.0 million
July 2002	702 debts	$85.0 million
Total	1502 debts	$185.0 million

In all columns, Medicare contractors will report the number of debts and the associated dollars for the debts that fit within the description of the column heading.

Column #1

Date - Month and year of activity.

Column #2

Debts Selected - This column refers to the potential eligible debt that has been selected for "intent to refer" letters to be sent prior to verification of the debt. Medicare contractors will post the number and dollar amounts under this column heading.

Column #3

Debts Resolved Without Intent Letters - This column refers to debts selected for "intent to refer" letters but, upon verification, it was found that the case could be resolved without an "intent to refer" letter being sent out. These are debts which are fully resolved without the issuance of an "intent to refer" letter. This does not include debts which do not receive an "intent to refer" letter because one of the exclusions from referral is

applicable. This does not include any debts selected and then determined to be eligible for write-off closed. Medicare contractors will post the number and dollar amounts under this column heading.

Column #4

Federal Agency - All debts where the only entity which received the last demand letter is the employer, and the employer is a Federal agency. This information should be posted in the format of numbers and dollars.

Column #5

CMS Identified Exclusions - All debts where CMS has identified a debt or group of debtors as excluded from DCIA referral (except exclusions for federal agency debt and debts under $25) should be posted here in the format of numbers and dollars until they are approved for write-off - closed and removed from the M751/MC751. Currently, the two CMS Identified Exclusions are (1) debts where a Federal agency is involved as the employer but the last demand was issued to the insurer (other than the Federal agency itself), third party administrator, GHP, or other plan sponsor and (2) debts where Amalgamated (including known affiliated and subsidiaries) is involved as the union plan/insurer are excluded, regardless of whether the demand was issued to the employer or to Amalgamated. Contractors should keep these files and totals separate if called upon by CMS to identify these two separate universes.

Column#6

Debts Under $25.00 - All debts identified under the DCIA initiative that are under $25.00 dollars (principal and interest) should be posted here in the format of numbers and dollars until they are approved for "write-off – closed" and removed from the M751/MC751.

Column#7

Other Exemptions – Contractors will report in this column the number and dollars of the remaining exemptions identified in this instruction. (See §60.2 of this chapter, i.e., bankruptcy, appeal and DOJ/Litigation.)

Column#8

Total Exemptions - This column refers to debts selected for "intent to refer" letters that have been verified, but are excluded from referral due to the guidelines outlined in this PM. Medicare contractors will post the number and dollar amounts under each column heading. This column is used to report **ALL** exemptions that have been identified in this PM, as being an exemption from referral to Treasury. (The information to be inputted here is a total of columns 4 through 7 above.)

Column #9

DCIA Intent to Refer Letters Sent - This column refers to all "intent to refer" letters sent out by the Medicare contractors during the month. Medicare contractors will post in this column the number and dollar amounts of all "intent to refer" letters sent to debtors **during the month**. Where an "intent to refer" letter is re-issued, it should not be included a second time.

Column #10

Collections- Medicare contractors will post in this column the number and dollar amount of any collection they receive at the Medicare contractor site during the month for a debt for which an "intent to refer" letter has been issued.

Column #11

Valid Documented Defenses - This column is only for debts for which a valid documented defense is established after an "intent to refer" letter has been issued. Medicare contractors will post in this column the number and dollar amount of any debts that are adjusted (full adjustment or partial adjustment) due to a valid documented defense. This includes adjustments resulting from valid documented defenses provided to the Medicare contractor, the PSC (or the PSC's contractor), or Treasury (or Treasury's contractors).

Column #12

Cases Entered Into the Debt Collection System (DCS) and Referred to Treasury – The information contained in this column shows the number and dollar amount of delinquent debts that have been entered into the DCS system for referral to Treasury by the Medicare contractor during the month.

Monthly MSP DCIA Status Report

(Through column 7. For additional columns, see next page.)

Monthly MSP DICA Status Report												
#1	**#2**		**#3**		**#4**		**#5**		**#6**		**#7**	
Date MM/YY	**Debts Selected**		**Resolved Without Intent Letter**		**Federal Agency**		**CMS Identified Exclusions**		**Debts Under $25.00**		**Other Exemptions**	
00/00	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars
Jun-02												
Jul-02												
Aug-02												
Sep-02												
Total												
Oct-02												
Nov-02												
Dec-02												
Jan-03												
Feb-03												
Mar-03												
Apr-03												
May-03												
Jun-03												
Jul-03												
Aug-03												
Sep-03												
Total FY 03												

Contractor Name and Number	
Month Ending	
Contact and Telephone Number	

Monthly MSP DICA Status Report										
#1	**#8**		**#9**		**#10**		**#11**		**#12**	
Date MM/YY	**Total Exemptions**		**Intent to Refer Letters Sent**		**Collections**		**Valid Defenses – after the Intent to Refer Letter has been sent**		**Cases Input into The Debt Collection System (DCS) and Referred to Treasury**	
00/00	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars
Jun-02										
Jul-02										
Aug-02										
Sep-02										
Total										
Oct-02										
Nov-02										
Dec-02										
Jan-03										
Feb-03										
Mar-03										
Apr-03										
May-03										
Jun-03										
Jul-03										
Aug-03										
Sep-03										
Total FY 03										

Contractor Name and Number	
Month Ending	
Contact and Telephone Number	

60.10.3 - Exhibit 3 - Treasury Address

(Rev. 1, 10-01-03)

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

U.S. Department of Treasury
Financial Management Service
Debt Management Service Branch
P.O. Box 830794
Birmingham, AL 35283

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

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

Program Support Center's (PSC)'s Address

The PSC's mailing address for contractors to send the recall spreadsheets and disk is:

