

MSP Recovery Policy Attachment

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Section J1.1

Interest on MSP Recovery Claims

Section 1862(b)(2)(B)(i) of the Social Security Act (the Act) and 42 CFR 411.24(m) provide express authority to assess interest on MSP debts. Interest is calculated on MSP debts using the method applicable to non-MSP Medicare overpayments and underpayments as stated in 42 CFR. 405.378. For Medicare overpayments and underpayments and MSP debts, interest is calculated in full thirty (30)-day periods. Interest instructions for Medicare overpayments and underpayments are found in Chapter 2 section 70 and following of CMS Pub.100-06, Medicare Financial Management Manual.

MSP Debt Interest Calculation Methodology

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

Interest is computed for both delinquent payments and installment payments as simple interest using a 360-day year. The U.S. Postal Service postmark date (or the date of physical receipt in the Contractor's mail area for a commercial shipper) is used to determine the receipt date of the payment.

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

1. Principal x Prevailing Interest Rate = Interest for Year
2. Interest for Year ÷ twelve (12) = thirty (30) day Interest

Effective October 1, 2004, 42 CFR 405.378 and 42 CFR 411.24 were amended to change how interest is calculated on MSP recoveries. For debts established before October 1, 2004, interest on delinquent debt is due and payable for the entire thirty (30)-day period as of the first day of each thirty (30)-day period. For debts established on or after October 1, 2004, interest on delinquent debts is due and payable as of the end of each thirty (30)-day period.

MSP Debt Interest Accrual

Interest "accrues" from the date of the recovery demand letter but is not "assessed" unless/until the debt becomes delinquent, (*i.e.*, if the first demand letter provided for sixty (60) days for the debtor to repay the debt and was dated August 31, 2004, the entire debt will become delinquent on 10/30/04 or sixty-one (61) days [one (1) day delinquent] after the date of the demand if it remains owing.)

The general rule is that interest will accrue from the date the debt is established. MSP debts are routinely established as of the date of the initial recovery demand letter. Interest is owed when the debt is not fully resolved or paid within the time period specified in the recovery demand letter (e.g., sixty (60) days). If payment is received within the time-frame specified in the recovery demand letter, no interest will be due or assessed. If payment is not received when due, interest is assessed on the outstanding principal amount from the date of the initial recovery demand letter for each full thirty (30)-day period. **Note: The date of the recovery demand letter (not the day after) is the first day of the first 30-day period.**

MSP Debt Interest Accrual on Partial Payments

For situations where partial payment is received on a debt with outstanding interest -- Payment is normally credited to interest first, principal (HI first, then SMI) second, leaving an outstanding amount of principal due (or in some situations, leaving both principal and interest due if the partial payment is insufficient to satisfy the outstanding interest amount).

For debts established before 10/01/04, interest for the entire 30-day period in which the partial payment was received is required to be accrued and posted before application of the partial payment. Consequently, further interest/any additional interest on the outstanding principal amount for an MSP debt established before 10/1/04 would be calculated **starting with the first day of the next 30-day period** following receipt of the check.

Example: Debt established 8/31/04 for \$500 and a partial payment of \$200 dollars was received (post marked) 11/1/04. Calculate and post interest specific to 3 30-day periods (63 days from date of demand equals 3 interest periods). Assuming the interest equaled \$5 for each 30-day periods, \$15 would be applied to interest and \$185 would be applied to principal. The remaining outstanding principal of \$315 would continue to accrue interest. Interest for an additional **prospective** 30-day period for the \$315 would be due on day 91 (the first day of a new 30-day period as interest is due and payable for the full 30-day period as of the first day of each period).

For debts established on or after 10/1/04 where a partial payment is received midway through the 30-day period, interest on the debt will not have accrued up to the date of payment, but only through the end of the prior 30-day period. Consequently, further interest/additional interest on the outstanding principal amount for an MSP debt established on or after 10/1/04 would be calculated on the principal amount outstanding as of the end of the 30-day period in which the partial payment was received and would be calculated **from the first day of the 30-day period in which the partial payment was received.**

Example: Debt established 10/01/04 for \$500 and a partial payment of \$200 dollars was received (post marked) 12/1/04. Calculate and post interest specific to 2 full 30-day periods (62 days from date of demand equals 2 full interest periods). Assuming the interest equaled \$5 for each 30-day periods, \$10 would be applied to interest and \$190 would be applied to principal. The remaining outstanding principal of \$310 would continue to accrue interest. Interest for an additional **retrospective** 30-day period for the \$310 would be due on day 91 (the day after the end of a current 30-day period, as additional interest is due only after each **full** 30-day period for that part of the principal that remains unresolved).

MSP Debt Interest Assessment

Under the regulations for calculating interest, as effective for MSP debts established on or after October 1, 2004, interest is assessed for each full 30-day period when payment is not made in full (both principal and interest) and continues to be assessed for each full 30-day period on any portion of the debt that remains outstanding. This change in the manner in which interest is calculated applies to all MSP debts, both GHP-based debt and non-GHP-based debt, regardless of who is the debtor. Interest on MSP debts established prior to October 1, 2004 will continue to be assessed under the former method (interest is due and payable as of the first day of each 30-day period for that full 30-day period) until recovered in full (Note: “interest only” debt does not accrue interest).

Additional Rules with Regard to the Assessment and Collection of Interest for MSP-based Debts

- Interest must be charged on all MSP debts except: 1) GHP-based debt where the beneficiary is the debtor, and 2) debt where the “current debtor,” as that term is defined in section 60.2 of Pub. 100-5, Chapter 7, is a Federal entity. To implement this requirement, the Contractor shall identify all outstanding debts where a Federal entity is the current debtor. Once identified, the Contractor shall make a downward adjustment for all accrued interest previously reported and associated with these debts.

NOTE: The rule applies only when the current debtor is the Federal entity. It does not apply in the rare circumstance where the employer is a Federal entity and the current debtor is the insurer or TPA.

- Interest charged is simple interest, not compound interest. The CMS does not charge interest on any outstanding interest. Interest accrues only on unpaid principal amounts.
- When compromising an MSP debt, CMS’ primary concern is protection of the Trust Funds. When CMS compromises a debt, the policy is to compromise interest first and principal second; otherwise, compromises would often be of little or no benefit to the Trust Funds. The only exception to this policy would be if a compromise agreement specifically allocates the amount to be repaid in some other manner. The amount compromised is written off closed as bad debt. Two examples of the correct application of payment received from the debtor when CMS has notified the Contractor of a compromise agreement include:
 - Assume there is an AR with principal due of \$1,000, interest due of \$200 as of the date of receipt of payment, and CMS has agreed to compromise for \$700. When the payment of \$700 is received, the end result must be: \$200 interest written off closed as bad debt, \$300 principal written off closed as bad debt, and the \$700 payment applied to principal.
 - Assume there is an AR with principal due of \$2,000, interest due of \$1,000 as of the date of receipt of payment, and CMS has agreed to compromise for \$2,200. When the payment of

\$2,200 is received, the end result must be: \$800 interest written off closed as bad debt, \$200 of the payment applied to interest, and \$2,000 of the payment applied to principal.

As long as the agreed upon compromise amount is paid within the time frame specified by the CMS Contractor PO, any interest accrued after the date of the compromise agreement is written off closed as bad debt.

Notes:

- The Contractor may not take write-off closed actions for the compromised (“forgiven”) portions of a debt until payment for the remaining portion of the debt has been received;
- The Contractor shall maintain the compromise instructions from CMS to support the associated write-off closed action(s) for principal and/or interest; and
- The Contractor will be notified by CMS when Treasury has compromised a debt and instructed as to how the compromise portion of the debt shall be shown on the financial statements.
- Where the principal amount of the debt is adjusted downward due to a valid documented defense or a waiver of recovery under § 1870 of the Act, the interest amount must be recalculated based upon the remaining principal. (Decisions for waiver of recovery under § 1870 of the Act are decisions with regard to the principal amount of the debt. For any amount of principal waived under § 1870, the associated interest ceases to exist and must be adjusted downward accordingly.)
- Where the Contractor is informed by CMS that CMS has waived some or all of the interest on a particular debt, the Contractor shall perform an adjustment for the amount of the waived interest before applying any payment. A waiver of interest is recorded as an adjustment on line 5(a). (Note: Use of line 5(h) is limited to waiver actions under § 1870 or § 1862 of the Act).
- Waiver of interest requests should be rare. If such a request is received, the request must state the basis for the request. When this information is received, Contractor shall forward the request to the CMS Contractor PO along with the applicable case file.
- Where a beneficiary establishes that he/she did not receive settlement/ judgment/award funds until after the issuance of the recovery demand letter, no interest is due until sixty (60) days from his/her receipt of such funds. Receipt of such funds by the beneficiary or his/her representative constitutes receipt by the beneficiary. In such situations, the Contractor shall adjust off any interest showing as owed within its financial tracking systems for the period prior to sixty (60) days from receipt of the funds. Such an adjustment is not a waiver of interest and shall not be treated as a waiver of interest and forwarded to CMS.

Section J1.2

MSP Debt Write-Off Procedures

General

The Contractor has primary responsibility for collecting all MSP debts and shall pursue recovery of all accounts receivable (AR) to the fullest extent possible, regardless of the identity of the debtor. Contractor shall follow all financial reporting requirements contained in Pub. 100-6, Chapter 5.

Reclassification to Currently Not Collectible (CNC)

The Contractor shall follow instructions regarding the identification, definition and recommendation for CNC reclassifications contained in Pub.100-6, Chapter 5, Sections 310 and 400 (exhibit 20).

Write-Off Closed for MSP AR

Identification of MSP Write-Off Closed Accounts

Generally, the Contractor may recommend write-off closed on debt which is being reported as part of its ending AR balance. ARs that have been referred to another location, without transfer, remain the responsibility of the contractor (*i.e.*, referred to Treasury for cross-servicing).

Note: These instructions apply only to established ARs (*e.g.*, a recovery demand letter has been issued). They shall not be used to close MSP liability/no-fault/workers' compensation leads where no settlement, judgment or award exists and no recovery demand has been issued.

Write-off closed Definition

The term, write-off closed, refers to an AR on which collection activity and servicing of the debt have been terminated. The Contractor shall maintain records of the debts written off as "closed." However, the debts are not to be used for future offset or interest accruals.

Bases for Termination of Collection

Title 42 CFR 401.621 sets forth several bases for the termination of collection action on debts. The criteria set forth in this instruction for write-off closed are based upon CMS' consideration of a combination of the bases set forth in this regulation rather than any single basis. In some situations, an AR could be written off as closed as of six (6) years from the original demand date solely based upon the statute of limitations for initiating litigation. In other situations, this would not be true because the statute may have been suspended for some period or started a new due to a particular event, but CMS may have still determined that write-off as closed is appropriate because of the likelihood of recovery and/or the cost of recovery, age, or the application of some other factor. In other instances, CMS may determine that collection action beyond six (6) years is appropriate, in part, due to the governments offset authority.

Criteria for MSP-Based Debts to Qualify for Write-Off Closed

In accordance with the Debt Collection Improvement Act of 1996 (DCIA), MSP AR which are 180 days delinquent must be referred to the Department's Program Support Center (PSC) for cross-servicing, which includes referral to the Treasury Offset Program.

No debt shall be recommended for write off closed without having first been referred for cross-servicing and subsequently returned to agency (CMS) by Treasury, unless one of the exceptions set forth below exists. Regardless of the existence of an exception, an approval for write off closed will not be granted in all instances.

With the above limitations, debts which can be recommended for write off closed without having first been referred to Treasury for cross-servicing are:

1. Debt less than \$25 (principal and interest combined);
2. Debt in which the debtor is deceased. Prior to recommending a write-off closed action the Contractor shall determine if the estate has been closed, when the beneficiary is the actual debtor;
3. Debt equaling \$100 or less (principal and interest) in which there is no Tax Identification Number (TIN) and development for the TIN has been unsuccessful;
4. Debt discharged/forgiven by the bankruptcy court is to be recommended for write off closed.

Note: Debts excluded from cross-servicing do not qualify for write off closed without CMS approval.

Additional Instructions Regarding Write-Off Closed Recommendations and Debts Excluded from Referral to Treasury

Litigation, CMS Identified Exclusion: Debtors currently excluded from consideration for write-off closed due to litigation in which the Department of Health and Human Services/CMS is a party or debts excluded due to a "CMS Identified Exclusion" will be communicated to the Contractor from CMS.

Pending Bankruptcy: Debts involved in a pending bankruptcy cannot be recommended or approved for write-off closed. If there are questions about the documentation regarding discharge, the MSRPC shall consult CMS.

MSP Beneficiary Debt under Appeal: Before recommending a beneficiary debt for write-off be closed, the Contractor shall follow appropriate debt referral procedures (see IOM Chapter 8). In the event the debt is actively being appealed, the Contractor shall respond to the appeal. After the appeal has been completed, if there remains a balance owing, the Contractor shall refer the debt to Treasury for cross-servicing after issuance of a proper "intent to refer" letter.

Note: A debt may not be recommended as write-off closed if the amount recommended for write-off is less than the full amount of an outstanding debt.

Deliverable Report Documenting the Recommended Debts to be Written-Off Closed

The Contractor shall submit a report to document debts recommended for write-off closed that will detail the reasons and situations which are prompting the request for write-off closed actions.

The report will be part of the required deliverables and will be submitted to the CMS Contractor PO in the timeframe specified on the deliverables listing.

Approval and Additional Acknowledgment of Write-Off Closed Debts and Recommendations

1. The PO will provide a written decision to the Contractor upon review of the write-off closed recommendations.
2. The Contractor shall take appropriate actions necessary to reflect the write-off closed approvals within their AR tracking system(s).
3. In the event the PO does not approve a recommendation for write-off closed, the Contractor shall continue collection efforts and maintain the AR on its tracking system.
4. The PO may also supply the Contractor additionally identified debts to be written off closed. These identified debts may result from Treasury notifications, conclusions to pending litigations, approval of compromise requests, bankruptcy discharges, etc.

The Contractor shall retain CMS write off closed notifications and approvals and make them available upon request (for the Office of Inspector General or any other internal or external review organization) in accordance with retention procedures.

Financial reporting for MSP write-off closed

The Contractor shall report on Form CMS-M751 and MC751 the amount that CMS has approved for write-off closed, including principal and interest, on line 6a (M751) and line 4d (MC751), bad debt for all debts not contained and maintained in the HIGLAS system (*i.e.*, converted ARs).

Section J1.3

Federal Bankruptcy/ State Insurer Liquidation Actions and MSP Debt

Action must be taken to safeguard the Medicare Trust Funds when an MSP debtor files a Federal bankruptcy petition (voluntary); creditors of an MSP debtor petition the bankruptcy court to order the MSP debtor bankrupt (involuntary); or an MSP debtor is ordered liquidated by a State government.

Types of Federal Bankruptcy Proceedings

Chapter 7 – Debtors or creditors file under this chapter to obtain discharge of debtor’s debts (liquidation). Companies generally close that file under this chapter (the debtor ceases operations and disposes of the assets over a period of time). A court-appointed trustee accumulates the assets of the debtor, sells them and distributes the money among those whom the debtor owes (creditors).

Chapter 9 - This type of bankruptcy involves municipalities such as a hospital district. This chapter provides for re-organization and debt restructuring to be developed and approved, much like Chapter 11.

Chapter 11 – Debtor files under this chapter to re-organize its business. The purpose of this chapter is to restructure company finances so that the debtor can continue to operate. To emerge from Chapter 11, the debtor submits a “Reorganization Plan.” This Plan indicates the amounts and schedules for payments to creditors. Creditors vote on the Plan and the bankruptcy court must confirm the creditors’ decision. Recovery amounts may vary. The Bankruptcy Code provides for the discharge of any remaining debts.

Chapter 13 – Debtors are individuals (including sole proprietorships) with regular income. Generally, the debtor must file a debt adjustment plan within 15 days after filing (it is better to file a proof of claim as early as possible after the filing date). This chapter allows the debtor to keep property and to pay debts over time, usually from three to five years.

State Ordered Insurer Liquidations

The State may order insurers, incorporated or otherwise organized, that do business in that State to be liquidated under certain circumstances. Generally, this occurs following:

1. A determination by a State agency (*e.g.*, Insurance Commission) that an insurer is insolvent or operating in financially hazardous manner; and
2. An order by a State Court that the insurer be liquidated. The assets of the insurer are sold and the proceeds are used to pay claims against the debtor as ordered by the Court.

Importance of Various Dates in Bankruptcy/Liquidation Proceedings

The filing date (*i.e.*, the date a petition of bankruptcy is filed with the U.S. Bankruptcy Court or the date a petition for insolvency (liquidation) is filed with the State courts) distinguishes “pre-petition” services from “post-petition” services. Events that occur on or before the petition date are pre-petition. Events that occur after the petition date are post-petition.

Initially, creditors file claims for pre-petition services. Creditors often update their pre-petition claims as additional debts are identified.

At various points during the process, the bankruptcy court may allow creditors to file claims for post-petition service.

