Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-01-83 **Date: MAY 23, 2001**

CHANGE REQUEST 1538

SUBJECT: Medicare Secondary Payer (MSP) Debt Collection Improvement Act of 1996 (DCIA) Activities

NOTE: The instructions contained in this Program Memorandum (PM) do not require nor does HCFA request Medicare contractors to make changes to their standard systems or their internal systems. Medicare contractors may request standard systems changes and/or non-standard systems changes to facilitate this process in the future, but implementation may not be delayed pending such changes.

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. For MSP debts, the designated DCC is the Department of Health and Human Services (DHHS)/Program Support Center (PSC). The Health Care Financing Administration (HCFA) is mandated to refer all eligible debt, over 180 days delinquent, for cross-servicing, including the Treasury Offset Program (TOP).

HCFA has the option of referring such debt before it is 180 days delinquent, but is required to refer all eligible debt that is more than 180 days delinquent. One hundred eighty days delinquent means 180 days after the payment due date stated in the recovery demand letter.

Per DCIA referral criteria, delinquent is defined as a debt (1) that 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) that 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 there is no valid documented defense is considered to be legally enforceable.

The DCIA states that certain debts such as those in bankruptcy or in litigation are not eligible for referral. See section II. for a more detailed listing of the exclusions that Medicare contractors will use.

Since 1998, HCFA has referred over $2.0 billion in eligible delinquent debt for cross servicing, including TOP. HCFA is committed to sending an additional $2.0 billion in eligible delinquent debt to the DCC for cross servicing by the end of fiscal year (FY) 2001, and 100 percent by the end of FY 2002. To meet this goal, HCFA will need the cooperation and assistance of Medicare contractors and Regional Offices (ROs).

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, PSC, 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 180 days delinquent, it will have been referred to the PSC 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 needs to be phased in at Medicare contractors to address the backlog first as well as the current/future workload 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 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 liability, no-fault, and workers' compensation, the debt includes all claims in the recovery demand letter.

(Although DCIA debt selection criteria currently do not include all of these types of MSP debt, this is the definition of "debt" that will continue to be used as the selection criteria are broadened in subsequent instructions.) 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 their own right, the debtor is the attorney or other representative.

Current debt selection criteria are as follows:

- Debts may be for Part A and/or Part B services.
- Debts must be $25.00 (principal plus interest) or more.
- Debts must be delinquent. (Medicare contractors should select from both old delinquent debt and newly delinquent debt. They should select debts of $5,000 or more during the first two quarters of each fiscal year and debts of $250 or more during the last two quarters of each FY. This approach is consistent with focusing on higher dollar debts first for HCFA's effort to eliminate the backlog of debt which will be referred to the PSC.)

- Debts must be Data Match (DM) debts or non-DM GHP debts where the demand was issued to the employer, insurer, third party administrator, GHP, or other plan sponsor.

- The first demand to the current debtor must have been issued on or after July 1, 1995, or a subsequent calendar year (i.e., 1996, 1997, etc.). (Debts where the first demand letter to the current debtor was issued prior to July 1, 1995, will usually meet one of the criteria for a Medicare contractor recommendation for "write-off -- closed" (now or within a few months of issuance of this PM) or fall under one of the DCIA referral exclusions.) (See PM AB-01-24, February 2001, for MSP "write-off -- closed" instructions.)

In addition to the above selection criteria, once a single debt for a particular debtor has been selected, all debt for a particular debtor that does not fall under a specific exclusion may be selected and referred. CO encourages Medicare contractors to at least select all of the debt for a particular debtor that was included in a particular demand letter regardless of the dollar amount involved. (For example, if a single demand letter was issued for 5 DM Report IDs, 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. See Section III. for a more detailed discussion of this situation. Additionally, if a Medicare contractor has no debts/insufficient debts of $5,000 or $250 to meet the workload standard set forth in Section III. of this PM, they should select debts below these thresholds. However, the $25.00 threshold must be met for each debt.