Debt Management Branch
Division of Financial Operations
Program Support Center
Parklawn Building, Room 16A-12
5600 Fisher Lane
Rockville, Maryland 20857

Attn: Mr. Elvis Davis

Telephone Number: (301) 443-4845
Fax Number: (301) 443-8081
E-mail Address: Edavis@PSC.gov

Contacts at the PSC are:
Mr. Elvis Davis
Ms. Janelle Chapman

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

OSI Collections Services, Inc.
P.O. Box 469
Owings Mills, Maryland 21117

Attn: Ms. Gemette Dorsey

OSI's Telephone Number: 1-800-234-3550 or (410) 602-6860
Fax Number: (410) 602-5375

Contact Person at OSI:
Ms. Gemette Dorsey

70 - MSP Accounts Receivable (AR) Procedures

PM AB-01-024, AB-02-102

(Rev. 1, 10-01-03)

70.1 - General

(Rev. 1, 10-01-03)

Contractors have primary responsibility for collecting all MSP debts and are expected to pursue recovery of all accounts receivable (AR) to the fullest extent possible, regardless of the identity of the debtor. However, when AR cannot be collected, an appropriate write-off is required.

Contractors previously received instructions stating non-MSP AR more than two years old would, with limited exceptions, be written off as "write-off - currently not collectible" (CNC) or "write-off - closed." The CMS is implementing these same categories for MSP AR; however, the criteria for selection for these categories and the specific instructions for implementation are different due to the differing natures of MSP and non-MSP debt. As with non-MSP AR, MSP AR that fall within either category of write-off will no longer be considered an AR for financial statement reporting purposes; however, subsequent contractor action will differ depending on the write-off classification.

The AR addressed in this instruction does not require recording on the Provider Overpayment Report (POR) or Physician/Supplier Overpayment Report (PSOR) systems. However, if any of the AR were previously recorded on the POR/PSOR systems, contractors must ensure the AR are removed simultaneously from the POR/PSOR systems when AR write-off is done per these instructions.

70.2 - "Write-Off" - CNC for MSP AR

(Rev. 1, 10-01-03)

This category is determined by CMS central office (CO) (vs. at the contractor level) for MSP AR that are more than 180 days delinquent. CO makes the appropriate adjustment on CMS' financial statements for this category. All such debts are currently on contractors' Form CMS-750 "Statement of Financial Position" and Form CMS-M751 "Status of MSP Accounts Receivable" (CMS-750/751 reports) and must remain on these reports until further notice. The CMS is developing instructions for contractor implementation of MSP CNC and will separately issue these instructions, including MSP CNC reporting instructions.

70.3 - "Write-Off - Closed" for MSP AR

(Rev. 1, 10-01-03)

A. Identification of MSP "Write-Off - Closed" Accounts

Generally, Medicare contractors may recommend "write-off - closed" only debt which is being reported as part of their ending AR balance. (See below for the exception to this rule.) AR that have been **transferred** to ROs for referral to other agencies or entities such as the Department of Justice or Office of General Counsel is addressed by the ROs. MSP AR with CO locations is addressed by CO. AR that have been **referred** to another location, without transfer, remain the responsibility of the contractor.

NOTE: These instructions apply only to established AR. They may **not** be used to close MSP liability/no-fault/workers' compensation leads where no settlement, judgment or award exists and no recovery demand has been issued.

B. "Write-off - closed" means the same thing for MSP AR as it does for non-MSP AR, but the criteria for selection for "write-off - closed" differs.

The definition of "write-off - closed" is AR on which collection activity and servicing of the debt has been terminated. The contractor maintains records of the debts written off as "closed." However, the debts are not be used for future offset or interest accruals. AR approved for "write-off - closed" classification is reported on line 6a, bad debt, of Form CMS-M751.

C. Criteria for MSP based debts to qualify for "write-off - closed" are:

AR meeting either of criteria 1 or criteria 2 below (see subsection D for information on how to measure the time period) are to be recommended for "write-off - closed" unless an exception exists or other justification is provided as to why the debt should not be written off and closed. The exceptions are AR in bankruptcy, under fraud and abuse investigation, with an appeal pending at any level, or included on CO's list of debtors excluded due to ongoing negotiations and/or litigation (see subsection D). ("All MSP AR" means all, without regard to whether the debt is group health plan (GHP) based or liability/no-fault/workers' compensation based and without regard to the type of debtor (employer, insurer, beneficiary, provider/supplier, etc.).)

Criteria 1

All MSP AR more than 6 years 3 months old:

- From the date of the initial demand to the current debtor with no payment or acknowledgement of the debt (Reason 1/R1);
- From the date of the last payment or acknowledgment of the debt by or on behalf of the current debtor (R2); or

- From the date of the initial demand to the current debtor with less than $600 in outstanding principal and no payment, collection, recoupment, offset, or adjustment activity, for 12 months (R3).

Criteria 2

Individual MSP based provider/supplier (including physician) debt and MSP based beneficiary debt that meet **all** of the following should be recommended for "write-off - closed" unless an exception exists or other justification is provided:

- More than two years old from the date of the initial demand to the current debtor;
- Less than $600 outstanding principal per debt; and
- No collection, payment, recoupment, offset, or adjustment activity for 12 months (R4).

The exceptions for either criteria are:

- AR in bankruptcy;
- Under fraud and abuse investigation, with an appeal pending at any level; or
- Included on CMS CO's list of debtors excluded due to ongoing negotiations and/or litigation.

Some contractors establish MSP AR at the Medicare paid claim level rather than at the recovery demand level (that is, if there are three Medicare paid claims involved in a recovery demand, they establish three AR). The $600 figure is based upon the entire debt (the outstanding principal amount), not an individual underlying Medicare paid claim. See subsection D, "Write-Off of Less Than Full Amount (not Permitted)," defining "debt" for purposes of this instruction.