Ultimately, a debtor will be discharged (released from the jurisdiction of the bankruptcy court). Generally the discharged entity is fully responsible for the debts arising from post-discharge services, unless the court makes other arrangements.

Difference among Automatic Stay, Relief, and Discharge

The “Automatic Stay” goes into effect when the bankruptcy petition is filed. It gives the debtor/entity a break from the creditors’ collection efforts. The “stay” is not permanent. In certain circumstances the creditor can ask for “relief” from the stay.

Relief from the stay is petitioned by the creditor and shall be granted only by the court.

The “Discharge” from bankruptcy occurs at the end of the court process and closes the bankruptcy. It voids any judgment to the extent that it is a determination of the liability of a debtor/entity for a pre-petition debt. The effect of the discharge is to totally prohibit debt collection activities against the debtor as specified in the discharge papers by the court.

Affiliates

A bankruptcy/liquidation proceeding may involve all affiliates all (the components of a complex business organization) or only certain affiliates. An affiliate is not automatically part of the bankruptcy unless the petition states that the affiliate is part of the bankruptcy.

Section J1.4

Handling FOIA and Subpoena Duces Tecum

Written requests for records from members of the public are treated as FOIA requests. In addition, legal requests in the form of non-Federal Court Subpoena Duces Tecum (i.e., Subpoenas for records) also are treated as FOIA requests. The processing of such requests has historically been addressed by Medicare claims processing internal FOIA coordinator/unit.

However, the following kind of requests and non-Federal Court Subpoenas directly received at the Contractor as the result of MSP recovery activity, shall be processed by the Contractor's staff: 1) written requests and subpoena's from a beneficiary's attorney or other representative, both of which must submit a beneficiary's written and signed authorization to release records.

If the Contractor receives any other kind of a subpoena or a written request for records, it shall immediately refer the request and all associated documentation to the PO. The PO will make a determination as to how to handle the subpoena and/or the FOIA request.

When the Contractor receives a verbal request for records from an individual or entity other than the beneficiary's representative, it shall advise the caller that his/her request must be made in writing and submitted to the PO at CMS.

The MSPRC shall address all beneficiary specific FOIA requests and Subpoenas from a third party as a possible MSP lead and take appropriate action (See Pub. 100-5 Chapter 7, Sections 40 and 50).

Note: Requests made to the Contractor from a beneficiary's attorney or other representative must be accompanied by a written and signed beneficiary authorization.

Referral of Cases to COTR for Possible Government Intervention and/or Legal Action

The Contractor shall refer the following situations to the COTR:

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

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

Section J1.5

Reopenings and Appeals

J1.5.1 Reopening of Medicare Initial Determinations

J1.5.1.1 Reopening

The MSPRC shall reopen an initial determination or a redetermination to review a decision in accordance with 42 Code of Federal Regulations (CFR) 405.980 and Internet-only manual (IOM) Pub. 100-4, Chapter 34 (disregard references to hearing officers and administrative law judge (ALJ) hearings).

Background: The reopening process is separate and distinct from the Medicare fee-for-service (FFS) appeals process.

Generally, a reopening of an initial claim determination or a redetermination is a remedial action taken to correct an initial determination, where appeal rights have been exhausted. The MSPRC may choose to reopen an initial determination on its own motion or at the request of a party to the initial determination or redetermination. However, the regulations governing reopenings do not permit unrestricted reopenings of determinations and decisions.

Note: In the MSP recovery context, only beneficiary and provider/supplier recovery demand letters or beneficiary 1870 waiver of recovery determinations are “initial determinations” pursuant to 42 CFR 924. Recovery demands with respect to other entities such as employers, insurers, third party administrators, plans or other plan sponsors are not initial determinations under these regulations. The MSPRC refers potential provider/supplier MSP debts to the claims processing contractor for collection and has no responsibility for appeals related to such debts. MSPRC actions pursuant to these reopening regulations are expected to be infrequent. Additionally, when a recovery demand letter is issued to a beneficiary or to another individual/entity on a beneficiary’s behalf, only the beneficiary is considered a party to the determination. Any individual or entity receiving a copy of the recovery demand letter does not have party status (and may only request a reopening on behalf of the beneficiary if he/she/it is the designated representative of the beneficiary).

J1.5.1.1.1 Reopenings on the MSPRC’s own Motion

The MSPRC shall conduct reopenings on its own motion in accordance with 42 CFR 405.980 (b).

J1.5.1.1.2 Reopenings on the Request of a Party

The MSPRC shall conduct reopenings on the request of a party to the initial determination or redetermination in accordance with 42 CFR 405.980 (c).

J1.5.1.1.2.1 Redetermination Resolutions for Clerical Errors

The MSPRC shall resolve redetermination requests where the reason for the recovery or the unfavorable 1870 waiver of recovery action involves only a clerical error or omission (for both MSPRC and beneficiary errors) outside of the Medicare claim appeals process in accordance with Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) 937 and 42 CFR 405.980(a)(3).

Background: The MSPRC must use the reopening process instead of the appeals process when an appeal has been requested to resolve recovery claims where the reason for the recovery claim or the unfavorable 1870 waiver of recovery action involves a clerical error or omission. (Examples of clerical errors include, but are not limited to, human and mechanical errors on the part of the beneficiary or the MSPRC such as mathematical or computational mistakes or inaccurate data entry.)

NOTE: Third party payer error does not constitute clerical error.

J1.5.1.1.2.2 Documentation Requests

The MSPRC shall process redetermination requests, where the MSPRC issued a recovery demand or an unfavorable 1870 waiver of recovery determination because requested documentation was not received during the case review process, as reopenings in accordance with 42 CFR 405.980(a)(2).

Background: For the MSPRC, this situation should not be routine but could arise when, for example, the beneficiary or their representative failed to respond to a request for documentation needed to support the pro rata reduction for procurement costs so that no such reduction was provided in the demand letter or the situation could arise where the beneficiary or their representative failed to provide requested documentation in connection with a request for 1870 waiver of recovery.

J1.5.1.1.3 Reopening Appeal Cases

The MSPRC shall reopen appeals cases remanded by the Qualified Independent Contractor (QIC) to the MSPRC.

Background: If a QIC remands a case to the MSPRC for a redetermination, the MSPRC must reopen the redetermination and issue a revised redetermination. If a party has filed a valid request for a redetermination and subsequently requests a reopening, the MSPRC must conduct the appeal redetermination and cannot conduct the reopening.

J1.5.1.2 Establishing Good Cause for Reopening Initial Determinations and Redeterminations

The MSPRC shall establish good cause for reopening a determination or decision in accordance with 42 CFR 405.986.

The MSPRC shall deny reopening requests based only on a change of legal interpretation or policy by CMS in a regulation, CMS ruling, or CMS general instruction, whether made in response to a judicial decision or otherwise, or based on a third party payer's error in making a primary payment determination.

Background: The MSPRC establishes good cause to reopen a decision, either on its own motion or at the request of a party, when there is new or material evidence that may result in a different decision, or when the evidence considered in making the decision clearly shows that an obvious error existed at the time the decision was made.

NOTE: Third party payer error does not constitute new and material evidence; it does not constitute good cause. The MSPRC may only reopen for third party payer error under the "within one year for any reason" standard. This is true for both the MSPRC's own motion reopenings as well as reopenings requested by a party. All providers, physicians, and other suppliers have a legal obligation to determine the correct primary payer when billing Medicare. Information regarding such error does not constitute "new and material evidence." A representation that CMS information concerning the primary payer is inaccurate or that the primary payer made an error does not constitute "new and material evidence."

J1.5.1.3 Reopening Decisions

The MSPRC shall issue its revised determination or decision to the parties to the initial determination or redetermination in accordance with 42 CFR 405.982.

Standard 1 The revised determination or decision is timely when it is issued within 60 calendar days from the date of receipt of request or the date of QIC remand.

J1.5.2 Appeals of Medicare Initial Determinations

J1.5.2.1 Redetermination Requests

The MSPRC shall process requests for redetermination of Medicare "initial determinations" in accordance with 42 Code of Federal Regulations (CFR) 405.940-958 and Internet-only manual (IOM) Pub. 100-4, Chapter 29, section 310.

Background: A beneficiary is a party (herein after called the appellant or the party) to an initial determination may request a redetermination. The redetermination is the first level of the administrative appeal process for initial determinations. The MSPRC is responsible for processing redeterminations with respect to debts transitioned to the MSPRC and initial determinations made by the MSPRC. The second level of the appeals process is called a reconsideration. Reconsiderations are processed by a separate appeals entities called a QICs.

The rules governing redeterminations are in 42 CFR 405.940-958.

NOTE: For the purposes of MSP post-pay appeals, “initial determinations” are as defined in 42 CFR 405.924 and 405.926. These include, for purposes of the MSPRC contract, recovery demand letters issued to beneficiaries and 1870 waiver of recovery determinations issued to beneficiaries. The MSPRC has responsibility for first level appeals for such initial determinations.

J1.5.2.1.1 Acceptance of Valid Redetermination Requests

The MSPRC shall accept valid written redetermination requests filed by a party to an initial determination in the form and manner prescribed in regulation and at 42 CFR 405.944.

Background: The party must submit the redetermination request in writing to the MSPRC indicated on the initial determination. The requests must be filed within 120 calendar days of the party receiving the notice of initial determination. The initial determination receipt date shall be presumed to be five (5) calendar days after the date of the notice of the initial determination, unless there is evidence to the contrary.

Any written beneficiary communication that indicates disagreement with the initial determination should be treated as a request for redetermination. For example, a written inquiry asking “Why was I overpaid?” or stating that a beneficiary disagrees with the amount of the recovery demand should be considered a request for a redetermination.

J1.5.2.1.2 Misdirected Appeal Requests

The MSPRC shall timely forward misdirected appeal requests to the appropriate claims processing contractor, or other adjudicator (QICs, ALJs, DAB, etc.).

Standard: Misdirected redetermination requests are timely when they are forwarded to the appropriate claims processing contractor or other adjudicator within five (5) calendar days of receipt.

J1.5.2.1.3 Granting of Extensions for Late Redetermination Requests and Determination of Good Cause

In accordance with 42 CFR 405.92X, the MSPRC shall accept late filed redetermination requests if the party demonstrates good cause for missing the deadline to request a redetermination. If the 120-calendar-day period for filing a redetermination request has expired, a party to the initial determination may request an extension for filing the redetermination request.

The request for extension must be filed with the redetermination request and must be in writing, state why the request for redetermination was not filed within the required time frame, demonstrate good cause, be filed with the contractor listed on the initial determination notice and meet the requirements of J1.7.2.1.3 above. (See 42 CFR 405.942 (b).)

Good cause is determined after considering:

- The circumstances that kept the party from making the request on time;
- Whether the contractor's actions misled the party; and
- Whether the party had physical, mental, educational, or linguistic limitations, including lack of facility with the English language that prevented the party from filing a timely request or from understanding or knowing about the need to file a timely request for redetermination.

J1.5.2.1.4 Consolidation of Multiple Requests for Same Claim

The MSPRC shall consolidate separate requests for redetermination relating to the same claim into one redetermination proceeding when multiple parties submit requests for redetermination of the same claim, and the additional requests are received before a decision is made on the first request.

If multiple requests for the same claim are received before a decision is issued, the MSPRC shall issue its decision within sixty (60) days of the latest filed request.

NOTE: This situation should not arise for the MSPRC as it will be dealing with appeals where the beneficiary is the identified debtor unlike appeals of prepayment decisions where both the beneficiary and the provider/supplier may be parties.

J1.5.2.1.5 Withdrawals and Eligibility-Based Dismissals

The MSPRC shall dismiss, and provide a written notice of the dismissal, a request for redetermination in a timely manner. If a debtor without party status (or its representative) submits an appeal request, the appeal shall be dismissed, and the MSPRC shall deal with the correspondence as rebuttal correspondence.

The MSPRC shall provide a written notice of the dismissal of the redetermination request, clearly stating the reasons for the dismissal either in its entirety or as to any stated issue, transmitted to the parties at their last known address under any of the following circumstances:

When the person or entity requesting a redetermination is not a proper party under 42 CFR 405.906(b) or does not otherwise have a right to a redetermination under § 1869 (a) of the Social Security Act (the Act);

- When the party fails to file the redetermination request within the proper time frames;
- When the beneficiary or the beneficiary's representative files a request for redetermination, but the beneficiary dies while the request is pending, and the beneficiary's surviving spouse or estate has no remaining financial interest in the case; no other individual or entity with a financial interest in the case wishes to pursue the appeal; and no other party filed a valid and timely redetermination request;
- When the party filing for redetermination submits a timely written request of withdrawal to the MSPRC before a redetermination decision has been issued. A party that files a request for

redetermination may withdraw his or her request by filing a written and signed request for withdrawal. The request for withdrawal must contain a clear statement that the appellant is withdrawing the request for redetermination and does not intend to proceed further with the appeal. The request must be received in the MSPRC mail room before a redetermination has been issued (See 42 CFR 405.952 (a)); and

- When there has been no initial determination on the matter for which a redetermination is sought.

NOTE: In the MSP recovery context, the MSPRC should receive few erroneous requests. The beneficiary (or the beneficiary's representative on the beneficiary's behalf) should be the only individual submitting an official appeal request as MSP provider/supplier recoveries will be done by the claims processing contractor.

J1.5.2.1.6 Assistance to Beneficiary

The MSPRC shall assist the beneficiary in obtaining from the provider any additional information needed to process and complete the redetermination.

The MSPRC shall clearly annotate the redetermination case file with any requests for additional information made on behalf of the beneficiary.

NOTE: This situation is not expected to arise in the MSP recovery context. Normally there would be no reason to contact a provider/supplier for further information as they would not have information relevant to the type of issue generally on appeal in connection with an MSP recovery demand.

J1.5.2.1.7 Conduct of the Redetermination

The MSPRC shall make a timely, independent, accurate, supportable decision on each issue in dispute, and issue a decision to dismiss, fully affirm, partially reverse, or fully reverse the initial determination in question, based on the evidence of record including applicable laws, regulations, and policies.

Background: A redetermination is an independent review of an initial determination. Redeterminations are conducted in accordance with § 1869 of the Act, 42 CFR 405.948–405.958, and IOM Pub. 100-4, Chapter 29, § 310.

Standard 1 Redeterminations are successful when all redeterminations (where no additional evidence is submitted after the request) are accurately processed and the redetermination decision notice is mailed within sixty (60) calendar days of receipt of the request in the corporate mailroom or within sixty (60) days of the latest filed request for consolidated redetermination requests for the same claim. The sixty (60)-calendar day decision-making time frame may be extended by fourteen (14) calendar days in accordance with 42 CFR 405.946.

NOTE: For the MSPRC, the issues on appeal will be either the existence or amount of the recovery claim and/or the prior 1870 waiver of recovery determination.

J1.5.2.1.8 Documenting the Redetermination Case Files

The MSPRC shall document the redetermination case files with all relevant information, evidence, and supporting documentation and identify the individuals involved in making the initial claims determination and the redetermination.

J1.5.2.1.9 Notice of Redetermination

The MSPRC shall mail, or otherwise transmit, to the beneficiary at his/her last known addresses, a written notice of the redetermination decision that is accurate, clear, concise, and is in printed form and written in a manner that is understandable to the individual entitled to notice in accordance with § 1869(a) of the Act and all current, related CMS operating instructions.

Standard 1 Redetermination notices are successful when they are processed and mailed within sixty (60) calendar days of the date the MSPRC receives the valid and timely filed request. (Note: If the appellant submits additional evidence after filing the request for redetermination, the MSPRC's timeframe for making the decision is extended by fourteen (14) calendar days). The sixty (60) calendar day decision-making time frame may be extended by fourteen (14) calendar days in accordance with 42 CFR 405.946.

Standard 2 All redetermination decisions on recovery claims must be addressed to the debtor with a copy to his/her representative (if applicable). The MSPRC shall not address the determination to the representative.

J1.5.2.2 Appeal Decision Effectuation

The MSPRC shall effectuate all levels of appeal decisions (redeterminations, reconsiderations, ALJ, DAB, and federal court) received from the QIC or AdQIC.

Standard 1: 95% of all of MSPRC redeterminations or subsequent appeal decisions are effectuated by the MSPRC within the same monthly financial reporting period as the date(s) of the decisions.

Section J1.6

Miscellaneous MSP Policy

Self-Insurance

Liability insurance includes self-insurance. Additionally, 42 U.S.C. 1395y(b)(2)(A) (Section 1862(b)(2)(A) of the Act) specifically provides that "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part."

Causation Issues

In liability, no-fault, or workers' compensation situations, the debtor/potential debtor may assert that certain Medicare reimbursed services are not subject to a MSP recovery claim because it has not been established that the accident/illness/injury/incident in question caused the condition requiring the services in question or it has not been established that the accident/illness/injury/incident is related to the services in question. A variation on this is an allegation that certain Medicare reimbursed services are not subject to an MSP recovery claim because a pre-existing condition would have required the services in question regardless of the accident/illness/injury/incident or the accident/ illness/injury/incident simply exacerbated a pre-existing condition.