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,
- 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 there is an extended repayment agreement and the agreement is not in default,
- Debts where the debtor is deceased and the estate is closed, or
- Debts where HCFA has specifically identified a debt or group of debtors as excluded from DCIA referral.

Debts currently subject to exclusion as "in litigation" or within a "HCFA identified exclusion" include:

- Debts which involve Aetna, Cigna, or New York Life (including known affiliates and subsidiaries) as the employer, insurer, third party administrator, GHP, or other plan sponsor may not be included in the DCIA referral process due to litigation.

- 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 "HCFA identified exclusion." (Absent this specific HCFA 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.

Medicare contractors must check the Common Working File (CWF) for any status changes prior to sending the "intent to refer" letter. They must also check to see if any correspondence and/or adjustments have come in that will change/alter the debt owed to Medicare. 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 updated before an "intent to refer" letter can be issued.

Any changes to status codes should be updated in all associated systems and interest accruals should be brought up to date at this time. On DM debts, Medicare contractors will change the status code of the debt on the Mistaken Payment Recovery Tracking System (MPaRTS) at the time the "intent to refer" letter is sent, as well as when the debt is referred to the PSC. The status code on MPaRTS when the "intent to refer"letter is sent will be "IL". The status code on MPaRTS when the debt is referred to the PSC will be "PS".

The parameters for debt selection will be updated each year in the Budget Performance Requirements (BPRs) and any interim change will be communicated through a formal instruction to contractors. As indicated by the selection criteria stated above, HCFA is currently focusing on the referral of third party payer group health plan debt. Future instructions will include additional MSP debt in the referral process.

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

To address the existing backlog of delinquent debt, Medicare contractors generally need to issue 200 "intent to refer" letters a month until they are current. These 200 "intent to refer" letters should focus on older delinquent debt but must also include some newer delinquent debt in order to avoid creating an additional backlog of more newly delinquent debt. Some of the debts which Medicare contractors select and review may be resolved without the need to issue an "intent to refer" letter. Medicare contractors must resolve at least 500 selected debts or issue 200 "intent to refer" letters each month, whichever occurs first, as long as they have sufficient delinquent debt to meet this requirement. This standard must be met for each Medicare contract. For example, if an entity holds a fiscal intermediary contract, a carrier contract, and a durable medical equipment regional carrier contract, the standard must be met for each contract held by a contractor.

Debt which 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.) However, 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". Medicare contractors may not meet their monthly "200/500" standard by selecting debts and "resolving" them by recommending them for "write-off-closed".

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, containing DCIA specific language, to the entity or individual who/which received the last demand letter. **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). This letter explains the referral process and the debtor's rights. (This letter must be generated without standard system changes. For most Medicare contractors this would mean PC based generated letters.)

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 follow the same procedures they would normally use when a demand letter is returned. If after trying to locate a better address through all the various means outlined in PM AB-98-6 (Change Request 265 dated March 1998) one is not located, Medicare contractors must document their file with all actions taken to locate a better address. Next, they must staple the envelope to the returned

"intent to refer" letter and file it in the case. The debt can then be referred to the PSC for further collection activity.

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 to the PSC.) Where multiple debts for the same debtor are selected, each debt will count toward the "200/500" workload standard stated above. There must be a separate "intent to refer" letter for each debt as well as an instructional cover sheet for each package of "intent to refer" letters when multiple "intent to refer" letters are sent to the same debtor at the same time. (See 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 not be aggregated or otherwise combined in a single "intent to refer" letter. "Intent to refer" letters must be debt specific. Input into the DCS must also be debt specific. (See 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 or non-DM inquiry.

IV. DCS System, DCS Input, Debt Transmission, Documentation to PSC

If the Medicare contractor receives a response to the "intent to refer" letter, they 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 (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.

The DCS is used to refer debts to the DCC/PSC for cross servicing of individual debts, including TOP. It is also used to track debts pending action at the DCC/PSC. Input into the DCS certifies the debt as valid, legally enforceable, and ready for referral to the PSC.