D. Additional Considerations for "Write-Off - Closed" for MSP

New ARs Identified Related to GHP Settlements

Contractors may identify some AR related to GHP settlements. If such AR meet the criteria for "write-off - closed," contractors include them in their "write-off - closed" recommendations to the RO (under R1, R2, R3, or R4, as appropriate). However, if such AR do not meet these criteria, they are **transferred** (not referred) to the RO, after receiving formal acceptance of the transfer from the RO.

Age of Debt

AR must meet the applicable age of debt criteria as of the last day of the quarter prior to the quarter in which the "write-off - closed" recommendation is submitted for RO

approval. For example, for recommendations submitted in the quarter ending June 30, 2003, the AR must have met the applicable age of debt criteria as of March 31, 2003.

Referral to PSC

In accordance with the Debt Collection Improvement Act of 1996 (DCIA), MSP AR which are 180 days delinquent must be referred to the Department's Program Support Center (PSC) for cross-servicing, which includes referral to the Treasury Offset Program. Where a contractor has issued a 60 day notice of CMS' intent to refer the AR to the PSC, the AR may not be recommended for "write-off - closed" until the AR has been referred to the PSC and there has been no collection, payment, recoupment, offset, or adjustment activity for 12 months from the date of the referral to the PSC. This means that for AR for which contractors have issued a notice of CMS' intent to refer the debt to the PSC and which would otherwise meet the criteria for "write-off - closed" set forth in subsection C or subsection C, no recommendation for "write-off - closed" should be made until the referral to the PSC has taken place and there has been no collection, payment, recoupment, offset, or adjustment activity for 12 months from the date of the referral to the PSC.

Litigation/Negotiation

Debtors currently excluded from consideration for "write-off - closed" due to litigation/ negotiations include New York Life, Aetna, and Cigna. This exclusion includes any known affiliates/subsidiaries (no specific list is available). Contractors should be careful to exclude obvious variations/abbreviations of these entities' names. If there are changes to this list, RO MSP coordinators will notify contractors of the applicable changes, including the removal of a particular debtor from the list or the addition of a particular debtor to the list.

Verification of "No Activity in the Past 12 Months"

The phrase "no activity in the past 12 months" requires careful application as it pertains to "write-off - closed." There may be AR in which the oldest of several debts is being collected first and, therefore, no collection activity may appear for the latter years. For provider/supplier (including physician) or beneficiary AR where there has been no activity for 12 months, the contractor shall verify that no collections are being made on other older debts for the same debtor before "write-off - closed" is recommended.

MSP Beneficiary Debt

For MSP beneficiary debt, Medicare may recoup from (1) future Medicare paid claims where the payment is issued directly to the beneficiary, or (2) the beneficiary's Social Security (SS) benefit payments. However, as a practical matter, this is generally an insufficient manner of recovery, particularly as the Social Security Administration (SSA) does not generally accept the referral of debts less than $1,000. Additionally, beneficiaries often delay consideration of repayment until all appeals have been exhausted. Therefore, before recommending a beneficiary debt for "write-off - closed," the contractor shall ascertain that at least 12 months have passed since the date the

beneficiary exhausted all appeal rights with respect to that AR. Contractors must also check the status of all debt which has been referred to SSA for collection before recommending “write-off - closed.” Where a debt referred to SSA for collection is approved for “write-off - closed,” SSA must close/return its file before the “write-off - closed” action is taken.

Referred Debt

Debt which has been referred to the RO or another agency or entity such as the Office of General Counsel or the Department of Justice and is still pending with the RO or that agency or entity is not to be recommended by contractors or approved by ROs for “write-off - closed.”

Write-Off of Less than Full Amount (not Permitted)

Contractors may not recommend “write-off - closed” of less than the full amount of an outstanding “debt.” For GHP-based AR where the demand was issued to the employer, insurer, or third party administrator, GHP, or other plan sponsor, the debt includes all of the claims in a demand to a debtor for a particular beneficiary. For GHP DM (Data Match) recoveries, this would be all of the claims associated with a particular mistaken payment and recovery.

For duplicate primary payment recovery demands to a provider/supplier (including physician), the debt includes all claims in the recovery demand regardless of the number of beneficiaries involved. For liability, no-fault, or workers’ compensation, the debt includes all claims in the recovery demand.

Separate MSP and non-MSP Requirements

Treating MSP based AR as non-MSP based AR (that is, using non-MSP rules) is not allowed.

Contractors must:

- Track and report MSP based provider/supplier (including physician) AR and MSP based beneficiary AR separately from non-MSP AR,
- Report all such AR on Form CMS-M751, and
- Follow the rules for MSP debt regarding referral for DCIA purposes, referral to the RO, write-off (both “write-off - closed” and “write-off - CNC”), or any other debt related activity.

The issue is the treatment of MSP based debt, not the system the debt is tracked in. Contractors may include MSP based AR in the same system as non-MSP based AR (for example, the POR/PSOR) as long as contractors:

- Can differentiate such MSP based AR from non-MSP based AR;

- Report such MSP based AR on their Form CMS-M751; and

- Follow MSP rules for the referral, transfer, or write-off of such debt.

Therefore, contractors may track MSP beneficiary AR or MSP provider/supplier (including physician) AR in the same system as non-MSP based AR as long as MSP and non-MSP are identified and reported correctly.

Multiple Reason Codes

Where an AR meets the criteria for "write-off - closed" under more than one of the reason codes, the contractor shall use a single code in the following order of priority: R1 first, followed by R2, R3, and R4.