42 U.S.C. 1395y(b)(2)(B) (§ 1862(b)(2)(B) of the Act) provides for reimbursement to the Medicare trust funds for conditional payments made by Medicare when it is demonstrated that a primary plan has or had a responsibility to make payment with respect to an item or service. The primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon a recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.

This means that Medicare looks to whether or not the items or services in question are/were related to what is/was claimed and/or released with respect to a settlement, judgment, award, or other recovery. The MSPRC does not make determinations about whether or not the accident/illness/injury/incident in question caused or is responsible for or related to the need for the Medicare reimbursed services in question.

Where a debtor/potential debtor is challenging the inclusion of a particular item or service included in Medicare's identified conditional payment amount or recovery claim, the contractor must obtain the beneficiary's liability, no-fault, or workers' compensation claim and/or pleading and settlement/judgment/award/recovery documents (i.e., the Complaint or Settlement Agreement) in order to determine what the beneficiary has claimed or released and whether or not the items or services in question are related to what has been claimed and/or released. The MSPRC shall routinely obtain these documents in product liability situations.

Along this same line, the MSPRC must be aware that statements that “liability has been denied,” “compensability has been denied,” etc. are insufficient to close a pending liability, no-fault, or workers’ compensation recovery case. If this type of statement is provided, the parties must state in writing that there has been no type of settlement, judgment, award, or other recovery (including a so-called nuisance settlement) and that there is no longer a pending claim.

Conditional Payment Letters

Interim conditional payment letters must state that the amount reflected, even if zero, is not a final amount; and that the amount must be updated once there is a settlement judgment or award.

Confidentiality Agreements

In some instances a beneficiary/beneficiary’s attorney will assert that the beneficiary cannot provide settlement documents because a confidentiality agreement was signed in conjunction with the settlement.

42 CFR § 411.23(a) requires that a Medicare beneficiary assist Medicare in obtaining information relevant to a payment from a primary plan. 42 CFR § 411.23(a). Further, 42 CFR § 411.24(a) provides that the filing of a Medicare claim by, on, or behalf of the beneficiary constitutes an express authorization for any entity, including State Medicaid and worker compensation agencies, and data depositories, that possesses information pertinent to the Medicare claim to release that information to CMS. A beneficiary’s assertion that he/she has signed a confidentiality agreement does not trump these pre-existing Federal regulatory provisions.

Section J1.7

General Medicare Secondary Payer (MSP) Recovery Policy

10 - General

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

Contractor shall acknowledge and respond to **all** correspondence within 45 calendar days from the date of receipt in their corporate mailroom or in any other mail center location, absent instructions to the contrary for a particular activity.

10.1 – IRS/SSA/CMS Data Match (Data Match) AND Non -Data Match GHP Identified Cases

1. The contractor shall use the data that Recovery Management and Accounting System (ReMAS) produces as an output to identify GHP leads. The contractor shall use ReMAS system batch processing to identify those claims potentially subject to recovery. The contractor shall send out a Primary Payment Notice (PPN), based on CMS mutually agreed upon thresholds and timeframes, to the potential debtor and their identified insurer/TPA requesting they verify primary payment responsibility for all claims generated by ReMAS system prior to issuing a GHP demand letters. The GHP MSP lead information with coverage dates for each beneficiary shall be sent to the insurer/TPA and employer/plan sponsor in the PPN package to determine the validity of the leads. The PPN will serve as a potential verification of GHP leads. For valid cases, the contractors shall send the employer a demand letter. The demand package shall include claims facsimiles or claims detail (i.e., Payment Record Summary) for the claims for which Medicare seeks payment and the other identified enclosures to the letter. Contractors shall aggregate (for mailing purposes) all Data Match and Non-Data Match letters. A courtesy copy of the entire employer demand package shall be mailed to the insurer/TPA, which includes the claims facsimiles or claims detail.

2. The employer or other entity acting on the employer's behalf may respond with a full payment. If the employer or other entity repays Medicare in full (including any applicable interest), contractors shall close the case. Contractors shall send an acknowledgment or response to the full payment by notifying the employer with a copy to the insurer/TPA, if the insurer/TPA had sent in full payment with an employer authorization to act as its agent.

3. If the employer or other entity provides a full payment for certain services and provides a valid documented defense for all other services, contractors shall close the case. A valid documented defense consists of evidentiary material demonstrating that the GHP is not obligated to repay Medicare pursuant to the MSP provision. (An assertion of a defense without supporting evidence is **not** a valid documented defense.) Contractors shall send an acknowledgment or response to the payment and acceptance of the valid documented defenses offered by notifying the employer, only. If the employer or other entity makes less than a full payment or provides less than a valid documented defense, contractors shall adjust the debt as

appropriate and continue collection activities. Contractors shall send an acknowledgment or response to the partial payment or invalid defense by notifying the payer.

1. To the extent that an employer or the other entity responds with a valid documented defense to any portion of a recovery claim, contractors shall adjust the debt accordingly. If the valid documented defense is that the GHP made primary payment to a provider/supplier or beneficiary, contractors shall recover from the provider/supplier or beneficiary. If an employer or other entity requests specific information or asks a specific question about the recovery claim, contractors shall provide the information or answer the questions. r's

2.).

10.3 – Other Sources of Recovery Actions

10.3.1 - GHP Acknowledges Specific Debt (42 CFR 411.25)

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

In some circumstances the GHP will specifically acknowledge debt through 42 CFR 411.25 notification. In 42 CFR 411.25, a GHP is obligated to provide notice to the contractor that paid the claim when the GHP learns that Medicare made a mistaken primary payment for which the GHP had primary payment responsibility. (For a more detailed explanation of a GHP's notification responsibility under 42 CFR 411.25, please refer to 10.3.1.A Exhibit on 42 CFR 411.25 Background Information.) If a contractor receives **notice only** under 42 CFR 411.25 from a GHP along with identification of the specific claims for which Medicare mistaken primary payments were made, the contractor shall:

Confirm whether a CWF record of the MSP situation has been established. If a record has been established, do not send an ECRS transaction to the COBC, as the COBC will already have the MSP information. This will eliminate duplication. If a record has not yet been established, send an ECRS transaction to COBC. After COBC updates the MSP record resultant from the GHP's submission, all appropriate contractors will receive an alert from CWF when the MSP record is posted to CWF. (For more detailed information regarding the automatic notice process, refer to Pub.100-05 MSP, Chapter 6, §30, Subsection 4 on Automatic Notice of Change to MSP Auxiliary File).

If a GHP sends **42 CFR 411.25 notice and a refund check** (classified as a voluntary/unsolicited refund) along with identification of the specific claims for which Medicare mistaken primary payments were made, the Medicare contractor shall:

- 1) Look for any indication that the GHP has advised COBC of its primary payment responsibility. (e.g., there may be a cc at the bottom of the requesting showing COBC was copied, etc.)

- 2) If there is no indication that the GHP has advised COBC of its primary payment responsibility, forward the 42 CFR 411.25 notice information to COBC via ECRS. If there is an indication that the GHP has advised COBC of its primary payment responsibility, do not send an ECRS request.
- 3) Process the refund check as described in Pub. 100-06 Chapter 5, §410.4.

10.3.2 - Recovery from the Provider, Physician, or Other Supplier

If both Medicare and the GHP made primary payment to the provider, physician, or other supplier, the contractor shall send notification to the claims processing contractors to recover from the provider, physician, or other supplier. Interest charges shall be assessed if repayment of the debt does not occur within the identified timeframe.

When a provider, physician, or other supplier receives payment from a GHP where Medicare has also paid, the provider, physician, or other supplier submits an adjustment bill showing the primary payment amount. The fact that the provider, physician or other supplier received two primary payments establishes the repayment obligation. The claims processing contractors shall instruct the provider, physician, or other supplier to return to the beneficiary the amounts of the Medicare deductible and coinsurance already paid. The provider, physician, or other supplier may retain any excess GHP payment over the gross amount payable by Medicare.

If duplicate payment was or will be made to the provider, physician, or supplier, i.e., the provider, physician, or supplier received both primary GHP payments and primary Medicare benefits, the claim processing contractors shall collect the duplicate primary payment from the provider, physician, or other supplier by sending the letter found at 10.5.3. The amount to be recovered is the lesser of the amount paid by Medicare and the amount that the GHP paid as its full primary payment. If the GHP is an HMO that paid the provider/physician or other supplier on a capitation basis, the appropriate amount to recover is the amount that Medicare paid.

10.3.3 – Recovery from a Beneficiary Who Has Received Primary Payment from Both Medicare and a GHP

If both Medicare and the GHP made primary payment to the beneficiary, the claims processing contractors recover the appropriate amount from the beneficiary. The appropriate amount to be recovered is the lesser of the amount that Medicare paid and the amount that the GHP paid as its full primary payment. Interest charges **shall not** be accessed to the beneficiary for this type of recovery situation.

If Medicare paid the provider, physician or other supplier and the GHP paid the beneficiary, Medicare does not recover from either entity. Likewise, Medicare does not recover from any entity if the GHP paid the provider, physician or other supplier and Medicare paid the

beneficiary. Medicare has recovery rights against providers, physicians and other suppliers, and beneficiaries only if BOTH Medicare and the GHP paid the same entity.

10.3.4 - Recovery When a State Medicaid Agency Has Also Requested a Refund from the GHP

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

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

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

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

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

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

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

10.3.5 - Identification of GHP Mistaken Primary Payments via the Recovery Management System (ReMAS)

ReMAS will aggregate claims, for which the same debtor or debtor relationship is responsible for payment, into one case lead in ReMAS. Therefore, a ReMAS GHP case may consist of one debtor or debtor relationship with an assortment of beneficiaries ReMAS will maintain lead listing of these new cases. The contractor shall access the lead list and select the GHP option, to identify its new GHP workloads and to determine completeness or accuracy of the debtor information. Currently the GHP Lead List in ReMAS does not display the employer and insurer name and address. The contractor shall access the case via the lead id number within the report and pull up the debtor information to determine validity. If the debtor information (e.g., employer information) is incomplete or inaccurate (e.g., there is no state code, the employer does not have a street address or P.O. Box, etc.), the contractor shall send an ECRS transaction to the COBC.

10.3.5.1 – Progression of ReMAS GHP Lead Identification

GHP Lead is added in status “DEV” – Ready to develop, unless:

- It has the same coverage effective date and MSP types as another lead already in the database. This situation will cause the lead to set as “DUP” – Duplicate Lead; and
- It has an overlap in coverage dates with another GHP lead that is already in the database. This situation will cause the lead to set as “CON” – Conflicting lead

The user can convert these statuses to either “DEV” to develop the lead or “DEL” to delete the lead. ReMAS will hold leads for a “waiting period” of 60 days before initiating a history search. This “wait period” is to ensure the validity of the record. Any CWF updates made by the COBC as a result of their responding to the ECRS referral or obtaining new information after the lead was created in ReMAS will be overlayed in the ReMAS lead case. Contractors shall track all ECRS referrals specific to inaccurate or incomplete debtor (employer) information. Upon the lead reaching 55 days from the date of accretion, the contractor shall delete all employer

information in the ReMAS case while the case is still in a “DEV” status, if it still remains incomplete or inaccurate, thereby enabling ReMAS to assign the insurer as the debtor prior to the case moving into a “RES” status. In the event the insurer information is not accurate or complete but there is accurate and complete employer information, delete the insurer information in the ReMAS case.

10.3.5.2 – Progression of ReMAS GHP History Search

Each Wednesday night the DESY request process sends out requests for any GHP lead within ReMAS that have been in the system for at least 60 days.

- Those cases having been in ReMAS for 60 days will have their status moved systematically to “DIN” – Development initiated, unless:
 - the lead coverage dates end before the GHP recovery date (begin date of history search request). This situation will prompt the case to be moved to a “PRR” – Prior to ReMAS recovery; no request is sent to DESY.

ReMAS will not initiate a national claims history search for GHP leads until 60 days after the lead was created/accreted.

Current ReMAS functionality does not allow a user to delete an employer or insurer from an MSP lead once the case is in status “RES.” An invalid debtor cannot be removed when in an “RES” status.

- When all claim requests for the lead are complete, the lead is put into status “DCM” – Development complete.
- On request the GHP case creation process is run. This aggregates all the claims that have been retrieved for leads that are in status “DCM” by debtor (i.e., employer/insurer combination, employer, or insurer) to create cases.
- The claims for these leads are assembled and, if the total mistaken primary payment exceeds the tolerance, a case is created and immediately put into status “RES” for transmission to HIGLAS.

HIGLAS will receive two files, one containing the debtor and debtor relationship information (ANSI 271) and one containing claims detail (ANSI 810). Depending on the actual debtor information interfaced to HIGLAS, there will be instances when HIGLAS will generate 1 of 3 letters; 1) an employer GHP letter, 2) an insurer/TPA GHP letter or 3) a letter having the employer and the insurer/TPA as addressees. In this instance, the employer is the primary debtor. The contractor will receive a second demand letter package addressed to the insurer/TPA through the HIGLAS letter generation function.

Upon successful interface with HIGLAS, the HIGLAS system will create the receivable and generate a demand package to be sent to the designated contractor’s print locations. All

activities or actions taken on the case/debt after the ReMAS interface to HIGLAS shall be addressed in HIGLAS. For example: if the debtor submits a valid documented defense, the adjustment shall be completed in HIGLAS by the contractor.

10.4 – Contractor Recovery Case Files (Audit Trails)

Contractors shall maintain arecovery case file for all cases in which they have attempted recovery. Contractor case files may be in an electronic format. Contractors shall recreate or retrieve requested cases files within two (2) business days of a request. Contractors maintaining an electronic case file must be able to supply complete demand packages, copies of refunds, copies of all correspondence disputing a debt and copies of all contractor response to correspondence. Contractors having ReMAS and HIGLAS access, shall supply, recreate or retrieve complete case data, whether contained in ReMAS, HIGLAS or hardcopy (e.g., correspondence) within two (2) business days of the request.

Each hardcopy case file must be organized as follows:

- Place the label on the outside of the folder where it can be readily seen, preferably at the upper left hand corner of the file folder with the name of the third party payer;
- Label the upper right hand corner of the file folder with the name and HICN of the beneficiary;
- The following documents should be inside the file folder;
- Copies of all demand letters;
- Copies of the return receipt mail card, if applicable;
- Copies of any responses from the debtor or entity acting on behalf of the debtor;
- Copies of all claims or claims detail for which a recovery is being sought;
- Any other materials or correspondence related to the case; incoming and outgoing responses/correspondence. This includes fax copies, telephone contact sheets, etc.
- All these materials should be fastened to the right hand side of the file folder.

NOTE: For those items/documents, which cannot be recreated via ReMAS, HIGLAS or contractor standard systems, contractors shall create case files to maintain the items.

10.5 - GHP Letters (Used for ReMAS-HIGLAS When the Only Debtor Interfaced to HIGLAS is the Employer)

10.5.1 – Beneficiary GHP Demand Letter (DPP scenario)

Beneficiary Name:

Beneficiary Address:

Beneficiary City, State, Zip Code

Debt Owed to Medicare: \$ _____

Debt Identification Number: _____

Dear [Beneficiary Name]:

Medicare has identified a claim or a number of claims (see enclosed documentation) for which you received primary payment from Medicare and the identified group health plan. The group health plan has acknowledged that it was the proper primary payer and has reported that it also made primary payment to you. Medicare's regulations require beneficiaries that receive a primary payment from Medicare and a primary payment from a group health plan to repay Medicare within 60 days of receipt of the second primary payment. We were unable to find any records showing that you previously refunded Medicare's payment. As we have no record of repayment, Medicare must recover at this time.

The Centers for Medicare & Medicaid Services (CMS) has determined that the amount of this debt is **[insert lesser of Medicare payment or GHP payment]**. Please send us a check or money order for the full amount due. Please make the check or money order payable to Medicare and reference the debt identification number provided in this letter. Please send your payment to:

Contractor Name – MSP Unit

Contractor Address

City, State, Zip Code

If full repayment of this debt cannot be made within 60 days of the date of this letter, you may send us a written request for an extended repayment plan. Your proposed repayment schedule should explain why repayment in full cannot be made at this time. Documentation to support the requested repayment schedule must be provided at the time that the request is made. The initial payment (first month) must accompany the request for an extended repayment plan.

[contractors-Insert standard paragraph concerning appeal rights pursuant to 42 CFR 405.700ff or 405.800ff]. You may request that collection of this debt (duplicate payment) be waived. For a waiver to be approved, both of the following conditions must be satisfied:

1. This debt (overpayment) was not your fault because the information you provided to the party that submitted the claim to Medicare was complete and accurate (including the name and primary payment responsibility of the identified group health plan); and, when the Medicare payment was made, you thought the amount of the payment was correct; **AND**
2. Paying this debt to Medicare would cause financial hardship OR would be unfair for some other reason.

If you believe that both of these conditions apply in this case, please let us know and provide a brief statement of the reasons for your belief. We may ask for additional information regarding your income, assets, expenses, etc. We will notify you if recovery of this debt (overpayment) can be waived.

