Program Memorandum Intermediaries/Carriers

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal AB-02-102 **Date: JULY 24, 2002**

CHANGE REQUEST 2145

SUBJECT: Medicare Secondary Payer (MSP) Debt Referral and Write Off Closed Instructions: 1) Expansion and Clarification of MSP Debt Collection Improvement Act of 1996 (DCIA) Activities; 2) Additional "Write-Off -- Closed" Instructions (Supplemental Instructions for PM AB-01-24)

This Program Memorandum (PM) incorporates and modifies PM AB-01-83 (CR 1538) to expand the MSP DCIA referral process to all MSP debts and debtors. PM AB-01-83 is now obsolete. PM AB-01-83 (CR 1538) previously addressed MSP DCIA activities only for certain third party payer Group Health Plan (GHP)-based debt. MSP DCIA activities now include all GHP-based debts, including those where the debtor is the provider, physician, other supplier, or beneficiary. Additionally, MSP DCIA activities also now include liability and no-fault- based debts of all types for all debtors, as well as workers' compensation-based debts for all debtors.

To the extent possible, changes from PM AB-01-83 are in italics in the text below in Sections I-X. However, contractors should read these sections in their entirety. Changes to the Attachments have not been put in italics. The letters in the Attachments have some revisions (including, for example, a change regarding the interest information provided in the "intent to refer" letter), and the monthly tracking report has significant revisions. Contractors must use the Attachments to this PM in place of the Attachments to PM AB-01-83.

Section XI contains additional instructions for "write-off-closed" activity for MSP debt. These instructions supplement PM AB-01-24.

The instructions contained in this PM do not require nor does CMS request Medicare contractors to make changes to their standard systems or their internal systems. CMS will attempt to accommodate standard/non-standard systems changes in the future as the standard/non-standard systems' release queue and/or funding permits.

The instructions for the DCIA referral process for MSP differ in some aspects from the instructions for the DCIA referral process for Non-MSP.

I. Background

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 *Centers for Medicare & Medicaid Services (CMS)* is mandated to refer all eligible debt, over 180 days delinquent, for cross-servicing, including the Treasury Offset Program (TOP).

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 section II. 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.

II. Debt Selection, Verification of Debt, and Updating of Interest

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 PM.

- 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. 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*s* for a particular debtor that *were* 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, 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 Section III. of this PM 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). See Section II. above for the definition of "debt" for purposes of this PM.*

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 General 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;
- 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 dollars (principal and interest). (This threshold was used as a debt selection criterion (vs. an exclusion) in PM AB-01-83. As debts under $25.00 dollars are excluded from referral, CMS has changed this aspect of the instructions.) See Section XI 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. 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 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 also, Change Request 1280/PM AB-01-24 and section XI of this PM 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. See PM AB-00-11 and PM AB-01-24 (section lll.D2.a) for specifics about various settlements and appropriate contractor action for the claims affected by those settlements.

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

Data Match (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 will be "IL". The status code on MPaRTS when the debt is referred to the Program Support Center (PSC) will be "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.

III. "Intent to Refer" Letter and Inquiries/Replies Related to DCIA Activities

PM AB-01-83 contained a "200/500" minimum monthly standard for contractors for the issuance of "intent to refer" letters and/or the resolution of selected debts. The PM required Medicare contractors 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 set forth in PM AB-01-83. All debts which are or will become 181 days delinquent on or before September 30, 2002, must be resolved or have 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 PM AB-01-24, February 2001.) *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, as indicated in PM AB-01-24 (see Section III.D.2.(c)), once such a debt has been referred for cross-servicing/TOP, it may be recommended for "write-off -- closed" if it meets the criteria set forth in PM AB-01-24, 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" (see section II for definition)*. *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). (Contractors should also refer to the definition of "debtor" in Section II of this PM.)* **Use of the attached "intent to refer" letter is mandatory (including a copy of the last demand letter and all attachments to the demand letter)** (see Attachment 1 – DCIA "Intent to Refer" Letter *(revised subsequent to PM AB-01-83) and Attachment 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. *Attachment 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 Attachment 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* <u>*demand packet*</u> *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, they must reply using the letter in Attachment 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 file. 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 7 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 Section II., 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 <u>for each package</u> of "intent to refer" letters when multiple "intent to refer" letters are sent to the same debtor at the same time. (See Attachment 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 <u>not</u> 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 Section II. 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**.**

IV. <u>DCS System, DCS Input, Debt Transmission, Documentation to PSC</u>

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 contactors 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 PM 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 which 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. (Medicare contractors must also remember that 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 input certified debts directly to the database. *(The user ID is the same one used for access to MPaRTS.)* When inputting the debt into the DCS system, the status code used

will be "UU" except for debts where the "intent to refer" letter was undeliverable which will be input with a status code of "UN" ("UU"= initial entry of the debt for referral; "UN" = undeliverable 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 Attachment 3 of this PM. *Contractors received 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 they have in-house and it is not within their authority to resolve, they must send an Electronic Control Response System (ECRS) inquiry to the Coordination of Benefits (COB) Contractor. The COB Contractor will investigate the query to resolution and update 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, the debt (both principal and interest) must be reduced accordingly **before** the remaining debt is entered into the DCS. On the Comments Screen of the DCS, the Medicare contractor will enter 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. The balance must be annotated to show principal amount, interest amount, and total amount.