R1, R2, and R3 apply to all MSP AR and all require that the AR for the current debtor be 6 years 3 months old from some particular event. This means that where a recovery demand was first issued to an insurer but then later issued to an employer, the six year three month period runs from the date of the demand to the employer. R1 has no dollar limit but requires no payment or acknowledgment of the debt. R2 addresses those situations where there has been some payment or acknowledgment. R3 has a dollar limit but could have had activity as recently as 12 months and one day as long as the dollar limit is met and the initial demand to the current debtor is at least 6 years 3 months old. R4 provides the possibility for an earlier than six year three month "write-off - closed" action but only for MSP based provider/supplier (including physician) and/or beneficiary AR.

Examples:

- A demand for $20,000 was sent to the insurer in January 1993 and then subsequently sent to the employer in January 1995. The 6 years 3 months for R1, assuming there has been no payment or acknowledgment of the debt, would run from January 1995. The employer is the current debtor for purposes of these criteria. Note the requirement/reference to the "current debtor" in R1, R2, R3, and R4.

- A demand for $40,000 was sent to the insurer in January 1993. The insurer paid $35,000 within 60 days. A subsequent demand was sent to the employer in June 1993. The employer paid $2,000 in June 1993, with no further communications after that payment. Assuming the additional considerations in this subsection are met, the contractor recommends "write-off - closed" based upon R2. (The current debtor is the employer. R1 is not applicable because there was partial payment by the employer. R3 is not applicable because of the amount of the outstanding principal.)

- A demand for $30,000 is sent to an employer in January 1995. Payment of $34,000 was made in February 1996. Assume that interest of $4,500 had accrued as of the payment receipt date. The $34,000 payment should have been applied to interest first, leaving an outstanding balance for principal owed of $500. Assume no further payment, collection, recoupment, offset, or adjustment activity. This

AR would qualify for R3 in April 2001 (6 years 3 months from the date of the demand; outstanding principal of less than $600; no activity for 12 months) and could be included in the contractor's recommendation for "write-off - closed" in the recommendations due to the RO on August 1, 2001 (the criteria must be met as of the quarter preceding the quarter in which the list is submitted).

- A demand for $12,000 was sent to a beneficiary in January 1997. Assume that at the time a payment of $12,000 was made in April 1997, $300 in interest had accrued. The $12,000 payment should have been credited to interest first, leaving an outstanding balance for principal owed of $300. Assuming that the additional considerations in this subsection are met and that there has been no payment, recoupment, offset, or adjustment activity for the last 12 months, this AR would meet the criteria for R4. If we assume the same facts except that the demand was sent to the insurer, the criteria for R4 are not met because R4 applies only to provider/supplier (including physician) or beneficiary AR.

Bases for Termination of Collection

Title 42 CFR 401.621 sets forth several bases for the termination of collection action on debts. The criteria set forth in this instruction for "write-off - closed" are based upon CMS' consideration of a combination of the bases set forth in this regulation rather than any single basis. For example, contractors should not assume that the mention of six years for a particular "write -off - closed" means that the basis for the write-off is the statute of limitations. In some situations an AR could be written off as "closed" as of six years from the original demand date solely based upon the statute of limitations. In other situations this would not be true because the statute may have been suspended for some period or started a new due to a particular event, but CMS may have still determined that "write-off - closed" is appropriate because of the likelihood of recovery and/or the cost of recovery, age, or the application of some other factor. Additionally, the fact that SSA may not accept a particular beneficiary debt or level of beneficiary debt for offset does not automatically justify a "write-off - closed" action.

Scope of Instructions

This instruction describe specific criteria for "write-off - closed" recommendations that will routinely be approved by CMS. It is not intended to address every possible situation where "write-off - closed" action may be appropriate. As noted in §70.4, ROs and CO have "write-off - closed" authority beyond the criteria set forth here. In addition, CMS may add additional criteria or implement additional specific "write-off - close" initiatives at a later date.

D. Data requirements and format for recommendations for "write-off - closed"

1. AR recommended for "write-off - closed" require the submission of the following information to the contractor's RO MSP coordinator:

    - Contractor name and number;

- Contractor mailing address;
- Contractor contact person/phone number/fax number/e-mail address;
- Type of MSP Debt (GHP or non-GHP (this includes liability, no-fault, and workers' compensation));
- Beneficiary Health Insurance Claim Number (HICN);
- Beneficiary name;
- Name of debtor;
- Name of insurer **for GHP based debts** where the current debtor is the insurer/employer/third party administrator/GHP/other plan sponsor;
- Type of debtor (A = insurer/employer/third party administrator/GHP/other plan sponsor; B = provider/supplier (including physicians); C = beneficiary, D = other (must specify));
- Date of initial recovery demand letter to current debtor =;
- Original AR amount for the current debtor;
- Existing AR amount (principal and interest listed separately, as well as a total amount for principal plus interest; HI/SMI must also be listed and reported separately);
- Date of last payment, collection, recoupment, offset, or adjustment activity (provide date or "none");
- Basis for recommendation (R1, R2, R3, R4, or R5);
- Tax Identification Number (TIN) for debtor. (The TIN is the Employer Identification Number (EIN) or Social Security Number(SSN);

NOTE 1: The debtor is the individual or entity to whom/which the last recovery demand was issued. Where the demand was issued to an individual in their capacity as legal counsel or representative of any type, the debtor is the beneficiary, provider/supplier (including physician), or other individual or entity being represented. Where recovery is being pursued from the attorney or other representative in their own right, the debtor is the attorney or other representative.

NOTE 2: The above listed data elements are mandatory for "write-off - closed" for all MSP AR established October 1, 2000, or later. It is also mandatory for all MSP AR with a recovery demand date of October 1, 2000, or later, regardless of when the AR was established (see §70.5). Where the TIN is unavailable, the contractor's write-off recommendation should leave this field blank. For "write-off - closed" recommendations

for AR established prior to October 1, 2000, contractors may submit recommendations without the following data elements if the “write-off - closed” recommendation certifies that these data elements are not readily available: beneficiary name and HICN where the beneficiary is not the debtor; insurer name where the insurer is not the debtor; and type of debtor.