If you have any questions about this letter or debt to Medicare, you may contact _____ at _____.

Sincerely,

MSP Supervisor

Enclosures

10.6 – Accountability Worksheet (Not Applicable to ReMAS/HIGLAS Users)

Data Match Report (if applicable): _____ Data Match Report Date

(if applicable): _____ Beneficiary Name:

_____ Beneficiary HICN:

_____ Third Party Payer:

_____ First Demand Sent:

_____ Second Demand Sent:

_____ Recovery Status:

_____ Recovery Status Date:

_____ Total Potential Mistaken Payment Identified:

\$ _____ Additions: _____ \$ _____ Total

Recovered: _____ \$ _____ Difference Between Identified

Amount and Amount Recovered (1) \$_____ Briefly Explain Above Entry: If the identified third party payer paid primary, list the entities from whom you were required to recoup duplication payment and amount recovered on an attachment.

**10.7 - MSP Summary Data Sheet (Not Applicable to ReMAS/HIGLAS Users)
- Field Descriptions on the MSP Summary Data Sheet**

MSP SUMMARY DATA SHEET	REPORT ID:
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TYPE OF MSP SITUATION: WORKING AGED

DATE OF ACTUAL NOTICE:

BENEFICIARY NAME:

HEALTH INSURANCE CLAIM NUMBER (HICN):
DATE OF BIRTH:
THIRD PARTY PAYER NAME:
THIRD PARTY PAYER ADDRESS:
COVERAGE BEGIN DATE: COVERAGE END DATE:
GROUP IDENTIFICATION:
PATIENT POLICY IDENTIFICATION:
SUBSCRIBER NAME:
EMPLOYEE ID NUMBER:
EMPLOYER NAME:
EMPLOYER ADDRESS:

REPAYMENT AMOUNT REQUESTED *SEE ATTACHED DOCUMENTATION
ACCRUED INTEREST/RATE/DATE
TOTAL REPAYMENT AMOUNT REQUESTED INCLUDING INTEREST
MAKE YOUR CHECK OUT TO: THE MEDICARE PROGRAM MEDICARE SECONDARY PAYER UNIT AT TAX EIN: PLEASE INSURE THAT THE REPORT ID AND HICN LISTED ON THE SUMMARY SHEET IS REFERENCED ON YOUR CHECK.
X CHECK BOX IF CASE WAS IDENTIFIED THROUGH THE IRS/SSA/CMS DATAMATCH

Type of MSP Situation - The contractor shall indicate whether the situation is working aged, ESRD, or disability.

Date of Actual Notice - For IRS/SSA/CMS Data Match recoveries this is the date the mistaken payment report (sent via National Data Mover (NDM) by CMS to the contractor) is run against the contractor's internal history file For NON-IRS/SSA/CMS Data Match recoveries this is the date the contractor had actual notice. Actual notice is when the contractor is aware of the following information:

- Name and Address of the insurer, underwriter, third party administrator;
- Name of the beneficiary;
- Health Insurance Claim Number or Social Security Number of the beneficiary;
- Name of the subscriber; and

• Effective dates of coverage under the plan. For some recoveries, contractors will not list a date because all the information to constitute actual notice is not available. However, contractors should still attempt recoveries and attempt to

obtain this information through the recovery process. If sufficient information is not available to establish actual notice, indicate "Actual Notice Not Established" in this field. Beneficiary Name

- Self Explanatory; Health Insurance Claim Number - Self Explanatory; Date of Birth - Self

Explanatory; Third Party Payer Name - The name of the entity that is identified as the primary insurer for the

beneficiary. (For example, Blue Cross and Blue Shield of Maryland, United Healthcare, etc);

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

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

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

applicable); Group Identification - The number or code assigned by the third party payer to represent the

group the beneficiary has coverage under. NOTE: Not all third party payers use group

identification numbers; Patient Policy Identification - The number or code assigned by the third party payer to represent

the policy number the beneficiary has coverage under. NOTE: Not all third party payers use

policy identification numbers; Subscriber Identification Number - The Social Security Number of the employee (beneficiary or spouse);

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

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

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

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

- First Demand Letter - Insert the date on which interest will begin to be charged and the rate of interest; or
- Second Demand Letter - The total amount of accrued interest, (also indicate the rate of interest) applicable to a debt which has not been repaid timely;

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

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

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

10.8 – Payment Record Summary (Used with ReMAS/HIGLAS Users but in a Modified Format)

PAYMENT RECORD SUMMARY

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

10.8.1 - Field Descriptions on the MSP Summary Data Sheet

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

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

- Name and Address of the insurer, underwriter, third party administrator;
- Name of the beneficiary;
- Health Insurance Claim Number or Social Security Number of the beneficiary;
- Name of the subscriber; and

• Effective dates of coverage under the plan. For some recoveries, contractors will not list a date because all the information to constitute actual notice is not available. However, contractors should still attempt recoveries and attempt to

obtain this information through the recovery process. If enough information is not available to establish actual notice, indicate “Actual Notice Not Established” in this field. Beneficiary Name

- Self Explanatory; Health Insurance Claim Number - Self Explanatory; Date of Birth - Self Explanatory; Third Party Payer Name - The name of the entity that is identified as the primary insurer for the

beneficiary. (For example, Blue Cross and Blue Shield of Maryland, United Healthcare, etc);

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

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

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

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

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

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

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

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

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

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

- First Demand Letter - Insert the date on which interest will begin to be charged and the rate of interest; or
- Second Demand Letter - The total amount of accrued interest, (also indicate the rate of interest) applicable to a debt which has not been repaid timely;

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

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

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

10.9 – Courtesy Copy of All MSP Employer GHP-Based Recovery Demand Packages to the Employer’s Insurer/Third Party Administrator (TPA)

All contractors currently initiate Data Match and Non-Data Match GHP-based recoveries of mistaken payments to the employer (considered the debtor if it received the original demand) if the employer is known. In order to facilitate employer efforts in responding to demand packages, contractors shall send a copy of these demand packages to the employer’s insurer/TPA, if the insurer/TPA is known. For purposes of this section, the term “demand package” also includes the “intent to refer” package Refer to the definition of “debtor” and “current debtor.” The courtesy copy sent to the employer’s Insurer/TPA does **not** change the employer’s status as the “debtor.” The insurer/TPA is **not** considered a debtor because the insurer/TPA was not the addressee on the original demand letter.] Contractors on ReMAS/HIGLAS shall also comply with the sending of the courtesy copy of the demand package(s) to the employer’s insurer/TPA. HIGLAS will print the demand letter with both addressees at the top. The employer is still considered the “debtor.” The insurer/TPA addressee will be used as the courtesy copy. Contractors shall attach a cover letter to the courtesy copy of the entire demand package to the insurer/TPA.

Contractors shall:

1) Send a copy of all GHP-based recovery demand packages issued (initial recovery demand and subsequent “intent to refer” letter and all enclosures) to the employer’s insurer/TPA at the same time they issue the original or subsequent demand package to the employer. A package issued to the Insurer/TPA shall contain a complete set of claims facsimiles used to calculate the demand amount. Send the copy to the address shown on the Common Working File (CWF) MSP Auxiliary File.

- a. o In the event the insurer/TPA is not known or the address is incomplete, the contractor should not develop further for the insurer/TPA name or address or send Electronic Correspondence Referral System (ECRS) inquiries to the Coordination of Benefits Contractor.
- b. o In the event the insurer/TPA copy is returned to the contractor as “undeliverable,” do not attempt to find a better address.
- c. o In the event a particular insurer/TPA consistently returns/refuses their courtesy copies of an employer’s demand packages, the contractor should cease mailing courtesy copies to that insurer/TPA for that employer.

(NOTE: Elimination of the courtesy copy shall be on a debtor specific basis only after written agreement by the contractor’s COTR)

- 2) Use a cover letter with the copy of the demand package sent to the insurer/TPA. This letter is mandatory in order to ensure consistency. This cover letter should be PC generated..
- 3) Maintain or ensure recreation of copies of all letters and demand packages sent to employers and insurers/TPAs within the case file. For those contractors on ReMAS and HIGLAS, both systems have a recreate function.

4) Respond to the appropriate individual/entity when contacted about a debt.

a.

If the insurer/TPA is acting as an agent of the employer, the contractor shall address correspondence to the employer with a copy to the insurer/TPA. The insurer/TPA cover letter sets forth the documentation required when an insurer/TPA wishes to act as an agent to resolve a debt on behalf of its client, an employer debtor.

b.

If an insurer/TPA submits payment or an alleged valid documented defense but has not submitted documentation establishing its authority to act on behalf of the employer to resolve the debt, contractor shall communicate with the employer only. You may accept the payment and/or

evaluate any documentation or defense provided, but contractor **shall not** share information about the case with the Insurer/TPA without the authorization.

Contractor shall follow debt referral procedures provided in this document. The fact that the insurer/TPA receives a copy of the demand package or that the insurer/TPA may be given authority to resolve a debt on behalf of its client (the employer) does **not** change the status of the employer as the debtor and as the entity to be referred to Treasury.

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

10.10 – ReMAS Error Reports

Error reports are sent to the ReMAS Central Office support staff by HIGLAS if there were errors or edits during the interface which resulted in a case not having an accounts receivable or demand letter generated.

ReMaS support staff will convey to contractors all case errors or edits related to the validity or integrity of the debtor information. The contractor shall submit an ECRS inquiry when necessary to correct any debtor information.

ReMAS support staff will provide more specific direction when trending has taken place and contractor needs identified.

10.11 – ReMAS/HIGLAS GHP Initiated Recoveries: General Information

10.11.1 – ReMAS/HIGLAS GHP Demand Process

The ReMAS and HIGLAS interface will afford the use of dual addressees. The ReMAS/HIGLAS GHP demand letter will be generated in HIGLAS when there is employer **and** insurer/TPA information (on CWF) interfaced from ReMAS to HIGLAS. This letter will be addressed to both the employer and the insurer/TPA.

If the ReMAS case has employer information contained within CWF and no insurer information, then HIGLAS will send a GHP demand to the employer only. If insurer information is contained within CWF without any or complete employer information, then the interface will take place with HIGLAS and an insurer/TPA GHP demand letter generated.

Contractors on the ReMAS/HIGLAS systems shall follow debt collection and referral procedures as defined in this document and Pub. 100-06, Chapter 5. All activities associated to the collection, adjustment, write off, referral or closure of this debt shall be documented within the HIGLAS. The employer within the ReMAS/HIGLAS dual addressee demand letter is the “prime” debtor and shall be referred for cross-servicing, if appropriate.

Contractors on the ReMAS/HIGLAS systems shall follow instructions specific to insurer/TPA employer authorizations and defenses.

HIGLAS will generate the demand letter specific to the debtor and type of case identified. Two letters will be printed; 1 for the employer and one for the insurer/TPA. The employer is the primary debtor, therefore any actions specific to non-response or delinquency shall be initiated against the employer. The ReMAS/HIGLAS GHP Demand letter will contain certain enclosures not reflected in these instructions. Those enclosures are listed at the end of the model letter.

20 - Medicare Right of Recovery

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

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

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

- May recover directly from employers, Workers’ Compensation (WC) carriers, or GHPs, Medicare benefits paid for services furnished to an individual for whom Medicare is the secondary payer. The Government may recover from WC regardless of whether or not a specific claim for the services for which recovery is sought was filed as long as the beneficiary filed a WC claim related to the underlying injury or illness.
- May recover or take legal action to recover erroneous primary benefits paid from any entity that has been paid by an employer, WC carrier or any GHP;
- May join or intervene in any WC claim where the compensability of the injury is at issue or in any legal action against a GHP related to the events that gave rise to the need for the items or services;

- Is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from a GHP, an employer or a WC carrier; and
- May bring legal action against any entity that is required to make or is responsible for payment and may collect double damages.

20.1 - Conflicting Claims by Medicare and Medicaid

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

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

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

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

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

claim does the beneficiary, attorney, provider, or supplier have the right to reimburse Medicaid or another entity.

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

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

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

Denial by an insurer on the ground that Medicare is primary payer may be a forerunner of similar action on multiple claims. The FI or carrier contacts the insurer and explains that under Federal law no-fault insurance is primary payer and Medicare is secondary regardless of the provisions of the no-fault insurance policy or the provisions of the State insurance law. It refers noncompliance cases to the RO.

20.3 - Coordination of Benefits Arrangements Between Private Plans

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

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

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

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

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

20.4 - Procedures for Actions With Legal Implications in MSP Situations

20.4.1 - Handling Freedom of Information (FOIA) and Subpoena Duces Tecum Received in the MSP Units

Written requests for records from members of the public are treated as FOIA requests. In addition, legal requests in the form of non-Federal Court Subpoena Duces Tecum (i.e., Subpoenas for records) also are treated as FOIA requests. The processing of such requests is usually handled by the contractor's internal FOIA coordinator/unit.

However, the following kinds of requests and non-Federal Court Subpoenas directly received in the MSP areas as a result of MSP recovery activity, shall be processed by the contractor's MSP staff: written requests and subpoena's from a beneficiary's attorney or other representative, both of which must submit a beneficiary's written and signed authorization to release records.

If a contractor receives any other kind of a subpoena or a written request for records, it shall immediately refer the request and all associated documentation to the contractor's internal FOIA Coordinator. The FOIA Coordinator shall make a determination as to how to handle the subpoena and/or the FOIA request.

When a contractor receives a verbal request for records from an individual or entity other than the beneficiary's representative, it shall advise the caller that his/her request must be made in writing and submitted to its internal FOIA Coordinator.

The MSP unit shall address all beneficiary specific FOIA requests and Subpoenas from a third party as a possible Medicare Secondary Payer (MSP) lead and take appropriate action (See Pub. 100-5 Chapter 5).

NOTE: Requests made to the MSP area from a beneficiary's attorney or other representative must be accompanied by a written and signed beneficiary authorization.

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

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

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

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

20.4.3 - Other Referrals to CMS

The FI or carrier refers all cases where recovery is not made to the RO. In addition, it refers all cases where a GHP or employer claims that it is secondary to Medicare (irrespective of whether or not any Medicare benefits were paid).

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

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

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

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

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

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

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

If the WC carrier either declines to refund the overpayment or indicates a long delay will be necessary, the FI or carrier refers the file to its appropriate RO. It fully explains the WC issue and recommendations for disposition of the case. It includes copies of all pertinent documents, including the WC award and correspondence and reports of contact with the WC carrier, the State WC carrier, the State WC agency, and the beneficiary. The CMS RO reviews the case and determines what further action to take.

20.5 - Mistaken GHP Primary Payments

The GHP, employer or other entity representing the GHP or the employer may request that the Medicare contractor pay the GHP, employer or other entity the amount the GHP paid, the amount that Medicare would have paid if a proper claim had been filed or some other amount. The contractor shall advise the GHP, employer or other entity that the Medicare law does not authorize payment to an entity other than the beneficiary, provider, physician or other supplier upon presentation of a claim for Medicare covered services which satisfies all of Medicare's claim filing requirements. Medicare does not recognize so called "assignments of right to payment" by providers, physicians, other suppliers and individuals to GHPs.

The GHP, employer or other entity may request the Medicare contractor's assistance in recouping its alleged mistaken primary payment and in having the provider or supplier bill Medicare. The Medicare contractor shall advise the GHP, employer or other entity that the Medicare contractor may not provide the requested assistance. The Medicare contractor shall further explain that Medicare does not waive its timely filing requirement for initial claims from providers, suppliers and beneficiaries when a GHP recoups its "mistaken primary payment." This is because there has been no Governmental error. In addition, Medicare does not re-open claims previously adjudicated and either denied or paid as a secondary payer beyond one year of the date of initial determination on the original claim. This is because Medicare's regulations establish that "good cause" for Medicare to re-open a claim after one year does not exist in this situation.

The GHP, employer or other entity may request that the Medicare contractor provide written agreement that it is the primary payer for certain specified services or all claims between specified dates. The Medicare contractor shall advise the GHP, employer or other entity that it will process claims in accordance with Medicare coverage rules and consistent with Medicare's

payment and claim submittal requirements. The Medicare contractor shall further advise the GHP, employer or other entity that Medicare does not waive its timely filing requirements for initial claims and does not re-open previously adjudicated claims beyond one year from the date of initial determination in these situations.

30 – Mistaken Primary Payment Activities and Record Layouts

30.1.1 - COBC Responsibility to Obtain Missing MSP Information

Development for other insurance information is the responsibility of the Coordination of Benefits Contractor (COBC). See Medicare Secondary Payer (MSP) Manual, Chapter 4, “Coordination of Benefits Contractor (COBC) Requirements,” for an explanation of development responsibilities.