The DCS database is accessed through the HCFA 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.

To enable immediate access once instructions are issued, Medicare contractors must e-mail Karen Ochab, HCFA CO (kochab@hcfa.gov), upon receipt of this PM, with the names and user IDs of the staff who will be performing the data entry. The user ID is the same one used for access to MPaRTS.

Medicare contractors will be given access to the DCS and will input certified debts directly to the database. 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, must be forwarded to the PSC within 7 calendar days from the date of input. The PSC’s address is contained in Attachment 3 of this PM.

When a Medicare contractor receives information from the PSC and/or an entity under contract to the PSC that conflicts with what they have in-house, they should check CWF for current MSP Auxiliary File information. If the information the Medicare contractor receives from the PSC and/or an entity under contract to the PSC is consistent with the information on CWF, then no further action is required. If the information the Medicare contractor receives from the PSC and/or entity under contract to the PSC conflicts with the CWF MSP Auxiliary File data and it is not within the Medicare contractor’s authority to resolve, 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.)

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

Once a debt is referred to the PSC, active collection efforts by the Medicare contractor, the RO, and/or HCFA must cease. However, debts at the PSC location on the DCS system must still be maintained in the Medicare contractors' internal systems and interest must continue to accrue in the Medicare contractor systems.

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 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.

PSC will service the debt by sending letters to the debtor. The PSC keeps the debt in house for approximately 60 days. If the PSC recovers on a case, they will notify the Medicare contractor via CO and the RO. After approximately 60 days, the PSC will refer the debt to the PSC contractor for further collection efforts. The PSC contractor will send letters to the debtor and/or call the debtor.

The PSC contractor will work the debt for a minimum of 6 months or a maximum of 3 years, depending on the activity on the case. If the PSC contractor recovers on an MSP debt, they will notify the PSC who will notify the Medicare contractor via CO and the RO. If no activity occurs on the case, the PSC contractor will return the case to the PSC, who will return it to CO with a recommendation regarding any further action on the debt. The PSC will make a recommendation only if there has been no activity on the debt. 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 to the PSC. Medicare contractors must identify which letter (PSC, PSC 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 PSC or PSC contractor letter, then the Medicare contractor needs to instruct the caller to send the check or correspondence to the PSC or PSC contractor, as appropriate, not the Medicare contractor. In addition, if the PSC or PSC contractor 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 is as follows:

- 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 the debt from the PSC 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 on the Comment Screen, and complete the weekly report on recall activity to the RO, CO and PSC. If a collection is received, the Collection Screen must also be updated. DCS updates must be done within 5 days.

- If the PSC (or the PSC contractor) 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 PSC will notify the Medicare contractor via CO and the RO. The Medicare contractor will not complete a recall report in this situation even if the PSC or PSC contractor has consulted with the Medicare contractor or obtained Medicare contractor concurrence on the action involved. However, the Medicare contractor must update the DCS within 5 calendar days of receiving a case status report of the applicable action from the PSC via the CO and RO. All three DCS screens must be updated, as appropriate. (If the PSC or the PSC contractor receives any partial or full collections for debts that have been referred, PSC will notify CO via an Online Payment And Collection (OPAC) report. The notification subsequently furnished to the Medicare contractor will detail how the collection was applied. Medicare contractors will use line 4 on the Form HCFA-M751 report to show these collections received by way of an OPAC. The Medicare contractor will update the DCS system and adjust or close their internal records accordingly. Medicare contractors will use line 5a on the Form HCFA-M751 report to adjust off related balances due to collections received by way of an OPAC in CO.)

- When the PSC 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.)

- 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.

Specific instructions for DCS input and recalls are included in the DCS Manual.

NOTE: Once a debt is recalled/returned from the PSC/OSI due to bankruptcy, the Medicare contractor is to follow normal procedures for bankruptcies.