NOTE 3: If a contractor has bulk ARs on the GTE system for older DM and non-DM GHP debt, the contractor - for these AR only - must:

1. Identify the AR as a bulk receivable on the GTE system,
2. Identify the insurer,
3. Identify the date of the demand, and
4. Identify the associated dollar amounts for principal and interest.

Any contractors who created bulk receivables for GHP based MSP debt using any system other than GTE must contact their RO for assistance. The RO will, in turn, discuss the issue with CO.

2. Subtotals for GHP based AR vs. non-GHP based AR (liability/no-fault/workers’ compensation) are required, and within GHP or non-GHP the AR must be grouped together by each different basis for the recommended “write-off - closed” action.

3. Each listing must contain a written certification that all of the criteria/considerations set forth in this instruction for “write-off - closed” are met. (See subsection E.)

4. A copy of the case file must be submitted to the RO for “write-off - closed” recommendations for all AR where the outstanding principal exceeds $100,000 except for bulk AR from the GTE system.

5. "Write-off - closed” recommendations should be submitted in the format shown in §70.8, Exhibit 1, below. (This spreadsheet format contains the required contractor certification.) The Vice President (VP) must sign recommendations for Medicare Operations. The VP’s signature constitutes their certification to all information/statements contained in the recommendation.

E. Write-Off Approval Process

1. Changes should not be made to the AR on any systems (contractor systems or other systems which contractors have responsibility for updating) for “write-off - closed” until the recommendation for “write-off - closed” has been processed by CMS, approved in writing, and returned to the contractor. The listing of approved

write-offs will be returned to the contractors by the ROs. Receipt of this approval authorizes the contractor to write-off the AR, and update the AR and associated case in all appropriate systems. Where the RO does not approve a recommended "write-off - closed" for a particular debt, the RO will annotate this clearly on the returned form.

2. CMS approval of AR written off must be retained and be available upon request (for the Office of the Inspector General or any other internal or external review organization) in accordance with retention procedures in the Medicare Intermediary and Carriers Manuals. Contractors are also reminded that under the Department of Justice's requested records freeze, all records must be retained indefinitely. This CMS approval must also be annotated by the contractor to indicate the date/quarter when the contractor writes off the AR.

F. Financial reporting for MSP "write-off - closed"

The following reporting is required for write-off of debts by contractors:

1. Associated "interest" for write-off - Contractors should use the amount of interest currently carried on Form CMS-750/751 reports for a particular AR. If a contractor's system has not automatically updated interest, the contractor should **not** calculate and update interest.

2. AR currently on Form CMS-750/751 reports will be written off as "closed." This action may not be taken until the contractor receives written approval from the RO. Contractors will record these write-offs as follows:

    a. On Form CMS-M751, the amount that CMS has approved for write-off, including principal and interest, is recorded on line 6a, bad debt. This will reduce the ending balance reflected on Form CMS-M751 (which flows to Form CMS-750 and Form CMS-751). The CMS recognizes that, for those systems where interest is updated automatically, the interest submitted with a recommendation for "write-off closed" may differ from the interest shown in the contractor's system at the time the contractor receives approval for the write-off. The CMS approval of the principal and interest recommended for "write-off -closed" is sufficient support for the subsequent write-off, including any increase in the interest, as long as the principal remains the same.

    b. The correct ending balance (reduced by the written off debt) is reported on the appropriate line in the asset section of Form CMS-750. Accordingly, the bad debt expense in the expense portion of Form CMS-750 should be increased to reflect the value of the principal portion of the debt written off (line 6a of Form CMS-M751). A reduction in revenue on the bad debt line is recorded in the revenue section of Form CMS-750 for the value of the interest written off.

    c. The contractor shows in the remarks section of Form CMS-M751 each quarter the amounts (principal and interest) that were written off as "closed" as a

result of implementation of this instruction. (These remarks must be carried over to Form CMS-751.)

G. Contractor Mailing Instructions

1. The contractor sends recommendations for the approval of “write-off - closed” to the RO MSP coordinator electronically and by hardcopy no later than the 1st day of the second month of each quarter (November 1, February 1, May 1, August 1). Hard copies must be dated and mailed the same day as the electronic transmission. The VP of Medicare Operations must sign the hardcopy.

2. The contractor must include a preprinted address label with the hardcopy for the return of approved write-off reports.

H. Annotation of Associated Case File to Show Case Closed and Date and Quarter of the Write-Off.

Contractors must also perform all other appropriate actions in connection with closing a case. This includes updating MPaRTS (where applicable, and using the standard MPaRTS codes for closed with no recovery or partial recovery) and all other affected systems (POR/PSOR, or other standard or internal contractor system where the case or debt has been recorded), as appropriate. No MPaRTS update should be done at the time a DM AR is recommended for “write-off - closed.” The contractor shall update MPaRTS within 10 days of taking the approved “write-off - closed” action on a particular AR.

I. Contractor Identification of Debt Meeting The Criteria For “Write-Off - Closed” Not Being Carried On Form CMS-750/751 Reports

Such debt must also be submitted to the RO for “write-off - closed” approval on a separate recommendation. The CMS expects such debt to be rare.

The format and all information for this recommendation should be the same as the recommendation for debt being carried on Form CMS-750/751 reports; however, the recommendation report should prominently state that it refers to debt that is **not** being carried on the contractor’s Form CMS-750/751 reports. Additionally, because such debt is not being carried on Form CMS-750/751 reports, it would **not** be reported on line 6a, bad debt, on the Form CMS-M751.