V. Actions Subsequent To DCS Input

NOTE: *As indicated in Section IV., 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 will, via the RO, furnish 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 will 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 will notify 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 HCFA-750 (Statement of Financial Position"), Form HCFA-751 (Status of Accounts Receivable), and Form HCFA-M751 (Status of MSP Accounts Receivable") (HCFA 750/751 reports).)

Medicare contractors may receive telephone inquiries/questions on debts that have already been referred. Medicare contractors must 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 a *letter from an entity responsible for cross-servicing*, then the Medicare contractor must instruct 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 is instructed to 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 will be used to pull back *a debt that was previously referred* or adjust the amount remaining at the PSC, as appropriate. Medicare contractors must 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 activity *and send it to the PSC in Rockville, Maryland.* If a collection is received, the Collection Screen must also be updated. DCS updates must be done within *15 calendar* days.

- If *a cross-servicing entity* discovers an error, collects, receives information establishing 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* via Central Office (CO) and the Regional Office (RO). The Medicare contractor will not complete a recall report in this situation even if the *cross-servicing entity* has consulted with the Medicare contractor or obtained Medicare contractor concurrence on the action involved. However, the Medicare contractor must update the DCS within *15* calendar days of receiving a case status report of the applicable action via the CO and RO. All three DCS screens must be updated, as appropriate. If *a cross-servicing entity* receives any partial or full collections for debts that have been referred, PSC will notify CO via an *Intragovernmental Payment And Collection (IPAC)* report. (The IPAC report was previously known as the Online Payment and Collection (OPAC) report.) The notification subsequently furnished to the Medicare contractor will detail how the collection was applied. The Medicare contractor will update the DCS system and adjust or close their internal records accordingly.

- When the *PSC/Treasury* takes action to reduce/eliminate a debt due to payment or a valid documented defense or otherwise terminates activity on a case, supporting documentation will be forwarded to the Medicare contractor. (Where the PSC or PSC contractor has received payment, this supporting documentation will be the report furnished by CO, via the RO, regarding collection of the debt.) (Reports on PSC activity are expected to be available no less than monthly.)

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 is to follow normal procedures for bankruptcies.

VI. MSP DCIA *Tracking* Report for Referral/Collection

CMS has 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 Attachment 2 - *MSP DCIA Tracking* Report for Referral/Collection, *revised subsequent to PM AB-01-83*). Medicare contractors must submit this report by the *21st* of each month for the previous month's activity. This report is a manual report. All Medicare contractors must forward the completed report to *their RO MSP Coordinator.* A copy must also be sent to *CO to a special mailbox that CO has designated for these reports. Contractors will 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 are contained in Attachment 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 are reminded that they need to be able to readily access the records for and identify all debts selected for the DCIA process which 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 hard copy due to privacy considerations.*

VII. Monitoring Debts Excluded from the DCIA Referral Process

Medicare contractors must monitor *and report on* debts that were selected for potential referral but met one of the exclusions to the DCIA referral process. Contractors are to monitor and determine any change in their status 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*).

VIII. Financial Reporting

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 will remain on Medicare contractors' internal records, remain on contractor systems, and be reported on Form HCFA-750

("Statement of Financial Position"), Form HCFA-751 (Status of Accounts Receivable), and Form HCFA-M751 ("Status of MSP Accounts Receivable") and *Form HCFA-MC751 for MSP "Write-Off -- Currently Not Collectible Debt" (collectively known as Form* HCFA 750/751 reports).

NOTE: *Medicare Contractors must refer to Change Request 1659 (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 will continue to accrue interest on a debt after the debt is entered into the DCS system. Although the DCS will not reflect this additional interest unless/until DCS is updated in connection with a collection, the PSC does take 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.

Contractors may not take any CFO action (adjustment due to a valid documented defense, collection, etc.) for debts resolved by the PSC *or Treasury* (or the PSC contractor *or a Treasury contractor*) until official notification is received from *CMS.*

Medicare contractors must maintain detailed support for all information reported on the monthly MSP DCIA *Tracking* Report.

IX. Compromise Requests, Extended Repayment Agreement Requests, *and Waiver of Interest* Requests

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 at 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 will review each case individually, write a recommendation, and forward *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 will communicate 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, will handle 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 Social Security Act (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.