VI. MSP DCIA Status Report for Referral/Collection

HCFA has developed a MSP DCIA Status Report for Referral/Collection to assist in monitoring and tracking the debts selected for potential/actual referral (see Attachment 2 - Status Report for Referral/Collection). Medicare contractors must submit this report by the 15th of each month for the previous month's activity. This report is a manual report. All Medicare contractors must forward the completed report to: HCFA OFM FSG DFI MSPO, Mailstop C3-14-00, 7500 Security Blvd., Baltimore, MD 21244-1850; Attention: Karen Ochab, Medicare Secondary Payer. A copy must also be sent to the RO MSP Coordinator. This report must be submitted on disk and by hard copy and must be received by CO by the 15th of each month (which may require the use of overnight mail).

The required format and instructions for the completion of the Monthly MSP DCIA Status Report (including the required CFO certification) are contained in Attachment 2. 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.

VII. Monitoring Debts Excluded from the DCIA Referral Process

Medicare contractors must monitor 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).

VIII. Financial Reporting

Medicare contractors are responsible for the financial reporting of all 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") (HCFA 750/751 reports).

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.

Where the PSC (or PSC contractor) receives payment, HCFA is notified and receives payment through OPAC. 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 OPAC payment.

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

Medicare contractors must maintain detailed support for all information reported on the Monthly MSP DCIA Status Report.

IX. Compromise Requests and Extended Repayment Agreement 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 in 42 CFR 401.613. Written compromise requests that state the reason for the requested compromise must be forwarded to the RO, within 15 days of receipt by the Medicare contractor. The Medicare contractor must send a copy of the case file and must include any supplemental information or documents furnished by the debtor. The RO will make compromise decisions within its Federal Claims Collection Act (FCCA) authority. ROs do not have the authority to compromise debts where the principal amount exceeds $100,000 or any third party payer debt (debtor is the insurer, employer, third party administrator, plan, or other plan sponsor) regardless of the amount. For debts exceeding $100,000 or any third party payer debt regardless of the amount, the RO will review each case individually, write a recommendation, and forward the recommendation to CO 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. Once the MSP DCIA referral process is expanded to include additional types of MSP debts, Medicare contractors will handle extended repayment agreements for providers/suppliers (including physicians) or beneficiaries under existing procedures.

MSP compromise requests and extended repayment agreement requests 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 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. No. The DCIA referral process for MSP debts is currently limited to GHP based debt where the demand was issued to the employer, insurer, third party administrator, GHP, or other plan sponsor. The process will be expanded to address other types of MSP debt in subsequent instructions. HCFA will address questions concerning other types of debts and the DCIA referral process when the expanded instructions are issued.

Q3. The language for the "intent to refer" letter indicates that a case ID number is part of the "debt identification number" and must be included on the letter for non-DM debts. Our non-DM debts do not have a case ID number. Do we need to assign case ID numbers to these cases or can we leave this information out of the "intent to refer" letter for non-DM debts? (We identify our non-DM cases by the Medicare HIC number.)

A3. No, you may not leave this information out. From the information in your question, the Medicare HIC number is what you use as a "case ID number" for non-DM cases. Therefore, you would use the HIC number as the case ID number in the "intent to refer" letter. Case ID numbers are how you identify a case (i.e., HICN, Report IDs, etc.).

Q4. Assume that: 1) we have a DM debt that is delinquent and has not yet been selected for the DCIA referral process/has not had an "intent to refer" letter issued, and 2) we receive a new DM tape which has another report ID for the same beneficiary. Do we keep the two cases separate for DCIA purposes (separate "intent to refer" letters, etc.) or do we somehow lump them together?

A4. You may not group them together in any manner. The information on the new DM tape is not a debt until a recovery demand letter is issued. Additionally, as stated in the instructions, multiple debts may not be aggregated or otherwise combined in a single "intent to refer" letter (see section III.). However, as further discussed in 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. No. The only situation in which a beneficiary would be involved with an "intent to refer" letter is when the beneficiary is the debtor in question. (Also, as previously explained, the current instructions are limited to GHP debts where the debtor is the employer, insurer, third party administrator, GHP, or other plan sponsor).