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

Medicare contractor send MSP recovery demand letters in MSP situations involving GHPs to the employer that sponsors or contributes to the GHP that provides coverage to the identified beneficiaries. There are three types of such recovery situations: The IRS/SSA/CMS Data Match situations where the requisite employer identification is always provided to the contractors by CMS; Non-Data Match situations that are identified in other ways which do not always identify the employer; and ReMAS identified newly accreted GHP records. Contractors refer Non-Data Match and ReMAS identified GHP lead situations where the employer is not identified or information regarding the employer is incomplete to the COBC via ECRS for development of missing information. The COBC will update the MSP Auxiliary File with complete employer information once it is obtained. The updated MSP Auxiliary file data will be overlaid in the ReMAS case file during the 60 day “wait period.”

30.1.1.2 - Time Limitation for GHP Recoveries

Federal law establishes time limitations on the Government’s ability to collect valid debts. As a general rule, the Government may collect a valid debt within 6 years of the date of actual notice by means other than offset of Federal payments to the debtor. The Government may collect a valid debt within 10 years of the date of actual notice through offset of Federal payments to the debtor. There will be instances where the time period to collect certain debts are longer, e.g., in the case of litigation or some other action that held the time periods in abeyance. See 42 USC 1395y(b)(2) and 42 CFR 411.24(f)

30.1.1.2.1 - Actual Notice

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

- Name of the third party payer;

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

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

NOTE: Contractor recoveries shall be pursued according to the priorities and tolerances sited above.

30.1.2 - Contractor History Search

Upon receipt of information indicating that a third party payer is primary to Medicare (non-data match GHP), the contractor that has not implemented ReMAS/HIGLAS shall search its paid claims history file every 60-90 days according to the search parameters and tolerances sited above to identify Medicare claims mistakenly paid as primary. If the effective dates of coverage under the plan are known, the standard systems will limit the review of the beneficiary's claims payment history to this period.

If **Non-Data Match** mistaken payments have previously been identified or recovered and are subsequently identified as being part of an IRS/SSA/CMS Data Match cycle tape, the contractor shall update MPaRTS to reflect the recovery status and amount recovered (if applicable).

30.1.2.1 - Aggregate Claims for Recovery

GHP recovery demand letters are routinely sent to employers. The contractor shall make attempts to aggregate Data Match demands or Non-Data match demands having the same employer into a single demand letter or package.

For those contractors on ReMAS/HIGLAS the debt aggregation process is done automatically when a case is sent from ReMAS to HIGLAS. ReMAS will identify debts owed by the same employer, insurer or employer/insurer combination.

30.1.3 -Documentation of Debt

The contractor shall provide the debtor (employer) with sufficient materials to document a debt owed Medicare. An MSP recovery package should be sent for each demand made to an employer. The MSP recovery package has four main components:

- Demand letter to the employer using language provided by CMS;
- MSP Summary Data Sheet;
-
- Insurers/TPAs only: Claim Facsimiles or claim detail for each claim mistakenly paid primary. The facsimiles or claim detail must contain the name of the provider, type or description of services, date of services, place of service, charged amount and Medicare paid amount. The demand package must summarize and total the amount due Medicare. The total must equal the claim facsimiles or claim detail.
- Contractors shall send all IRS/SSA/CMS Data Match demands and Non-Data match GHP demands by certified mail with return receipt requested. The courtesy copy sent to the insurer/TPA shall not be sent first class or certified mail.

30.1.4 - Documentation of Debt

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

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

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

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

30.3 - Communications Received in Response to Recovery Actions

If a GHP or employer states that a primary payment was made, the contractor shall request an explanation of the benefits paid. Claims processing contractors shall recover any duplicate payment from the provider. If payment was made to the beneficiary, the contractors shall obtain a copy of the EOB from the employer/GHP or the party that received the payment to confirm whether a true duplicate primary payment situation exists with the beneficiary.

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

Contractor shall acknowledge and respond to **all** correspondence within 45 calendar days from the date of receipt on their corporate mailroom or any other mail center location, absent instructions to the contrary for a particular activity.

30.4 - Communications Received in Response to Recovery Actions

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

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

Other unacceptable reasons may be:

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

Section 1862(b)(2)(B) of the statute, as amended by §2344(b) of the Deficit Reduction Act of 1984 (Pub. L. 98-369), gives the Government the right to recover conditional Medicare payments. Medicare must be reimbursed conditional primary benefits paid. The FI or carrier

advises the employer and the beneficiary of the private right of legal action to collect double damages. If the employer still refuses to reimburse Medicare or does not respond to requests, the FI or carrier refers the case to the RO.

If there is indication that, under the employer's/GHP's contract, that a higher payment amount should have been paid, the FI or carrier contacts the employer/plan and explains that under the statute the employer/plan must make full payment in accordance with its contract. If the employer/plan refuses to cooperate, the FI or carrier refers the case to the RO if the amount in question exceeds the recovery tolerance above. The RO determines the need for further action.

30.5 - Recovery From the Provider

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

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

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

30.6 - Recovery From the Beneficiary

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

40 - Overpayment Due to Workers' Compensation Coverage

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

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

40.1 - Action Subsequent to Conditional Payment

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

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

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

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

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

40.2.1 - COBC Determines Lead Contractor for Recovery in WC Cases

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

40.2.2 - Duplicate Payment Received by Provider

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

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

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

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

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

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

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

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

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

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

40.3 - Settlement Issues

40.3.1 - Medicare Made Party to WC Hearing

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

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

40.3.2 - Party Requests That Medicare Accept Less Than Its Claim

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

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

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

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

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

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

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

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

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

The contractor sends compromise cases to:

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

40.3.4 - Effect of Lump Sum Compromise Settlement

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

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

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

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

sum agreement and flags any new claims for the condition for which the beneficiary received the lump sum payment.

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

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

- **First** to any beneficiary payments for services payable under workers' compensation but not covered under Medicare,
- Second to any beneficiary payments for services payable under WC and also under Medicare Part B. (These include deductible and coinsurance amounts and, in unassigned cases, the charge in excess of the reasonable charge.) and
- Third to any beneficiary payments for services payable under WC and also covered under Medicare Part A. (These include Part A deductible and coinsurance amounts and charges for services furnished after benefits are exhausted.)

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

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

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

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

Services not covered under Medicare

\$1,500

Excess of physicians' charges over reasonable charges	\$500
Medicare Part B coinsurance	\$1,400
Part A deductible	\$520
Total	\$3,920

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

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

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

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

EXAMPLE 1:

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

The State WC agency subsequently approved a compromise settlement, under the terms of which the WC carrier admitted liability for the hip fracture but not for the stroke. The settlement provided payment to the beneficiary of \$18,000 plus payment to the hospital of \$1,200 for his stay through the date of the surgery. Following the settlement, the beneficiary requested the intermediary to pay for the three months of hospitalization following the surgery, since the settlement did not stipulate that treatment of the stroke was work-related. The intermediary determined that payment under WC for treatment of the stroke could reasonably have been

expected if the beneficiary had not agreed to give up his right to such compensation. It, therefore denied the claim. The provider has the right to bill the beneficiary, since these services would have been covered by WC and, therefore, are not payable by Medicare.

EXAMPLE 2:

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

1. Pay the individual a lump sum of \$50,000 as compensation for permanent and total disability;
2. Pay all of the individual's medical expenses related to his work injury until he became entitled to benefits under Medicare or any other government medical benefit program; and
3. Continue to pay, without any time limitation, any portion of his medical expenses for the work injury that was not reimbursable under a government program.

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

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

EXAMPLE 3:

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

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

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

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

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

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

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

- It determines the ratio which the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount which would have been payable under WC for both medical and hospital expenses (including expenses not covered under Medicare) and income replacement, if the claim had not been settled by compromise; and
- It multiplies this ratio by the total medical and hospital expenses incurred as a result of the injury or disease up to the date of the settlement. The product is deemed to be the amount of WC settlement intended as payment for medical and hospital expenses. It applies the latter amount to the medical and hospital expenses incurred due to the work-related injury.

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

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

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

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

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

EXAMPLE 4:

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

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

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

EXAMPLE 5:

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

Mr. B settled his WC claim by accepting a lump sum compromise payment of \$50,000, \$10,000 of which represented attorney's fees. Medicare submitted a claim to Mr. B's attorney requesting

reimbursement for the amount it had paid. The WC lump sum represented a compromise settlement of Mr. B's present and future disability benefits, estimated at \$35,000, and past medical expenses (including \$48,000 paid under Part A, \$12,000 covered under Part B, and \$5,000 for expenses not covered under Medicare). Had Mr. B not compromised, the total amount that would have been payable for disability and medical expenses would have been \$100,000 (\$35,000 for disability and \$65,000 for medical). There did not appear to be an attempt to shift the WC liability to Medicare.

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

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

40.3.5 - Workers' Compensation: Commutation of Future Benefits

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

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

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

appropriate action. Regional Offices must comply with general CMS rules regarding collection of debts.

Medicare is secondary payer to WC; therefore, it is in Medicare's best interests to learn the existence of WC situations as soon as possible in order to avoid making mistaken payments. The use of administrative mechanisms sometimes referred to by attorneys as Medicare Set-Aside Trusts (hereafter referred to as "set-aside arrangements") in WC commutation cases enables Medicare to identify WC situations that would otherwise go unnoticed, which in turn prevents Medicare from making mistaken payments.

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

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

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

One of the distinctions that Medicare's regulations and manuals make between compromise and commutation cases is the absence of controversy over whether a WC carrier is liable to make payments. A significant number of WC lump sum cases are commutations of future WC benefits where typically there is no controversy between the injured individual and the WC carrier over whether the WC carrier is actually liable to make payments. An absence of controversy over

whether a WC carrier is liable to make payments is not the only distinction that Medicare's manuals and regulations make between compromise and commutation cases. Thus, lump sum settlements should not automatically be considered as compromise cases simply because a WC carrier does not admit to being liable in the settlement agreement. Conversely, lump sum settlements should not automatically be considered as commutation cases simply because a WC carrier does admit to being liable in a settlement agreement. Therefore, an admission of liability by the WC carrier is not the sole determining factor of whether or not a case is considered a compromise or commutation.

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

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

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

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

Set-aside arrangements are most often used in those cases in which the beneficiary is comparatively young and has an impairment that seriously restricts his or her daily living activity. These set-aside arrangements are typically not created until the individual's condition

has stabilized so that it can be determined, based on past experience, what the future medical expenses may be.

Medicare regulations at 42 CFR 411.46 state that:

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

In addition, as this document states:

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

40.3.5.1 - Questions and Answers Concerning WC Commutation of Future Benefits

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

Question 1

a.

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

b.

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

c.

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

Answer 1

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

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

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

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

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

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

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

Question 2

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

Answer 2

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

Question 3

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

Answer 3

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

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

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

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

- Beneficiary Name;

- Beneficiary HIC;
- Date of Incident;
- DX code(s): If you do not have dx codes readily available, you must include a description of the illness/injury. Note: Do not forward to COB without a dx or description.
- Administrator of Trust, and
- Claimant Attorney Information.

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

Question 4

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

Answer 4

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

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

In every set-aside arrangement case, the contractor responsible for monitoring the individual's case (with assistance from the RO, if necessary) should ensure that Medicare does not make any payments until the contractor responsible for monitoring the individual's case can verify that the funds apportioned to the arrangement have truly been exhausted.

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

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

Question 5

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

Answer 5

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

Evaluation criteria:

- 1 -Date of entitlement to Medicare.
- 2 -Basis for Medicare entitlement (disability, ESRD or age). If the beneficiary has entitlement based on disability and would also be eligible on the basis of ESRD, this should be noted since the medical expenses would be higher. This would also be true for beneficiaries who are over 65 but had been entitled prior to attaining that age.
- 3 - Type and severity of injury or illness. Obtain diagnosis codes so injury or illness related expenses can be identified. Is full or partial recovery expected? What is the projected time

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

- 4 - Age of beneficiary. Acquire an evaluation of whether his/her condition would shorten the life span.
- 5 - WC classification of beneficiary (e.g., permanent partial, permanent total disability, or a combination of both).
- 6 - Prior medical expenses paid by WC due to the injury or illness in the 1 or 2 year period after the condition has stabilized. If Medicare has paid any amounts, they must be recovered. Also, this would indicate that the case may not purely be a commutation case, but may also entail some compromise aspects, e.g., the WC carrier or agency may have taken the position that the services were not covered by WC.
- 7 - Amount of lump sum or amount of structured settlement. Obtain as much information as possible regarding the allocation between income replacement, loss of limb or function, and medical benefits.
- 8 - Is the commutation for the beneficiary's lifetime or for a specific time period? If not for lifetime, what is the basis? Medicare must insist that there is a reasonable relationship between the respective allocation for services covered by Medicare and services not covered by Medicare. For example, is it reasonable for the settlement agreement's allocation for services not covered by Medicare to be based on the beneficiary's life time while the agreement's allocation for services covered by Medicare is based on a lesser time period? What is the State law regarding how long WC is obligated to cover the items or services related to the accident or illness?
- 9 - Is the beneficiary living at home, in a nursing home, or receiving assisted living care, etc.? If the beneficiary is living in a nursing home, or receiving assisted living care, it should be determined who is expected to pay for such care, e.g., WC (for life time or a specified period) from the medical benefits allocation of lump sum settlement, Medicaid, etc.
- 10 - Are the expected expenses for Medicare covered items and services appropriate in light of the beneficiary's condition? Estimated medical expenses should include an amount for hospital and/or SNF care during the time period for the commutation of the WC benefit. (Just one hospital stay that is related to the accident could cost \$20,000.) For example, a quadriplegic may develop decubitus ulcers requiring possible surgery, urinary tract infections, kidney stones, pneumonia and/or thrombophlebitis. Although each case must be evaluated on its own merits, it may be helpful to ascertain for comparison purposes the average annual amounts of Part A and Part B spending for a disabled person in the appropriate State of residence. Keep in mind that these Fee-for-Service amounts are for all Medicare covered services, while our focus here only deals with services related to the WC accident or illness. Therefore, the RO should use appropriate judgment and seek input from a medical consultant when determining whether the amount of the lump sum or structured settlement has sufficiently considered Medicare's interests.

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

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

Question 6

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

Answer 6

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

Question 7

What other issues should be considered?

Answer 7

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

Question 8

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

Answer 8

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

Question 9

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

Answer 9

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

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

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

Before evaluating whether an arrangement reasonably covers/considers Medicare's interests, **the RO must know** whether the arrangement is based upon WC fee schedule amounts or full actual charge amounts. If the arrangement is based upon WC fee schedule amounts, then, the RO cannot provide a written opinion on the sufficiency of an arrangement until the arrangement's settlement agreement contains specific provisions that establish that the WC carrier can and will

ensure that the arrangement cannot be charged more than what would normally be payable under the WC plan. The WC carrier must require all entities and individuals that accept WC payments to agree not to charge the arrangement more than what the WC plan would normally pay.

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

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

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

Question 10

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

Answer 10

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

A copy of the settlement agreement, or proposed settlement agreement, a copy of the life care plan (if there is one), and, if the life care plan does not contain an estimate of the injured individual's estimated life span, then a "rate age" may be obtainable from life insurance companies for injuries/illnesses sustained by other similarly situated individuals. In addition, documentation that gives the basis for the amounts of projected expenses for Medicare covered services and services not covered by Medicare (this could be a copy of letters from doctors/providers documenting the necessity of continued care).

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

Question 11

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

Answer 11

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

Question 12

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

Answer 12

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

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

When providers, physicians and other suppliers submit claims to Medicare related to the individual's work-related injury or disease, claims processing contractors should deny those claims and instruct the entity or individual to seek payment from the administrator of the arrangement. Since the injured individual will be a Medicare beneficiary at the time when the provider, physician, or other supplier submits the claim to Medicare, the contractor responsible for monitoring the individual's case will have already updated the Common Working File to indicate that the injured individual's claims should be denied. However, when a provider, physician or other supplier submits any claims that are for injuries or

diseases that are not work-related, then contractors should process those claims like they would any other claim for Medicare payment.

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

50 - Recoveries From Liability Insurance (Including Self-Insurance) and No-Fault Insurance

50.1 - General Operational Instructions

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

Section 1862(b) of the Act grants Medicare a priority right of recovery. Section 1862(b) also gives the Medicare program the right of subrogation for any amounts payable to the program under §1862 of the Act. In order to recover the conditional payment, Medicare may bring direct action in its own right against the entity responsible or required to pay Medicare, or against any other entity that has received payment. In addition, Medicare has, under subrogation law, a right to recover its payment from an individual or other entity that received payment from a third party payer.

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

on Medicare's statutory priority right of recovery when corresponding with the beneficiary and/or the beneficiary's attorney.

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

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

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

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

The provider and beneficiary (or the beneficiary's representative) are responsible for taking whatever action is necessary to obtain any payment that can reasonably be expected under no-fault insurance. Therefore, unless conditional payments can be made under §50.2.2, the FI or carrier shall not make any Medicare payments until the provider or the beneficiary has exhausted the entire claims process under no-fault insurance. Conditional benefits are not payable if payment cannot be made under no-fault insurance because the provider or the beneficiary failed to file a proper claim. (See Chapter 1, §20 for definition.)