70.4 - RO Responsibilities

(Rev. 1, 10-01-03)

A. “Write-off - Closed"

ROs are responsible for approval or denial of all recommendations for “write-off - closed” for MSP AR made based upon the criteria set forth in §70.3.

NOTE: For any other MSP AR "write-off - closed" requests which do not meet the criteria set forth in §70.3, ROs have approval authority within the limits of their delegated Federal Claims Collection Act (FCCA) authority. (In addition to limitations on the dollar amounts that ROs may approve, RO FCCA authority does not include third party payer debt.) ROs must obtain CO approval for all other "write-off - closed" recommendations, including debts of more than $100,000. CO will be responsible for any necessary referrals to the Department of Justice.

RO approval must be by the ARA for Financial Management. ROs must complete their review of contractors' recommended write-offs and return their approval or denial of such write-offs by the 1st of the last month of each quarter (December 1, March 1, June 1, September 1). ROs may return an electronic copy annotated to show approval or denial by the RO ARA for Financial Management in order to meet the required time frame for approval, but this must be followed by a hardcopy that was signed and dated by the ARA for Financial Management, within the required time frame.

Where an RO does not approve a recommended "write-off - closed" for a particular AR, the RO must annotate this clearly on the returned form. This information must be clearly shown on both any advance electronic copy of the approval as well as the hardcopy signed by the ARA for Financial Management. ROs must send copies of the signed RO approval or denial each quarter to CO to the attention of: (1) Chief, MSP Operations Branch, Division of Financial Integrity, Office of Financial Management; and (2) Chief, Financial Reporting and Oversight Branch, Division of Accounting, Office of Financial Management.

ROs must include transfer debt on Form RM751. Form RM751 must show the transfer in of this AR (on line 5b) and then must write-off the amount of the AR as a bad debt (on line 6a.

Where the contractor treats MSP based provider/supplier (including physician) AR and/or MSP based beneficiary AR as non-MSP AR, the RO must process such AR in the same manner that the contractor is processing such AR. If an MSP based provider/supplier (including physician) AR or an MSP based beneficiary AR is carried on the contractor's Form CMS-751 but not on the contractor's Form CMS-M751, then the AR must be carried on Form R751 but not on Form MSP R751 - that is, the reporting by the contractor and the RO must be consistent with regard to whether an AR is or is not included in Form M751.

70.5 - Elimination of Automated/Systems "Write-off - Closed" Actions for MSP AR; Reminder Regarding Zero "Backend Tolerance" for MSP AR

(Rev. 1, 10-01-03)

Some contractor and/or standard systems include automated "write-off - closed" actions for certain MSP AR based upon the outstanding amount of the AR (often referred to as a "backend tolerance"), the age of the AR, or other criteria, without specific CMS approval

of the write-off of individual AR. All such automated “write-off - closed” actions must cease as soon as appropriate systems changes are made. Contractors are prohibited from performing any manual write-off actions without specific approval for such actions and were previously reminded in the Fiscal Year 2001 Budget Performance Requirements that there is no “backend tolerance” for MSP AR. MSP AR “write-off - closed” actions may take place only after recommendation for “write-off - closed” is made to CMS and written approval for such write-off is received by the contractor. Reduction of the outstanding principal below a certain amount does not automatically justify a “write-off - closed” action nor does the age of an AR, by itself, always justify a “write-off - closed” action. Changes must be made to both the standard systems and contractors systems, where necessary.

Any contractors currently performing such automated “write-off - closed” actions must track all such future automated write-offs in sufficient detail to enable the contractor to take future corrective action once CMS issues instructions for corrective actions for these automated “write-off - closed” actions.

NOTE: The CMS has not approved an automatic “write-off - closed” action, automated or otherwise, for any type of AR (MSP or non-MSP AR). Systems changes will need to be made as necessary to all affected systems. This issue will be addressed further for non-MSP AR in a separate instruction.

70.6 - Date for Establishment of MSP AR

(Rev. 1, 10-01-03)

MSP AR must be established as of the date of the recovery demand letter or the payment receipt date, **whichever date is earlier**. This includes unsolicited/voluntary refunds. In most instances, the contractor does not receive payment until a recovery demand letter is issued. However, particularly in MSP liability situations, a contractor may receive payment (including an unsolicited/voluntary refund) before a recovery demand letter is issued. Where this happens, the AR should be established in an amount equal to the amount of payment until further development/research is completed. Once the development/research is complete, the contractor may need to do an adjustment and refund of any excess payment or an adjustment to increase the amount of the AR with an accompanying demand letter explaining why the payment was insufficient, depending upon the results of the development/research.

Contractors may not delay establishment of the AR until payment is received. The fact that standard systems users may need to manually calculate the AR at the time the demand is issued is not a basis for delay in establishment of the AR (the amount of the AR needs to be calculated in order for the demand to be issued, regardless of when the AR is established). The contractor with responsibility for issuing the recovery demand letter in a liability, no-fault, or workers’ compensation case is the contractor with the responsibility for establishing the AR

70.7 - Additional Instructions for "Write-Off - Closed" for Debts of Less Than $25.00

(Rev. 1, 10-01-03)

- MSP has no front-end tolerance with respect to sending an initial demand for: (1) liability, no-fault, or workers' compensation based recoveries; (2) duplicate primary payment recoveries; /or (3) "42 CFR 411.25 Notice" recoveries.

- Established debts must be less than $25.00 including both principal and interest to be considered for "write-off–closed" based upon this criterion.

- Where an initial demand letter is for less than $25.00 and there is no response within 60 days, the debt may be recommended for "write-off - closed" on the next quarterly "write-off -closed" recommendation report sent to the RO.

- Contractors must reply to any response to a demand letter appropriately, regardless of the amount at issue.