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.

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. 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?

A9. Interest continues to accrue from the date of the demand letter. This means that the debt will have accrued an additional two 30 day periods of interest, if the debtor delays repayment until the 60th day after the "intent to refer" letter. The information is included to inform the debtor of exactly how much must be repaid if he/she does not make repayment immediately upon receipt of the "intent to refer" letter.

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.

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. 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.

Q12. On the Debt Collection System (DCS) there is a field for the Taxpayer Identification Number (TIN). Is this a required field?

A12. This is a required field if the TIN information is available.

***Funding*:** Supplemental Budget Requests (SBRs) will be considered, as appropriate. SBRs must explain exactly what effort will be required and why it justifies additional funding. (For example, Medicare contractors may be able to justify temporary hires to assist with some of the clerical aspects of debt validation, mailings, etc., while working the backlog of existing delinquent debt.) SBRs must also differentiate between requests for non-systems funding and funding for non-standard systems changes. (Although implementation may not be delayed pending any systems changes, HCFA will consider systems changes to facilitate this process in the future.)

Effective date: May 23, 2001.

Implementation date: Medicare contractors who did not participate in the DCIA pilot process must issue their first 200 “intent to refer” letters (or resolve their first 500 selected debts) by June 30, 2001. Thereafter, Medicare contractors must meet the “200/500” standard each month. Contractors who participated in the pilot (pilot contractors) must meet this standard as of May 31, 2001. (Pilot contractors should already be issuing 200 "intent to refer" letters each month.) Pilot contractors must begin using the revised "intent to refer" letter provided in this PM within 30 days of the issuance of this PM. This requirement applies even if they have been using a systems generated "intent to refer" letter and compliance by this date would require they use a PC based letter.

Medicare contractors must complete their first Monthly MSP DCIA Status Report in the month following the issuance of their first "intent to refer" letter or their resolution of any selected debts. Instructions for DCS input are being issued under separate cover. Pilot contractors may begin using this report (in lieu of the existing more detailed monthly MSP DCIA status report they have been completing) for DCIA activities for the month of May 2001. They must begin using this report no later than their report for DCIA activities for the month of June 2001.

Medicare contractors are already required to maintain an appropriate audit trail and sufficient detail to support their Form HCFA-M751 reports. This information should be used to identify and select debts for the DCIA process. Consequently, these instructions do not require standard or non-standard systems changes. Medicare contractors must implement these instructions within the time frame specified above, even if this requires a non-automated effort for debt selection and validation, letter issuance (i.e., PC based letters), and/or tracking and reporting. Medicare contractors may request standard systems changes and/or non-standard systems changes to facilitate this process in the future, but implementation may not be delayed pending such changes.

This PM may be discarded June 30, 2002.

If there are questions regarding the DCIA process, Medicare contractors should contact their RO MSP coordinator and ROs should contact Karen Ochab at kochab@hcfa.gov.

Attachment 1: DCIA "Intent to Refer" Letter

[Insert: Date]

[Insert: Debtor Name
Debtor Address
Debtor City/State/Zip]

Past-due debt owed HCFA as of **[insert: last interest accrual date]** $**[insert: total principal and interest]**.
Date debt became past-due: **[insert: 61st day after demand letter date for GHP debts]**
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)]**
Beneficiary's Name: **[insert]**
Beneficiary's HIC#: **[insert]**

NOTICE OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY'S 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 a 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 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. HCFA 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). For MSP debts, the Debt Collection Center is the Program Support Center (PSC) of the Department of Health and Human Services (DHHS). 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). The PSC 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 the PSC, 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 PSC 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.

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's 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 HCFA as of **[insert: last interest accrual date]**, including interest accrued through **[insert: last interest accrual date]**, is **[$]**. If the debt remains outstanding after **[insert specific date: (30 days from the date of this letter)]**, the amount of the debt, including interest, will be **[insert dollar amount]**; and, if no payment is received by **[insert date: (add an additional 30 day time period to the preceding date)]**, the amount of the debt will be **[insert: dollar amount, including interest]**. Be advised that interest is accrued monthly and is added to the balance of the debt. Please make your check or money order payable to **[Name of Medicare Contractor - MSP Unit]**, include a copy of this notice and forward both to the address below.