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

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

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

50.2.2 - Conditional Primary Medicare Benefits

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

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

When such conditional Medicare payments are made, they are made on condition that the beneficiary will reimburse the program to the extent that the liability/no-fault insurer subsequently makes payment. When making such payments, the FI or carrier notifies the beneficiary and the insurer of the requirement for repayment. (However, failure to do so does not relieve the beneficiary or insurer of the obligation to refund the payments.)

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

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

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

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

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

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

Upon receipt of information that a liability/no-fault insurer paid a provider or physician for services previously paid for by Medicare, the FI or carrier determines the amount of Medicare secondary benefits payable on the claim. It recoups from the provider or physician any portion of the amount Medicare paid in excess of the amount of Medicare secondary benefits payable, subject to the overpayment recovery tolerance in The Medicare Financial Management Manual. Where no Medicare secondary benefits are payable, the FI or carrier recovers the amount of the Medicare payment. The provider or physician may keep the full liability/no-fault insurance payment but may not charge the beneficiary any amount for the services and must return any deductible and coinsurance amounts paid by or on behalf of the beneficiary. (See Chapter 3, §30.2.1.3, where the provider did not file a proper claim.)

50.3.1 - Insurance Pays Service Benefits

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

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

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

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

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

50.3.3 - Other Situations

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

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

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

50.4 - Pre-Settlement Issues

50.4.1 - Existence of Overpayment

In MSP liability situations, before a settlement is reached between the beneficiary and the liable party or a court renders a judgment, there is no overpayment. Medicare's claim comes into existence by operation of law (42 U.S.C. 1395y(b)(2)(B)(ii)) when payment for medical expenses that Medicare conditionally paid for has been made by a third party payer. Consequently, while Medicare may alert beneficiaries and their attorneys of Medicare's right to recover settlement proceeds in pre-settlement correspondence, no demand for recovery may be made until a settlement has been reached. However, the FI or carrier should send a letter to the beneficiary and attorney giving notice of possible recovery by Medicare.

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

carrier will continue to be responsible for all activities related to identification and recovery of MSP-related debts.

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

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

- Instructs the party to either make its request for compromise in writing, in which case the contractor forwards the request to its RO, or
- Refers the party directly to the appropriate RO staff person to handle the negotiation.

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

50.4.3 - Pre-Settlement Communications

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

If the beneficiary is pursuing the claim, the FI or carrier advises the beneficiary of Medicare's interest in the matter. In addition, it advises the liability insurer directly that Medicare is a party to any settlement. If the beneficiary has engaged counsel, the FI or carrier notifies both the beneficiary and the beneficiary's attorney. It retains copies for the file. If the beneficiary has not engaged counsel, there will probably be no procurement costs to subtract from Medicare's claim. As with beneficiaries and their attorneys, contractor are not permitted to conduct negotiations with liability insurers.

50.4.4 - Designations in Settlements

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

50.4.5 - Allegation of Preexisting Conditions

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

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

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

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

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

If a Medicare claim has been paid and there is indication that a liability claim is pending, the contractor takes steps to assure that, in the event a liability insurance payment is made, any conditional primary Medicare payments are refunded for services related to the injury. If the

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

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

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

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

50.5.1 - Contractor Coordination Responsibilities

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

50.5.1.1 - Recovery Contractor Responsibilities

When a claim is identified in which litigation either has been or may be undertaken by the beneficiary, the Medicare Recovery contractor should contact the beneficiary and the beneficiary's attorney and advise them of Medicare's interest as soon as possible, to protect Medicare's claim. The Recovery contractor must also notify the liability insurer, or alleged liable party, of Medicare's interest in the litigation. If a settlement has not been reached, it forwards a notice of Potential Medicare Recovery, to the beneficiary and attorney. Once a settlement is

reached, the Recovery contractor should forward the standard Recovery/Initial Determination Letter. It retains copies of all correspondence for the file.

If the adverse party, or its representative or insurer, makes inquiries about the details of Medicare's claim, such as asking for an itemization of the services paid, the contractor shall refer it to the beneficiary's attorney. Where the adverse party supplies a Consent to Release, the contractor shall provide the requested information.

50.5.2 - Contractor Settlement Communications/Correspondence

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

50.5.2.1 - Issuance of Recovery Letter

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

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

50.5.2.2 - Consideration of Procurement Costs

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

If the reimbursement is not made, CMS:

- May bring legal action against any entity required to make or responsible for payment;
- May take legal action to recover its benefits from any entity that has received primary payment from the Insurer for items and services furnished to an individual for whom Medicare is the secondary payer;

- May join or intervene in any legal action against the Insurer related to the events that gave rise to the need for the items or services; and
- Is subrogated to the extent it paid for items or services to the rights of any individual who is entitled to receive primary payment from a Insurer.

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

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

To determine procurement costs, the contractor asks the attorney to furnish (in writing) the costs, including attorney fees, incurred by the individual to procure the settlement/judgment. If these costs appear in excess of the prevailing costs in the area for similar claims, it asks for an itemized statement of costs or copy of a contingency agreement, if applicable, or other appropriate documentation. If the procurement costs are documented, the contractor allows them. Should a contractor need advice on what constitutes procurement costs in a particular case, it consults contractor legal counsel or the RO.

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

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

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

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

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

50.5.2.3 - Collecting Interest on the Liability Claim

A. Medicare's Right to Collect Interest

Medicare assesses interest on MSP debts by exercising authority that is consistent with the Federal Claims Collection Act (FCCA) and implementing regulations. (See 45 CFR 30.13.) If CMS does not receive a full refund, CMS requires that the beneficiary or another entity repays CMS within 60 days of the date on the demand letter. (See 42 CFR 411.24(h).) If CMS is not reimbursed within 60 days of the date on the demand letter, interest accrues from the date of the demand and is assessed on day 61.

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

In cases of joint and several liability among two or more debtors, Federal regulations at 42 CFR 401.623 prohibit CMS from allocating the burden of claims payment among the debtors. The CMS will proceed with collection action against one debtor even if other liable debtors have not paid their proportionate shares. Therefore, if one of the joint debtors owes Medicare, contractor may assess interest on the debt. Regulations at 45 CFR 30.13(a) provide for assessing the higher of the private consumer rate (PCR) or the current value of funds (CVF) rate of interest on overpayments and underpayments.

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

B. How to Calculate Interest

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

- Interest can be charged only after the responsible entity has been notified of the debt and a demand for payment has been made, and has had thirty days in which to make repayment. Interest due is calculated beginning from the date of the original demand letter;
- Interest cannot be assessed on deductible and coinsurance amounts; and
- Even though contractors will be requesting repayment of the gross Medicare payment, interest can be charged only on the actual Medicare payment or the provider's charges, if less. Therefore, these amounts must be separated to determine the amount on which interest will be charged.

50.5.2.4 - Release Agreement Form

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

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

50.5.3 - Recovery from Liability Insurers (Including Self-Insured Entities)

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

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

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

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

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

50.5.4 - Recovery from the Beneficiary

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

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

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

50.5.4.1 - Recovery From Estate of Deceased Beneficiary

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

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

- When the contractor learns that the beneficiary has died, it identifies and contacts the executor or administrator, or whoever is acting in that capacity. It finds out if they are in possession of all Medicare correspondence that had been sent to the beneficiary while alive. If the information was not available, it sends the executor or administrator dated copies of all such notices;
- If a settlement has been reached, a letter containing an initial determination should have been sent. The rights to request waiver and/or appeal that are expressed in this letter apply equally to the estate, if there is a surviving spouse or dependent that is entitled under Title II or XVIII. Where neither of these parties exists, waiver under §1870(c) may not be granted. (However, relief may still be available under §1862(b) or FCCA.); and
- The contractor will ensure that the executor or administrator understands Medicare's priority right to satisfaction of its claim by re-emphasizing that fact in conversations. The contractor employee should also attempt to end each conversation with a specific action that the administrator should take within a specific time period. If this time limit passes and the action has not occurred, the contractor contacts the administrator again. The most

important thing is the prevention of settlement of the estate prior to satisfaction of Medicare's claim.

50.5.4.1.1 - Wrongful Death Statutes

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

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

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

50.5.4.2 - Beneficiary Fails to Respond to Requests for Payment

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

The contractor will follow the instructions provided in this documents under, "Debt Collection Improvement Act of 1996 (DCIA)," when efforts to collect the MSP overpayment are unsuccessful (e.g. the debt is not resolved within 180 days of the Demand issuance and there are no outstanding appeals or waiver requests).

50.5.4.3 - Beneficiary Refunds to Medicare

A. Installment Payments

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

B. Multiple-Party Settlement Checks

If a liability insurer sends the Medicare contractor a check intended to repay Medicare benefits paid on the beneficiary's behalf, but which is made out jointly to the contractor (or Medicare) and to other parties, such as the beneficiary or representing attorney, the contractor shall deposit the check within 24 hours of receipt. The contractor will then refund any remaining amount to the other parties listed on the check after satisfying any existing debts (or, if the check is the initial notification that an MSP case exists, after creating and developing a case and identifying any potential debts).

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

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

50.5.4.4.1 - Beneficiary Must Submit Waiver Request

The beneficiary must request a waiver in writing. Once the waiver request has been received, the contractor will send the beneficiary and attorney a letter acknowledging the request and must include a copy of Form SSA 632-BK - Request for Waiver of Overpayment. The letter will also inform the beneficiary that a determination will be sent once it is reached.

The Social Security Administration Request for Waiver of Overpayment Recovery (Form SSA-632-BK) can be viewed and downloaded at the following internet address:

<http://www.ssa.gov/online/ssa-632.pdf>

50.5.4.4. 2 - Timely Processing of Waiver Determinations

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

50.6 - Contractor Criteria for Waiver Determinations

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

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

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

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

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

50.6.1 - Collect All Pertinent Data

The contractor sends the beneficiary a Form SSA-632-BK, (obtained from the following Social Security Administration (SSA) internet address: <http://www.ssa.gov/online/ssa-632.pdf>), with appropriate supporting documentation. Enclose this form with a response letter acknowledging the request. The beneficiary does not need to complete Section 1 - "Without Fault" - of the SSA-632-BK because at this time, beneficiaries are deemed to be without fault. The contractor retains the right to request additional documentation when the beneficiary asserts the following:

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

50.6.2 - Apply §1870(c) Waiver Criteria

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

- a. Who is without fault, and
- b. When adjustment or recovery would either:
 1. Defeat the purpose of title II or title XVIII of the Act, **or**
 2. Be against equity and good conscience.

50.6.3 - Factors to Consider in Determining if a Full or Partial §1870(c) Waiver is Warranted

50.6.3.1 - Allowing Out-of-Pocket Expenses in §1870(c) Waiver Determinations

Out-of-pocket expenses should be considered in determining if a full or partial waiver is warranted. Out-of-pocket expenses are defined as those medical expenses for which a beneficiary has paid or is responsible to pay incurred for injuries directly related to the accident and that are not covered by insurance (including Medicare), settlement proceeds, or court-awarded damages.

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

A. Beneficiary Documents Out-of-Pocket Expenses.

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

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

B. Beneficiary's Assets Insufficient to Repay Medicare

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

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

- Housing renovation - beneficiary's residence had to be modified to accommodate beneficiary because of an accident-related injury e.g., addition of a ramp to accommodate a wheel chair;
- Adult diapers - where the accident caused loss of bladder use;
- Prescriptions for medication needed as a result of an accident-related injury;
- Private duty nursing or custodial care not covered by Medicare;

- Coinsurance and deductibles not covered by supplemental insurance; and
- Expenses for dental work caused by the accident.
- Contractor should not consider:
- Funeral expenses; or
- Travel for relatives (even if accident-related).

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

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

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

50.6.4 - Determining Beneficiary Fault

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

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

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

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

- Expenses for the support of others for whom the beneficiary is legally responsible; and
- Other miscellaneous expenses which may reasonably be considered necessary to maintain the beneficiary's current standard of living.

50.6.5.1 - Examples of Financial Hardship

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

- The beneficiary has spent the settlement proceeds and the only remaining income from which the beneficiary could attempt to satisfy Medicare's claim would be from the money that is needed for the beneficiary's monthly living expenses. Waiver may be appropriate under this aspect of the waiver criteria. If documented and appropriate monthly expenses consume the entire amount of money available, a full waiver may be warranted. A partial waiver may be appropriate if the beneficiary retains at least some (for example \$25.00) discretionary income each month;
 - The demonstrated beneficiary income and resources are at a poverty level standard, such as being in an SSI pay status. A beneficiary may demonstrate proof of SSI pay status by
 - requesting the Form SSA-2458, Benefit Verification, from a SSA office. If Medicare's claim would have to be satisfied from income and resources that meet an established level of poverty, waiver may be appropriate. However, preexisting financial hardship alone may be an insufficient basis for granting a waiver. All factors, not just the existence of poverty, must be weighed before a waiver decision can be made; or
- An unforeseen severe financial circumstance existing at the time Medicare's claim comes into existence can also constitute financial hardship. If a beneficiary has become legally financially responsible for an unforeseen obligation, has acted in good faith at all times with respect to Medicare's claim, and has no other financial resources to meet this legal obligation, waiver may be warranted. For example, waiver would be appropriate if a beneficiary's grandchildren became the legal responsibility under a will or trust that came into existence upon the sudden death of the beneficiary's child (the parent of the grandchildren).

NOTE: The contractor should assume in all waiver examples that the attorney has already taken attorney fees from the settlement proceeds, and the beneficiary does not have to pay the attorney from the settlement figure shown. Also, it should assume that the settlement proceeds are being retained in an escrow account by the attorney and have not been spent. In cases where the funds have already been spent by the beneficiary, the beneficiary's monthly financial situation and the likelihood of recouping the monies will be significant factors.

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

A. Example 1

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

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

Action: Grant full waiver.

B. Example 2

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

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

Action: Grant a partial waiver of the amount owed.

50.6.5.2 - Recovery Would Be Against Equity and Good Conscience

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

- The degree to which the beneficiary contributed to causing the overpayment;

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

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

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

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

A. Example 1

Facts: The beneficiary sustained injuries in an automobile accident. Medicare made conditional payments in the amount of \$7,500 on the beneficiary’s behalf. The beneficiary later filed suit for the injuries and damages suffered as a result of the accident and received a \$5,000 settlement. There were no attorneys fees, thus Medicare’s claim is \$5,000. The beneficiary requested a waiver of the overpayment. The beneficiary submitted documentation demonstrating that the money received was used to replace the automobile that was totaled in the accident.

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

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

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

B. Example 2

Facts: The beneficiary sustained multiple injuries in an automobile accident, including a permanent injury that will preclude employment ever again. Monthly income equals monthly expenses. Medicare's conditional payments were \$8,500. The beneficiary received a liability insurance payment of \$5,000 (which was the limit of the policy). No attorney was retained. Therefore, Medicare's recovery becomes \$5,000. The beneficiary incurred allowable, properly documented out-of-pocket medical expenses of \$4,500. Analysis: Because the beneficiary is now unable to work, the ability to absorb the out-of-pocket medical expenses has greatly diminished. A valuable right, i.e., the right to be gainfully employed, is a change in one's position, it would be against equity and good conscience for Medicare to recoup its entire recovery. As Medicare stands to recover 100 percent of the settlement amount, it may waive 100 percent of the out-of-pocket costs. It would not be feasible to pursue recovery of the remaining \$500. Action: Grant full waiver.

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

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

A. Example 1

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

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

Action: Waiver request is denied.

B. Example 2

Facts: The beneficiary was unemployed before injury that triggered Medicare conditional payments. However, the accident has reduced the probability that the beneficiary will ever be able to work again. Medicare's recovery is \$11,000. No attorney was used in procuring the settlement, nor were there other procurement costs. Therefore, no procurement costs were

subtracted from the amount of Medicare's recovery. The beneficiary received a \$55,000 settlement. Documented out-of-pocket medical expenses equal \$10,000. Monthly expenses are \$2,068 and monthly income is \$1150 (\$771 social security benefits, \$344 unemployment, \$35 interest income).

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

Action: Waiver request is denied.

50.6.5.4 - Waiver Indicators

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

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

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

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

- Medicare asserted its right to recover before the settlement proceeds were disbursed (and there is correspondence in the case file which provides documentation of Medicare's timely assertion);

- Beneficiary receives a large settlement;
- Beneficiary's income exceeds ordinary living expenses;
- After repaying Medicare and allowing for out-of-pocket medical costs (if such allowances are necessary), the beneficiary will be left with a substantial amount of the settlement proceeds; and
- Beneficiary has substantial assets.

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

50.7 - Waiver and/or Compromise Exercised Only by CMS

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

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

50.7.2 - Compromise of Claim, or Suspension or Termination of Collection, Under the Federal Claims Collection Act (31 U.S.C. 711)

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

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

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

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

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

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

50.8 - Appeals Procedures for MSP Liability Overpayments

These instructions prescribe procedures to be used in processing appeals of MSP liability overpayment and waiver determinations. Since recovering MSP liability overpayments involves procedures which vary somewhat from those used for general overpayments, the following recovery instructions are to be used in place of the general overpayment instructions found in the Medicare Customer Service Manual, Chapter 1, except where specific references to those sections are provided. These instructions supersede any conflicts in the procedures. As a general reminder, any additional collection activity (e.g. referral to Treasury) is not to be taken on debts that are in waiver/ appeal status until a decision is made regarding that appeal or waiver request.