- Where an initial demand is for more than $25.00 and partial payment has reduced the debt to less than $25.00 (principal and interest), the debt may be recommended for "write-off – closed" on the next quarterly "write-off – closed" recommendation report sent to the RO.

- Contractors should use Reason 5/R5 when recommending debts less than $25.00 (principal and interest) for "write-of – closed."

Debts involved in a pending bankruptcy cannot be recommended or approved for "write-off - closed." Debts that are discharged/forgiven by the bankruptcy court are to be recommended for "write-off – closed" on the next quarterly "write-off – closed" recommendation report sent to the RO after the Medicare contractor receives appropriate notification/documentation of discharge even if the debts do not meet the criteria for R1, R2, R3, R4, or R5. If there are questions about the documentation regarding discharge, Medicare contractors should consult their RO. Reason B/RB is used when recommending a "write-off – closed" action for a MSP debt discharged in bankruptcy.

All debts which are excluded from DCIA referral due to litigation or a CMS identified exclusion are also subject to exclusion from "write-off - closed" absent specific instructions to the contrary for a particular debtor.

- See §60.1 of this chapter for these DCIA exclusions.

- This statement does not change the list of "write-off - closed" exclusions previously communicated; it simply provides another way of identifying some of these exclusions.

- See §60.2 of this chapter for specifics about "write-off - closed" for New York Life due to the conclusion of the New York Life litigation.

- See §60.2 of this chapter for specifics about Aetna and Cigna debt. Contractors should not recommend any Aetna or Cigna debt for "write-off closed" if it is excluded from referral based upon the dates set forth in this section. They may recommend other Aetna or Cigna debt if the debt otherwise meets the criteria for "write-off – closed."

ROs are responsible for approval or denial of all recommendations for "write-off – closed" for MSP account receivable made based upon the criteria set forth in these instructions.

70.8 - Exhibit 1 - MSP Accounts Receivable: Contractor Recommendation for “Write-Off - Closed"

(Rev. 1, 10-01-03)

Contractor Name and Number:

Contractor Contact Person/Phone/Fax/E-mail Address:

Contractor Mailing Address:

Name of Insurer:

Type of MSP Debt	Beneficiary HICN	Beneficiary Name	Debtor Name	Debtor Type	Date of Initial Demand to Current Debtor	Original AR Amount for Current Debtor	Outstanding Principal Balance (HI)	Outstanding Interest Balance (HI)	Outstanding Principal Balance (SMI)	Outstanding Interest Balance (SMI)	Total Principal and Interest	Date of Last Payment, Offset Recoupment, or Adjustment	Reason Code	TIN of Current Debtor

(Provide totals for each column if applicable)

Vice President of Medicare Operations: (signature required) (Signature constitutes certification that all CMS specified criteria for "write-off closed" are met.)

Associate Regional Administrator/Division of Financial Management: (signature required) ___ Concur ___Non Concur

Date of Referral to RO : _____

Date of RO decision: _____

Date/quarter when approved AR are written-off as closed: _____

80 – Federal Bankruptcy/State Insurer Liquidation Actions and Medicare Secondary Payer (MSP) Debt

(Rev. 1, 10-01-03)

PM AB-03-107

Action must be taken to safeguard the Medicare Trust Fund when an MSP debtor files a Federal bankruptcy notice or is ordered liquidated by a State government.

A – Federal Bankruptcy Proceedings

Types of Federal bankruptcy filings that may involve Medicare MSP debtors include:

1. **Chapter 7** - Debtor files under this chapter to obtain discharge of their debts (liquidation). Companies generally close that file under this chapter. A court-appointed trustee cumulates the assets of the debtor, sells them and distributes the money among those whom the debtor owes (creditors).

2. **Chapter 9** - This type of bankruptcy involves municipalities such as a hospital district. This chapter provides for re-organization, much like Chapter 11.

3. **Chapter 11** – Debtor files under this chapter to re-organize his business. (the purpose of this chapter is to restructure company finances so that the debtor can continue to operate). To emerge from Chapter 11 the debtor submits a "Reorganization Plan." This Plan indicates the amounts and schedules for payments to creditors. Creditors vote on the Plan and the bankruptcy court must confirm the creditors' decision. Recovery amounts may vary. The Bankruptcy Code provides for the discharge of any remaining debts.

4. **Chapter 13** – Debtors are individuals (including sole proprietorships) with regular income. Generally the debtor must file a debt adjustment plan within 15 days after filing (it is better to file a proof of claim as early as possible after the filing date). This chapter allows the debtor to keep property and to pay debts over time, usually from three to five years.

B – State Ordered Insurer Liquidations

The State may order insurers authorized to do business in that State liquidated under certain circumstances. Generally, this occurs following:

1. A determination by a State agency (e.g., Insurance Commission) that an insurer is insolvent or operating in financially hazardous manner and

2. An order by a State Court that the insurer be liquidated. The assets of the insurer are sold and the proceeds are used to pay claims against the debtor as ordered by the Court.

C – Importance of Filing Date

The filing date (i.e., the date a petition of bankruptcy is filed with the U.S. Bankruptcy Court or a petition for insolvency (liquidation) is filed with the State courts) distinguishes "pre-petition" services from "post-petition" services. Events that occur **on or before** the petition date are pre-petition. Events that occur **after** the petition date are post-petition. Medicare's right to recover in these situations will depend on when services were provided.

80.1 – Notice of Bankruptcy/Liquidation

(Rev. 1, 10-01-03)

The CMS through its RO or contractors may receive notice of bankruptcy/liquidation from many sources, including:

- The debtor/entity filing the bankruptcy or being liquidated;
- The State; or
- Information received by the RO in the course of non-bankruptcy activities such as information from the RO provider certification staff or regional counsel.