[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 and/or relating to the submission of evidence, you may contact:

[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,

[Name
Title
Contractor's Name - MSP Unit]

Attachments:
Demand Letter
Claims Summary/Claims Facsimiles

Attachment 1A:
Cover Instruction Sheet When Contractor Sends Multiple "Intent to Refer" Letters to the Same Debtor in One Package

Date: **[Insert]**

[Insert: Debtor Name
Debtor Address
Debtor City/State/Zip]

MULTIPLE NOTICES OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY'S DEBT COLLECTION CENTER FOR CROSS-SERVICING AND OFFSET OF FEDERAL PAYMENTS

The Health Care Financing Administration (HCFA) 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's 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 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

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]**

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:

[Name of Medicare Contractor -MSP Unit
Attention: Contact Person's Name
Address of Medicare Contractor
Telephone Number of Contact Person]

Sincerely,

[Name
Title
Contractor's Name – MSP Unit]

ATTACHMENT 1C:
Unacceptable Defense for All Claims in the Intent to Refer Letter --Reply

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]**

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:

[Name of Medicare Contractor -MSP Unit
Attention: Contact Person's Name
Address of Medicare Contractor
Telephone Number of Contact Person]

Sincerely,

[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

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.]**
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 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:

[Name of Medicare Contractor -MSP Unit
Attention: Contact Person's Name
Address to Medicare Contractor
Telephone Number of Contact Person]

Sincerely,

[Name
Title
Contractor's Name – MSP Unit]

Enclosure

Attachment 2
Instructions for the required format for the Monthly MSP DCIA Status Report

HCFA has designed the MSP DCIA Status Report to assist in the monitoring and tracking of debts eligible for referral to the Program Support Center (PSC). Medicare contractors **must** complete the MSP DCIA Status Report by the 15th of each month for the previous month's activity. The purpose of the Status Report is to provide HCFA 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 2000	300 debts	$4.0 million
July 2000	200 debts	$1.0 million
Total	500 debts	$5.0 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**{**tc \l2 "Column #1**}**

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. Medicare contractors will post the number and dollar amounts under this column heading.

Column #4 (a – i)

Debts Excluded from Referral – This column refers to debts selected for "intent to refer" letters that have been verified but are excluded from referral due to guidelines outlined in this PM. These exclusions are as follows: (4a) Appeal, (4b) Bankruptcy, (4c) Fraud and Abuse, (4d) Litigation, (4e) Federal Agency, (4f) Extended Repayment Agreement (not in default), (4g) Deceased, Estate Closed, (4h) HCFA Identified Exclusions, and (4i) Other (for future use). Medicare contractors will post the number and dollar amounts under each column heading.

Columns 4 (a-i) defined:

4a – Debts Excluded from Referral –Appeals (A)
All debts in an appeal status should be posted here in the format of numbers and dollars. An appeal is an administrative process of seeking review by a higher authority of a decision made by a lower authority.

4b – Debts Excluded from Referral – Bankruptcy (B)
All debts in bankruptcy should be posted here in the format of numbers and dollars.

4c- Debts Excluded from Referral – Fraud and Abuse (F)
All debts under fraud and abuse investigation should be posted here in the format of numbers and dollars.

4d – Debts Excluded from Referral – Litigation (L)
All debts where HCFA is in litigation with the debtor and the contractor has been so notified of such action by HCFA should be posted here in the format of numbers and dollars.

4e - Debts Excluded from Referral – Federal Agency (G)
All debts where the only entity, which received the last demand letter, is the employer and the employer is a Federal agency should be posted here in the format of numbers and dollars.

4f – Debts Excluded from Referral – Extended Repayment Agreement (not in default) (E)
All debts where there is an extended repayment agreement with the debtor and the agreement is not in default should be posted here in the format of numbers and dollars.