50.8.1 - Initial Determinations

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

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

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

50.8.2 - Notification of the Right to Appeal

The beneficiary must be given notice of appeal rights within the document reflecting the initial determination. The beneficiary must also be informed that while interest will continue to accrue while an appeal or waiver request is pending, any other collection activities (e.g., referral to Treasury for collection) will be suspended. If the beneficiary continues to follow through with the appeal process, notice of the next sequential appeal right must be given with each new determination

50.8.3 - Appeals of MSP Liability Overpayments

MSP liability determinations that may be appealed are listed above. The contractor is responsible for processing appeals of these determinations.

A. Requests for Appeal

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

B. Combined Requests for Waiver and Appeal

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

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

If the initial overpayment determination is affirmed, then the contractor proceeds with evaluation of the waiver request. It issues the waiver determination.

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

C. Combined Part A and Part B Appeals

When an appeal request is made which involves both Part A and Part B payments, the lead contractor is responsible for ensuring that payments under Part A are processed using the reconsideration process, and that Part B payments are processed under the review process. These are two separate and distinct processes. Contractor is responsible for ensuring that Part A and B

appeals are conducted according to their respective processes. To do so, the contractor separates the Part A payments from those made under Part B.

Contractor is also responsible for all aspects of conducting the appeal, including evaluation of the record, issuance of the appeal decision and workload reporting. The contractor processes all subsequent appeal activities, e.g., ALJ hearing requests and ALJ hearing determination effectuation.

D. Steps in Deciding an Appeal

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

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

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

50.9 - Allocation of Recovered Medicare Payments

If the amount recovered is less than the amount claimed, the contractor applies the payment collected so that available benefits are restored, in the following order:

- Inpatient hospital days first;
- SNF days second; and
- Other Part A benefits third.

If payments were made for both Part A and Part B services, the contractor applies the funds first to Part A expenses in the same order.

60 - Medicare Secondary Payer (MSP) Debt Collection and Referral Activities

Contractor shall comply with all debt collection requirements and processes more specifically defined in this document. Upon MSP debts becoming eligible for referral to Treasury for cross-servicing, contractor shall implement the Debt Collection and Improvement Act of 1996 (DCIA) actions for all types of MSP debts and their associated debtor(s).

The CMS has attempted to identify sections specific to HIGLAS users or sections revised to incorporate HIGLAS functionality with the operationally defined processes.

60.1 - Background

(The DCIA requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center (DCC) for cross servicing and/or Treasury offset program (TOP). The CMS is mandated to refer all eligible delinquent debt, over 180 days' delinquent, to Treasury for cross-servicing. The CMS has the option of referring debt before it becomes 181 days' delinquent but only after the contractor has notified the debtor of CMS' intent to refer the debt to Treasury for cross-servicing. Delinquency status occurs when a debt is still owed (either in full or partially) and is at least one day after the repayment date given within the demand letter. For example, a GHP demand dated 12/1/05 gives the debtor 60 days to respond, or interest will be accrued and assessed from the date of the demand. If the debt is still unresolved as of 2/2/06 (63 days after the date of demand) the debt is considered 3 days' delinquent.

60.2 - Debt and Debtor Definitions

- For 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 HIGLAS users, one debt will contain claims for multiple beneficiaries having the same debtor or debtor combination specific to a jointly and severally liable situation.)
- For duplicate primary payment (DPP) 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 DPP recovery demands to a beneficiary, the debt includes all claims in the recovery demand letter. Medicare may only make such recoveries when Medicare made and the beneficiary received the primary payment directly **AND** the insurer also paid the beneficiary.

- For liability, no-fault, and workers' compensation, the debt includes all claims in the recovery demand letter, minus Medicare's pro-rata share of procurement and attorney costs/fees.

Debtor:

The debtor is an individual to whom or an entity to which the last recovery demand was issued. Where the demand was issued to an individual in his/her 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 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.

“Jointly and Severally Liable Debtors” is a reference to multiple entities having equal responsibility for repayment of a debt. HIGLAS users will initiate this type of GHP recovery upon receipt of a “joint and several” debtor combination interfaced from ReMAS. Non-HIGLAS users will not initiate demands to this type of debtor.

60.3 - Debt Selection and Verification

The recovery contractor shall identify delinquent debts from their existing debt (open Accounts Receivable [AR]) balances and issue a DCIA Intent to Refer (ITR) to Treasury letter for all valid delinquent debts that are not in any “special” status (such as under appeal or with a pending waiver request). The ITR will advise the debtor of CMS' intention to refer the debt to Treasury for further collection if the debt is not resolved within the time limit established by CMS and Treasury, as well as the amount of principal and interest to be referred. The referral process for MSP debts involves reviewing debts based on specific criteria, in order to certify these debts as valid.

For purpose of DCIA debt selection/referral 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 an outstanding debt for which any of the following apply: (a) full payment has not been made, (b) no response from the debtor regarding the debt, or (c) 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.

For purposes of debt identification and referral, any dollar threshold includes both outstanding principal and outstanding interest. Also, because some Medicare contractor record their AR at

the claim level (Example: 5 claims in a demand = 5 ARs) and others record at the demand level (Example: all claims for a particular beneficiary = 1 AR) contractor shall refer based on the total demand amount.

60.3.1 - Debt Selection Criteria

All outstanding/open delinquent MSP debts shall be reviewed. Debts may be for Part A and/or Part B services and specific to data match, non-data match GHP, Liability, no-fault, and workers' compensation cases. Liability debts may include Federal Tort Claim Act debts or other debts established by Central Office (CO) and transferred to the contractor for collection and DCIA activities.

NOTE: Contractor shall not refer debts of those debtors that have entered into an approved extended repayment schedule (ERS) unless they default on the agreement. Debts under an ERS are considered current unless or until the debtor defaults. (See Pub. 100-06 Part 3 for definition of "default".)

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. The **CO encourages Medicare contractor to select all of the debt for a particular debtor that was included in a particular demand letter regardless of the dollar amount involved.** (For example, if a single demand letter was issued for 5 DM Report IDs, the contractor should select all 5 debts.) This will be less confusing to the debtor and decrease the number of "intent to refer" packages which are issued to the same debtor. Medicare contractor shall group GHP-based debts; however, it is less likely an option for liability, no-fault or workers' compensation-based debts. Contractor shall only group individual debts that meet the \$25 threshold. Debts less than \$25 (principal/interest) are excluded from referral and shall not be grouped.

60.3.1.1 - Debts Excluded from Referral

- Debts in appeal (pending at any level);
- Debts where the debtor is in bankruptcy or, in the case of an insurance company, in "State Order" liquidation proceedings [Information on current bankruptcy exclusions will be updated through your RO MSP Coordinator];
- 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) not to attempt collection;
- Debts in litigation [Information on current litigation exclusions will be updated through CMS CO. 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 where the identified debtor received the last demand letter is the employer and the employer is a Federal agency;
- Debts where the debtor is deceased;
- Debts where CMS has identified a specific debt or group of debtors as excluded from DCIA referral [Information on current “CMS Identified Exclusion” will be updated through your RO MSP Coordinator];
- Debts where there is a pending written request for a waiver or compromise;
- Debts less than \$25.00 (principal and interest); and
- Debts of \$100.00 or less (principal and interest) where **NO** Tax Identification Number (**TIN**) is available. Cross-Servicing Technical Bulletin dated February 13, 2004 (Number 04-03) states: “Treasury will only accept debts of \$100.00 or less (principal and interest) if the TIN is provided.”

NOTE: In the event the waiver or compromise decision is unfavorable to the debtor, the contractor shall continue the debts on to debt referral.

NOTE: For debts of \$100.00 or less (principal and interest) and having **NO TIN**, contractor shall access and search their database to identify if there is a TIN for a debtor of the same name and address. If the TIN can be matched to the debtor, follow the DCIA referral process. If the contractor is NOT able to identify the TIN of the debtor by searching its database, document efforts taken to find the TIN and follow instructions regarding write off in this document. Contractor is reminded that the term TIN includes either the Employer Identification Number (EIN) of an entity or a Social Security Number (SSN) (for example, for a beneficiary debtor).

60.3.1.2 - Monitoring Debts Excluded From the DCIA Referral Process

Medicare contractor shall monitor and report on debts that were selected for potential referral but met one of the exclusions to the DCIA referral process. Contractor shall monitor and determine any change in the status of such debts which would lift the exclusion and make the debt subject to referral (for example, if a debtor loses an appeal and still refuses to make payment or if CMS eliminates a litigation exclusion or a CMS-identified exclusion). Contractor shall refer a previously excluded debt to Treasury within 15 calendar days after the date of a status change, unless there are instructions to the contrary (applicable to HIGLAS users, also).

NOTE: Information on current litigation exclusions and on current “CMS Identified Exclusion” will be updated through CMS CO.

60.3.2 – Validation of Possible Eligible Debts for Referral

For GHP debts; Medicare contractors shall access and confirm the MSP issue specific to the GHP debt (only) is valid (e.g., a Common Working File [CWF] record exists and is applicable to the dates of services within the debt). Contractors shall include a screen print of the CWF

information within the case file. This review is to enable contractors to close debt, where appropriate, if the MSP record has been updated or terminated. **NOTE:** Contractor is 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.

Contractor is 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, Aetna/Cigna settlement, etc.), those claims released in the settlement may not be included in the ITR letter and must be handled appropriately.

NOTE: Contractor shall follow all CMS communications specific to litigation or negotiation activities as conveyed by CMS and ensure compliance with all instructions. **For Non-GHP debts;** The contractor shall confirm notice of settlement, judgment, award or other payment had been received on a liability, no fault or workers’ compensation case and a recovery demand letter was issued.

For DPP debts; Where a provider, physician, or other supplier overpayment is the result of a GHP duplicate primary payment, it is not necessary to check CWF. The demand shall not have been issued unless insurer information had already confirmed the existence of a duplicate payment.

For ALL Debt types; Contractor shall bring closure (e.g., apply or respond) to all checks related to an established debts, posed defenses, waiver requests or compromise requests to a debt prior to the sending of an ITR to Treasury letter or the eventual referral to Treasury for cross-servicing, including TOP.

. 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 ITR letter.

Contractor using the ReMAS/HIGLAS systems shall document all actions taken on a debt after the demand (e.g., posting check, adjusting for a defense, etc.) within the HIGLAS system. Contractors shall maintain all incoming correspondence and copies of outgoing correspondence within a case file. Contractors that maintain case files and correspondence electronically shall ensure case retrieval or recreation take place within 2 business days of a request.

Additionally, contractors, not on HIGLAS, shall check their internal systems for an updated debtor address before sending the DCIA ITR letter. Contractors shall review this information and update the case file before an ITR letter can be issued.

Contractor shall update any changes to status codes within **all** associated systems, including HIGLAS, and shall update interest accruals while performing the debt validation process. This includes updates to internal systems and/or spreadsheets so that Medicare contractor can easily ascertain from their systems and/or spreadsheets what stage of the DCIA referral process a particular debt is in.

60.4 - Issuance of the “Intent to Refer” (ITR) Letter and Inquiries/Replies Related to DCIA Activities

The DCIA requires agencies to inform the debtor in writing of the agency’s ITR the debt to Treasury for further collection activities, including TOP, and to provide the debtor information concerning the rebuttal and referral process.

60.4.1 – Issuance of the “Intent to Refer” (ITR) to Treasury Letter

Once the contractor has identified and validated all eligible delinquent debts having a balance remaining, they shall send an ITR to Treasury letter with all appropriate attachments to the current debtor or joint and several debtor combination. Contractors shall send ITR letters via certified mail, return receipt requested, to the “current debtor” or “joint and several debtor combination.”

Use of the ITR letter is mandatory (including the payment summary form and/or claims detail from the original demand letter properly annotated showing payments and/or valid documented defenses). Contractor shall generate the ITR letter without standard system changes. For most contractors, this would be a PC-based generated document.

In the case of a GHP debt the contractor shall:

- Send the “intent to refer” letter to the employer;
- Provide a courtesy copy to the employer’s insurer/TPA;
- Enclose a copy of the payment summary form and/or claims detail with a proper accounting of all services/portion of the debt still owed Medicare; and

NOTE: Do not send a copy of the original demand letter.

- Enclose a copy of attachment 1E, which contains the most commonly posed defenses and how the debtor may support the defense. (This listing is not inclusive of all defenses that may be raised.)

In the case of a Jointly and Severally Liable Debt within HIGLAS, the contractor shall:

- Send the “intent to refer” letter, inclusive of required attachments, to both joint and several debtors, if funds are still owing by both entities;
- Enclose a copy of the payment summary form and/or claims detail with a proper accounting of all services/portion of the debt still owed Medicare by each of the joint and several debtors;

NOTE: Do not send a copy of the original demand letter.

HIGLAS NOTE: All contractors using HIGLAS system will have the ITR letter generated via the HIGLAS, along with the payment summary form.

On Data Match debts recorded on the Mistaken Payment Recovery Tracking System (MPaRTS), Medicare contractors shall update the debts status code with an “IL” no later than one business day after the ITR letter is sent. Contractors on ReMAS and HIGLAS for GHP debts shall not update MPaRTS on newly identified ReMAS GHP cases or actions. Contractors having had active Data Match ARs converted into HIGLAS shall still be responsible for updating MPaRTS with all required status codes until closure of the case.

NOTE: When the ITR letter is issued and the amount of the debt has been previously reduced from the original demand letter, contractors shall appropriately annotate the payment summary form and/or claims detail. The debtor must be able to understand the figures referenced in the ITR letter. Consequently, screen prints or other annotations to the case file are insufficient.

For liability, no-fault, and worker’s compensation cases, contractor shall:

- Send an ITR to the current debtor. Address the ITR letter to the beneficiary when the beneficiary is the debtor, with a copy to the beneficiary’s attorney or other representative (if applicable);
- Enclose a copy of the payment summary form and/or claims detail with a proper accounting of all services/portion of the debt still owed Medicare;

NOTE: Do not send a copy of the original demand letter.

- Send the ITR letter directly to the no fault insurer with a copy to the beneficiary, when the no fault insurer is the actual debtor; and
- Send the ITR letter directly to the workers’ compensation carrier and a copy to the beneficiary, when the workers’ compensation carrier is the debtor.

Regardless of the identity of the debtor, contractor shall attach to each ITR letter a copy of the payment summary form and/or claims detail with a proper accounting of all services/portion of the debt still owed Medicare. Once a single debt for a particular debtor is selected, all debt for that debtor that do not fall under a specific exclusion may be selected and referred. Contractors shall issue a separate ITR letter for each debt, as well as an instructional cover sheet **for each package** of ITR letters when multiple ITR letters are sent to the same debtor at the same time. Contractors shall generate this sheet without shared 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 ITR letter. The ITR letters shall be debt specific. Input into the DCS shall also be debt specific.

NOTE: Contractor shall issue an ITR letter to allow the debtor to respond in the required timeframe contained in the letter and still, if necessary, refer the debt prior to or by the time it reaches 180 days delinquency.

60.4.2 – Responding to Correspondence as a Result of the Issuance of the ITR Letter

Contractor that receive a response to the ITR letter which challenges the amount of the debt, shall reply using the appropriate letters shall generate these letters without shared systems changes. For most Medicare contractors, this would mean PC-based generated letters. For those contractors on the HIGLAS system, these letters will be part of a future release. Until that time, rebuttal letters for HIGLAS users shall be issued via PC. All replies to one of the jointly and severally liable debtors shall also be copied and sent to the non-responding joint and several debtor. The contractor shall inform the debtor or debtors of the amount that remains subject to referral where a debtor establishes that the debt or part of the debt should not be referred to Treasury due to one of the exclusions. (The response should indicate what amount will be excluded from referral at this time and what amount continues to be subject to referral.)

Contractor shall respond to ITR responses (i.e., posed defenses) within 30 calendar days of receipt and update all applicable internal system financial/debt tracking systems including HIGLAS, if appropriate.

In the event the response from the debtor or debtors is an actual repayment (either in part or in full), the contractor shall apply the check to the debt within 20 calendar days of its receipt and update all applicable internal and shared system financial/debt tracking systems (e.g., HIGLAS, MARTISMART, RSC etc.,).

For non-HIGLAS GHP Users: if an ITR letter is returned and stamped “Undeliverable Mail,” contractor shall make one attempt to locate a better address (for example, by calling directory assistance to obtain a phone number for the debtor and calling the debtor). If a better/new address is obtained, contractors shall re-issue the ITR letter with a new issuance date and shall ensure that CWF is updated, via an ECRS CWF Assistance Request. If this limited development effort does not result in a new address, contractors shall document its development attempt, staple the envelope to the returned ITR letter, and file it in the case. The debt shall be referred immediately to the PSC/Treasury for further collection activity.