X. Miscellaneous Questions and Answers

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 <u>you</u> 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 section III. 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 Section III. of this PM, 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 Section II. of this PM.*

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* *<u>as set forth in PM AB-01-83</u>* *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.

XI. Additional Instructions for "Write-Off-Closed" for MSP Debts (Supplemental Instructions for CR 1280/PM AB-01-24)

The following rules apply with respect to "write-off -- closed" for debts of less than $25.00:

- *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." (PM AB-01-24 included definitions for R1 –R4 but mistakenly referenced a non-existent "R5" in section III.E.1.)*

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-of f-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 should be 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-of f -- closed" absent specific instructions to the contrary for a particular debtor.

- *See section II of this PM for these DCIA exclusions.*

- *This statement does not change the list of "write-off – closed" exclusions in CR 1280/PM AB-01-24, section III.D.1.a., it simply provides another way of identifying some of these exclusions.*

- *See section II. of this PM for specifics about "write-off – closed" for New York Life due to the conclusion of the New York Life litigation.*

- *See section II. Of this PM for specifics about the for the 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 (which supplement CR 1280/PM AB-01-24.

The *effective date* for this Program Memorandum (PM) is July 26, 2002.

The *Implementation date* for this PM begins July 26, 2002. (CMS will attempt to accommodate standard/non-standard systems changes in the future as the standard/non-standard systems' release queue and/or funding permits, but implementation <u>may not be delayed</u> pending such changes.)

These instructions should be implemented within your current operating budget. (*DCIA activities for liability, no-fault, and workers' compensation based debt were considered in arriving at the FY 2002 budget. Consequently, contractors are to implement these instructions within their current operating budget. CMS will continue to fund justified Supplemental Budget Requests (SBRs) to the extent funds are available.)*

This PM may be discarded after September 30, 2003.

If you have any questions regarding the DCIA process or access to the DCS system for MSP debts, Medicare contractors should contact their RO MSP coordinator, and ROs should contact Deb Pujals at <u>dpujalskeyser@cms.hhs.gov</u>.

Attachment 1: DCIA "Intent to Refer" Letter
(Revised subsequent to PM AB-01-83)

[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 letterl** $**[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 & 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. 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 **[$]**. By regulation, interest is due and payable for each 30-day period as of the first day of that 30-day period. 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]

ATTACHMENT 1A
Cover Instruction Sheet When Contractor Sends Multiple "Intent to Refer" Letters to the Same Debtor in One Package
(Revised subsequent to PM AB-01-83)

Date: **[Insert]**

[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 & 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.

ATTACHMENT 1B

Valid Documented Defense for All Claims Included In the Intent to Refer Letter-- Reply
(Revised subsequent to PM AB-01-83)

Date: **[Insert]**

[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]

ATTACHMENT 1C
Unacceptable Defense for All Claims in the Intent to Refer Letter --Reply
(Revised subsequent to PM AB-01-83)

Date: **[Insert]**

[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 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]

ATTACHMENT 1D
Payment and/or Acceptable Defense for One or More But Not All Claims in the Intent to Refer Letter--Reply (Revised Subsequent to PM AB-01-83)

Date: **[Insert]**

[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 # plus MPaRTS Report ID # 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 to Medicare Contractor
Telephone number of Contact Person]

Sincerely,

[insert: Name
Title
Contractor's Name – MSP Unit]

Enclosure

Attachment 1E
Enclosure for "Intent to Refer" Letter to Employer, Insurer, Third Party Adminstrator, Group Health Plan (GHP), or Other Plan Sponsor

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, both 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.

No. 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.

No. 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.

No. 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.

No. 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 non-covered 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.

No. 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.

No. 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 at least 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. (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.)

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.

No. 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.

No. 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.)

Attachment 2
Instructions for the Required Format and *content of the*
Monthly MSP DCIA Tracking Report *for Referral/Collection*

NOTE*:* Both the format and the content of this report have been revised.

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 PM. (See Section II of the PM, 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.

Attachment 3

Treasury Address

The address for debtors to utilize when corresponding with Treasury:

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 if a debtor needs to write or call Treasury.

Program Support Center's (PSC)'s Address

The PSC's mailing address for contractors to send the recall spreadsheets along with a disc 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

Mr. 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

#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	Dollar
Jun-02												
Jul-02												
Aug-02												
Sep-02												
Total	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
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	0	$0	0	$0	0	$0	0	$0	0	$0	0	$0
Contractor Name and Number:												
Month Ending:												
Contact and Telephone Number:												

#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 Inputed 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	0	$0	0	$0	0	$0	0	$0	0	$0
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	0	$0	0	$0	0	$0	0	$0	0	$0
Contractor Name and Number:										
Month Ending:										
Contact and Telephone Number:										