It is imperative to act quickly when a debtor/entity files for bankruptcy or is ordered liquidated in order to meet the filing deadlines established by the bankruptcy court/liquidation court.

The RO staff and contractors must be alert to news for potential bankruptcies/liquidations and/or bankruptcy/liquidation filings by debtors/entities. Contractors must report any bankruptcy/liquidation information immediately to their MSP RO Coordinator, via telephone call, fax, or hardcopy.

NOTE: Information sent by Internet e-mail to the RO is not secure. Contractors should refrain from Internet e-mail communications.

80.2 – Recovery Efforts

(Rev. 1, 10-01-03)

A - RO's Role

The RO must gather basic information, such as date of bankruptcy, court where the bankruptcy was filed, bankruptcy chapter, debtor/entity name, EIN, etc. This information is listed in the RO's Bankruptcy Manual, §4.

The RO's have the responsibility to be proactive in establishing and maintaining ongoing communications with their regional counsel. This is important because Court rules may differ significantly from one jurisdiction to the next.

B – Contractor's Role

When a contractor has received notification of a bankruptcy/liquidation or potential bankruptcy/liquidation situation, in their MSP department, the Contractor must immediately notify their MSP RO coordinator. The contractor must request a copy of the petition for bankruptcy/liquidation from the debtor/entity (if not already received). Once the petition is received, the Contractor must copy the entire file, add a cover letter and forward to their MSP RO coordinator. Contractors must maintain the original file. Contractors are responsible to ensure the MSP department is made aware of all non-provider/supplier bankruptcy/liquidation notifications received at the Contractor.

When a contractor learns of a bankruptcy/liquidation filing they are required to research and identify **all** MSP debts specific to the bankrupt/liquidation debtor/entity.

Pursuant to the type of bankruptcy/state ordered liquidation filed, contractors must take the following actions:

Chapter 7 – Liquidation

1. Cease new MSP recovery demands for the debtor involved in bankruptcy proceedings, regardless of filing dates.

2. Recall from Treasury previously referred debts for the debtors. Do not do any further referrals to Treasury for these debtors.

3. Report the debt on the financial statements within the appropriate bankruptcy detail line of the Form CMS-751 reports.

Chapter 9 – Municipal Reorganization

Follow the Chapter 11 guidance, set forth below.

Chapter 11 – Reorganization

1. Cease recovery efforts and do not issue new MSP recovery demands for claims with dates of service **on or prior** to the filling date of the bankruptcy.

2. Pursue debts for claims having dates of service **after** the filing date, after consulting with regional counsel. These debts are enforceable.

3. Recall any debt involving dates of service **on or prior** to the filing date which have been referred to Treasury.

4. Report the amount of debts **on or prior** to the filing period in the appropriate CFO detail line as well as other pertinent reports (i.e., Debt Collection Improvement Act (DCIA) status reports).

NOTE: When a debtor that is in Chapter 11 subsequently converts to Chapter 7, contractors must follow Chapter 7 guidelines as outlined above.

Chapter 13 – Individuals

In the event that a contractor has or receives notice of this bankruptcy type, the Contractor must contact their RO MSP coordinator for further instructions.

State Ordered Liquidation

Contractors should follow the procedures above for Chapter 7 liquidation for the State liquidation proceedings.

Bankruptcy debts discharged by the U.S. Court/Liquidation debts discharged by State Court

Debts involved in a pending bankruptcy/liquidation cannot be recommended or approved for "write-off closed." Debts that are discharged/forgiven by a U.S. Bankruptcy Court/State Court are to be recommended for "write-off closed" on the next quarter's "write-off closed report." If there are questions about the documentation requirements regarding discharge, the Contractor must obtain advice from the RO. Reason B/RB must be used when recommending a "write-off closed" action for an MSP debt discharged in bankruptcy/liquidation.

Bankruptcy debts dismissed by the U.S. Bankruptcy Court

Occasionally, the U.S. Bankruptcy Court dismisses a bankruptcy action because the debtor does not qualify for bankruptcy or for some other reason. When there is a dismissal, with the advice of regional counsel, the RO and contractor can usually treat the case as if the bankruptcy action never occurred and continue the normal recovery process. (See CR 2145, PM AB-02-102 for specifics about the recovery process.)

80.3 – When Office of General Counsel (OGC) Pursues a Medicare Claim on CMS' Behalf

(Rev. 1, 10-01-03)

As a result of notifying the RO's of a bankruptcy filing, the regional OGC will make, in consultation with CMS, a decision as to the pursuit of a claim. When OGC does pursue a claim on behalf of Medicare, the RO's will notify contractors of this decision and the need to quantify Medicare's claim. Contractors must take the following actions:

1. Contractors must transfer established debt (including principal and accrued interest) as of the filing date to the lead RO (see note below).

2. Contractors must document the transferred debt as specified in instructions found in the Medicare Intermediary Manual Part 1 - Fiscal Administration Manuals §1960.17, Exhibit 17, and Medicare Carrier Manual Part 1 – Fiscal Administration Manual §4960.10, Exhibit-10.

3. Debts **on or prior** to the bankruptcy filing period where OGC on behalf of CMS **does not** plan to pursue a claim must be reported in the appropriate bankruptcy detail line of the financial reports, as well as other required CMS reports (i.e., DCIA status reports).

NOTE: Once a contractor has converted to HIGLAS, bankruptcy debts will no longer need to be transferred to the RO.

Reminder: The RO that has jurisdiction over the State in which the debtor/entity files bankruptcy usually is the lead RO. Contractors will be notified of any exceptions as they occur.

A list of known bankrupt debtors and liquidated debtors will be supplied to the contractor by its RO and subsequent bankrupt/liquidation debtor notifications will come from the RO.