4g - Debts Excluded from Referral – Deceased, Estate Closed (D)
All debts where the debtor is deceased and the estate is closed should be posted here in the format of numbers and dollars.

4h - Debts Excluded from Referral – HCFA Identified Exclusions (H)
All debts where HCFA has identified a debt or group of debtors as excluded from DCIA referral should be posted here in the format of numbers and dollars.

4i - Debts Excluded from Referral – Other (for future use) (O)
This column is reserved for future use.

Column #5

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.

Column #6

Collections by Medicare Contractors – Cash/Checks – Medicare contractors will post in this column the number and dollar amount of any collections they receive at the Medicare contractor site during the month, as a result of the "intent to refer" letters being sent.

Column #7

Medicare Contractor Collections via Internal Offset – Medicare contractors will post in this column the number and dollar amounts collected by internal offset as a result of the "intent to refer" letter being sent during the month.

Column #8

OPAC Information Rec'd from CO – Medicare contractors will post in this column the number and dollar amounts that were collected via OPAC, supplied by CO, during the month. This information reflects amounts collected by or through the PSC, including TOP collections.

Column #9

Medicare Contractor Adjustments – This column is **only** for valid documented defenses. 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 or the PSC (or the PSC's contractor).

Column #10

Cases inputted into the Debt Collection System (DCS) - The information contained in this column shows the number and dollar amount of debts that have been entered into the DCS system for referral to the PSC by the Medicare contractor during the month.

Overall, Medicare contractors will post to the spreadsheet the number and dollar amounts of debts that:

- met the eligibility criteria for referral;
- had an intent letter sent to the debtor;
- the 60-day response period expired; and
- were input into the DCS.

Or

- met the eligibility criteria for referral;
- had an intent letter sent to the debtor;
- the intent letter was undeliverable; and
- were input into the DCS prior to the expiration of the 60 days.

Attachment 3

Program Support Center (PSC)'s Address:

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

Monthly MSP DCIA Status Report

#1	#2			#3			#4a			#4b			#4c			#4d			#4e			#4f			#4g	
Date MM/YY	**Debts Selected**			**Resolved Without Intent Letter**			**Debts Excluded From Referral**	**Appeal(A)**		**Debts Excluded From Referral**	**Bankruptcy(B)**		**Debts Excluded From Referral**	**Fraud & Abuse(F)**		**Debts Excluded From Referral**	**Litigation(L)**		**Debts Excluded From Referral**	**Federal Agency(G)**		**Debts Excluded From Referral**	**Extended Repayment Agreement(Not in default)(E)**		**Debts Excluded From Referral**	**Deceased, Estate Closed(D)**
00/0000	Number	Dollars		Number	Dollars		Number	Dollars		Number	Dollars		Number	Dollars		Number	Dollars		Number	Dollars		Number	Dollars		Number	Dollars
May-01																										
Jun-01																										
Jul-01																										
Aug-01																										
Sep-01																										
Oct-01																										
Nov-01																										
Dec-01																										
Jan-02																										
Feb-02																										
Mar-02																										
Apr-02																										
May-02																										
Jun-02																										
Jul-02																										
Aug-02																										
Sep-02																										
Cumulative Total To Date																										
Contractor Name and Number:																										
Month Ending:																										
Contact and Telephone Number:																										
I hereby certify these debts as valid and legally enforceable.																										
Name of Contractor CFO / Date																										

Monthly MSP DCIA Status Report

#4h		#4i		#5		#6		#7		#8		#9		#10	
Debts Excluded From Referral	**HCFA Identified Exclusions(H)**	**Debts Excluded From Referral**	**Other(For Future Use)(O)**	**Intent To Refer Letters Sent**		**Collections by Contractors-Cash/Checks**		**Contractors' Collections via Offset**		**OPAC Information Rec'd from CO**		**Contractor-Adjustments**		**Cases Inputed Into The Debt Collection System**	
Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars	Number	Dollars