If the mail delivery to the debtor is “refused,” the contractor shall re-mail the original ITR letter, by regular mail, within 7 calendar days of receiving the refusal. The contractor shall re-mail the existing letter (re-issuing the letter with the current date) by regular mail and proceed with the referral process based upon the date in the original letter. Contractor shall retain documentation of the refusal and annotate the file to show the date the letter was re-mailed.

If mail delivery to the debtor is returned as “unclaimed,” contractors shall follow the same procedures as they would for “refused” mail.

Medicare contractor shall answer all inquiries resulting from the DCIA ITR letter. Contractor shall bring closure (e.g., post or address) to all checks or posed defenses to a debt prior to the actual referral to Treasury for cross-servicing via the DCS system.

For HIGLAS Users Addressing a Non-GHP Debt or a Single GHP Debtor Situation: if an ITR letter is returned and stamped “Undeliverable Mail,” contractors shall refer the debt

immediately to the PSC/Treasury for further collection activity. **For HIGLAS Users Addressing a GHP Joint and Several Debt :** If an ITR letter is returned from **one** of the joint and several debtors, contractors shall continue collection efforts with the remaining debtor. This action does not mean the “undeliverable” ITR entity is no longer responsible for repayment of the delinquent debt.

REMINDER: Contractor shall bring closure (e.g., post or address) to all checks related to established debts, posed defenses, waiver requests or compromise requests to a debt prior to the actual referral of the debt(s) to Treasury for cross-servicing.

NOTE: For debtors that have administrative appeal rights and/or the right to request a waiver of recovery under section 1870 of the Social Security Act, the contractor shall evaluate whether any written reply constitutes an implied appeal (if the time period for an appeal has not expired) or a request for a waiver has not previously been requested.

60.5 - Debt Collection System (DCS) and DCS Entry

Contractor shall use the DCS to refer MSP debts to the PSC, as the PSC is still responsible for completing the referral process to Treasury cross-servicing and TOP.

60.5.1 – DCS

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. (See Pub. 100-06 Chapter 4 for the DCS User Guide.)

HIGLAS users will no longer manually update the DCS with initial referrals to Treasury for cross-servicing, or downward adjustments and collections received at the contractor subsequent to the initial referral. HIGLAS will systematically send these transactions to DCS.

60.5.2 – DCS Entry of Delinquent Debt

Contractor shall individually enter debts eligible for referral to Treasury for cross-servicing for which correspondence has been received and responded into the DCS, if appropriate. Contractors shall complete DCS entry and other system updates within 10 calendar days after correspondence is worked and/or checks posted (this includes HIGLAS, etc.).

Generally, contractor have 30 calendar days to respond to ITR-generated correspondence barring instructions to the contrary. Some examples of instructions to the contrary are: 1) Contractor shall apply checks to a debt within 20 calendar days of receipt and 2) See Section 60.6.1 for timeframes specific to a contractor’s response to a Treasury Action Form (TAF).

NOTE: Contractor shall manage workloads in such a way to afford the debtor(s) appropriate time to respond and refer eligible delinquent debt to Treasury for cross- servicing on or before it becomes 180 days’ delinquent.

Contractors on HIGLAS shall no longer be required to update DCS with the initial referral information. HIGLAS will provide a listing of all debts eligible for referral to Treasury for cross-servicing. HIGLAS users shall update the case status to allow HIGLAS to send all appropriate debts to the DCS system for transmission to the PSC systematically. Some fields in DCS will require manual entry. For example: Contractor shall change SA code from COR to IND if a debtor is an individual. Contractor shall review the DCS report before transmitting to DCS. Debts less than \$100 with no TIN shall be excluded, at the time of review, from referral. Contractor shall follow instructions regarding debts less than \$100 with no TIN.

Once the debt has been entered into the DCS or successfully transmitted to the PSC, all contractor shall forward a copy of the ITR letter with all attachments and/or enclosures, to the Treasury in Homewood, Alabama within 7 calendar days from the date of DCS entry. When sending cases to Treasury, Contractor need to send a complete copy of the case file.

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 Treasury, it reduces the debt (both principal and interest) accordingly **before** entering the remaining debt into the DCS. On the Comments Screen of the DCS, the Medicare contractor shall 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 ITR letter; the amount of any collection; and the resulting balance being referred. The contractor shall annotate the balance to show principal amount, interest amount, and total amount.

60.6 - Contractor Actions Subsequent to DCS Entry

All contractor, RO and CO shall cease recovery efforts once a debt is referred to Treasury. However, contractors shall maintain and track debts referred to Treasury in their financial systems (such as HIGLAS, SMART, MARTI, etc.). Interest shall continue to accrue on all debts referred to Treasury for cross-servicing. The CO, via the RO, furnishes Medicare contractor with routine reports of debts transmitted to Treasury as of a certain date.

If Treasury or an entity on its behalf (Private Collection Agencies (PCAs)) recovers on an MSP debt, notification of the recovery will be sent to the contractor from CMS CO. (Posting of a Treasury collection in DCS does not equal “contractor notification.”) Contractor shall **not** take any action on a debt that has been referred to Treasury, unless notified by CMS to do so.

In the event contractor receive a check or a valid documented defense directly from the debtor after the debt had been referred to Treasury, the contractor shall update all applicable financial systems and show any collection or adjustment due to the valid defense within the collection screen in the DCS system. HIGLAS users shall not update DCS collection screens in this situation. HIGLAS users will update the applicable HIGLAS collection screens. Once updated on HIGLAS, the update information will be transmitted to DCS systematically. Contractor may receive telephone inquiries/questions on debts that have already been referred to Treasury. Medicare contractor shall attempt to identify the creator of the letter the inquirer is in receipt of (PSC, PSC contractor, Treasury, Treasury contractor, or Medicare contractor) and direct the caller to send any correspondence, defenses or repayments to the creator of the letter.

All contractor shall copy and send to Treasury all waiver or compromise requests received directly from the debtor after the debt has been referred to Treasury.

60.6.1 - Steps Contractor Shall Take Upon Knowledge or Receipt of Certain Information

A. Contractor shall update their internal financial systems of a collection made by Treasury when notified by CMS CO. In the situation of Treasury collections, CMS CO will update the DCS with the collection information.

Contractor shall update their financial systems and DCS (manual DCS updates are not applicable to HIGLAS users) when acknowledging a valid documented defense, either submitted directly to the contractor by the debtor or via a TAF from Treasury/PCA.

B. Contractor may receive correspondence stating the insurer or employer has paid the provider/physician or other supplier. In this situation, the contractor shall ask for proof of payment. The insurer or employer still owes any interest that accrued up until the date it paid the provider, physician, or other supplier. If it 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.) On the Data Entry Screen within DCS the contractor shall enter in the Principal Referred Amount field, one dollar with a penny (\$1.01) and in the Interest Referred amount field the amount of interest still due and owed by the debtor. The contractor shall 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.

NOTE: HIGLAS users shall manually enter into the DCS the \$1.01 for interest only debts, ONLY after having received the notice of DCS acceptance from the CO via an NDM file or an email notice.

C. If a cross-servicing entity receives partial or full collections for debts that have been referred, Treasury will notify CO via an Intergovernmental Payment and Collection (IPAC) report. (The IPAC report was previously known as the OPAC report.) The notification when furnished to the Medicare contractor will describe how the collection shall be applied. Contractor shall not update DCS with a Treasury collection. The DCS update will be done by CMS CO.

D. If a PCA discovers an error, receives information that establishes a valid documented defense, or receives information that would exclude all or part of a debt from DCIA referral, the Medicare contractor shall receive a TAF from the PCA via the CO/RO. The TAF is not an OMB-approved form. Therefore, contractor may see different formats used by the PCAs. The TAF, along with supporting documentation, is sent to CMS by Treasury for contractor decision.

The TAF is not a resolution of a debt by Treasury; it is a request for the Medicare contractor to review the documentation and provide a decision. Therefore, it is the Medicare contractor's responsibility, after review of the TAF and supporting documentation, to initiate all required actions including total debt recalls or adjustments due to valid documented defenses. Medicare contractor shall update all systems, including DCS, HIGLAS and other CFO tracking systems, if the decision so warrants within 30 calendar days. Medicare contractor shall notify Treasury of their decision either via fax or mail (Treasury needs the decision and its rationale; contractor shall **not** send back the case documentation). This notification of the contractor's decision shall include the applicable Debt Management Service Center Number in their response (the number is located at the top left of the TAF).

NOTE: HIGLAS users shall manually update DCS ONLY when changing and "X" code back to a "UJ" code. For example: A posed defense is sent via a TAF to the contractor and the contractor determines the defense to be invalid; the contractor shall change the DCS code back to the "UJ" code; collection efforts will continue.

E. If the Medicare contractor discovers an error, receives a direct repayment (by check or internal offset), directly receives information from the debtor establishing a valid documented defense, or receives information that would exclude all or part of a debt from DCIA referral, the contractor shall update the DCS Data Entry Screen with status updates and changes to the dollar amount prior to the transmission to Treasury and the Collection Screen for all other scenarios listed above.

HIGLAS users shall update the HIGLAS system with all appropriate downward adjustments (includes collections) and status codes prior to the debt being released for a systematic DCS interface.

Contractor shall no longer send the recall reports to the Treasury. Recalls will be transmitted automatically to Treasury by CO. If a collection is received by the contractor, the contractor shall update the collection screen within the DCS (not applicable to HIGLAS users). For further instructions about the DCS system, see the DCS User Guide.

F. If a debt has been referred to Treasury and falls under the \$100 or less, no TIN category, due to an adjustment or collection at the contractor's site, these debts shall not be recalled by the contractor. Contractor will be notified by CMS CO as to the action to take (applicable to HIGLAS users, also).

H. Contractor may receive a request for a "waiver of interest." This issue is not within 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. The 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. The contractor shall take all actions necessary to implement the decision and update all appropriate records and systems.

NOTE: Contractor shall not refer requests for waiver of interest on cases in which the debtor has supplied to the contractor proof of actual receipt date of settlement proceeds. (For example, a copy of the settlement check, front and back.) If repayment to Medicare is not made by the due date in the recovery demand letter or within 60 calendar days from the date the beneficiary receives the settlement proceeds, whichever is later, then interest accrues from the date of the demand letter or the date of the receipt of the settlement proceeds, whichever is later.

NOTE: If a debt is recalled/returned from Treasury due to a bankruptcy notification, the Medicare contractor shall follow bankruptcy procedures.

60.7 - DCIA Treasury Collection

60.7.1 - Background

Collections from the Department of the Treasury (Treasury) as a result of cross-servicing efforts are received by CMS central office (CO) through the Intra-governmental Payment and Collection (IPAC) system. Collections may be received as a result of collection efforts by Treasury's Servicing Center or by a Treasury contracted Private Collection Agency (PCA) including installment payments on Treasury approved extended repayment schedules or payments from offsets from the Treasury Offset Program (TOP). Treasury provides the CMS CO with a collection report generated from the IPAC system through the Program Support Center (PSC) of the Department of Health & Human Service (HHS) on a monthly basis.

60.7.2 - Intra-governmental Payment and Collection System

The collection report generated from the IPAC system includes a break out of principal and interest collected on individual debts; however, the report does not show the outstanding balance and the status of the debt after the collection. Due to system limitations, interest on the CMS debts that have been referred to Treasury and its PCAs does not continue to accrue on Treasury/PCA records during the entire collection process. Therefore, the amount of interest collected by Treasury or its PCAs may not equal the amount of interest shown as accrued by the Contractor.

60.7.3 - Debt Collection System

The CMS CO shall update the Debt Collection System (DCS) for collection activity reflected in the IPAC collections reports. The principal balance reported in the DCS should reflect the principal balance being pursued by Treasury and its PCAs and should equal the principal balance reflected in Contractor' internal systems after posting the collection.

However, if the principal balance in Contractor' system does not agree with the principal balance reported in the DCS, Contractor shall research the discrepancy by querying the DCS collection screen to compare collection/adjustment entries to their internal systems/records to determine the difference. Any differences shall be reconciled and the appropriate systems shall be updated.

60.7.4 - Collection/Refund Spreadsheet

Contractor will receive the IPAC collections information from CMS CO via the Collection/Refund Spreadsheet. The Collection/Refund Spreadsheet, initially prepared by CMS CO, shall be forwarded to Contractor within 15 calendar days of receipt of the IPAC collections. However, no Collection/Refund Spreadsheet shall be forwarded to Contractor with less than 15 calendar days remaining in the quarter.

For each debt listed on the Collection/Refund Spreadsheet, Contractor shall apply the collection to principal and interest amounts as indicated on the Collection/Refund Spreadsheet. For collection of interest only, Contractor shall post the interest as shown on the Collection/Refund Spreadsheet. No interest adjustment is required prior to posting the collection. For collection of principal and interest, Contractor shall manually adjust the amount of interest accrued to the amount of interest collected as listed on the Collection/Refund Spreadsheet. This will make the amount of the accrued interest equal to the amount of interest collected and listed on the Collection/Refund Spreadsheet and allow posting of the collection in contractor systems, which require collections be applied first to interest accrued and the balance to principal. Once accrued interest is adjusted to the amount of interest collected, contractor are able to post the amount of principal collected as indicated on the Collection/Refund Spreadsheet.

If a principal balance remains after posting the collection, interest, if appropriate, shall continue to accrue on the remaining principal balance. Contractor shall use the current date as the date of collection to post the Treasury collections to their systems.

Contractor shall complete the Collection/Refund Spreadsheet and return it to CMS CO within 20 calendar days of receipt.

Note: Any principal balance that remains in Contractor' systems, after posting the collection activity, will be carried forward. Interest shall continue to accrue, as applicable, on any outstanding principal balances until notified by CMS CO that the debt is paid in full or compromised.

60.7.5 - Financial Reporting for Collection/Refund Spreadsheet

Collections posted to the debts listed on the Collection/Refund Spreadsheet shall be reported in Section A, Line 4C, Collections Deposited at Other Location, and Section C, Line 4C, Collections Deposited at Another Location, of Forms CMS H/M 751. If the debt is in a Currently Not Collectible (CNC) status, the amounts collected shall be reported in Section A, Line 4A, Re-established as Active A/R, and Section C, Collections on CNC Debt, of the Forms CMS C/MC 751 and in Section A, Line 6B, Transfers In From CNC, and Line 4C, Collections Deposited at Other Location on Forms CMS H/M 751.

The amount of accrued interest that is adjusted in order to equal the amount of interest collected and posted to the debt shall be reported on Line 5A, Adjusted Amounts, Internal Adjustments, of Forms CMS H/M 751 or Line 4E, Other, of Forms CMS C/MC 751, as applicable. Contractor shall separately track interest adjustment amounts reported on the "Adjusted Amounts" line on Forms CMS H/M 751 or reported on the "Other" line on the Forms CMS C/MC 751. The interest adjustment amounts shall be reported in the "Remarks" section of all Forms CMS 751.

For Contractor who have transitioned to the Healthcare Integrated General Ledger Accounting System (HIGLAS), collections reported and posted to the debts on the Collection/Refund Spreadsheet shall be reported on the Treasury Report on Receivables and Debt Collection Activities Report (TROR), Part I, Section A, Line (4)(D), Collections by Treasury through Offset and Cross-Servicing and in Part II, Section C, Line (1)(G), By Treasury/Designated Debt Collection Center Cross-Servicing. If the debt is in a CNC status, the amounts collected shall be reported in Part I, Section A, on Line (4) (D), Collections by Treasury Through Offset and Cross-Servicing, and Line (5) (E), Written-Off Debts Reinstated for Collections and also in Part II, Section C, Line (1) (G), By Treasury/Designated Debt Collection Center Cross-Servicing.

60.7.6 - Debt Paid in Full

If the principal balance of the debt in DCS after the IPAC collection is posted is zero, the status code of the debt will not be systematically changed to a paid in full status code. There have been instances in the past where a debt has been collected by Treasury and the collection received in one IPAC, and a reversal of the collection occurs in a subsequent IPAC. Contractor shall not initiate any case “close out” activity on the debt based on the IPAC report information. CMS will provide separate instructions on debts returned by Treasury as paid in full or closed.

Note: If Contractor’ system does not reflect a zero principal balance after posting the collection, Contractor shall research the discrepancy by querying the DCS collection screen to compare collection/adjustment entries to their internal systems, and update all the applicable systems and internal systems to reflect the appropriate adjustment.

60.7.7 - Treasury Approved Extended Repayment Schedule (ERS)

Treasury and its PCAs have authority to approve extended repayment schedules (ERS) up to 60 months without requesting CMS approval. The ERS requests in excess of 60 months shall be referred to CMS CO for approval.

When Treasury notifies CMS CO of an approved ERS, CMS CO shall update the DCS with the DCS status code of UR. The periodic payments on the approved ERS received by Treasury or its PCAs will be forwarded to CMS CO on an IPAC collections report. When CMS CO receives the IPAC collections on the approved ERS, CMS CO shall indicate the ERS status on the Collection/Refund Spreadsheet to notify Contractor of such status. Upon receipt of the collection on the approved ERS on the Collection/Refund Spreadsheet from CMS CO, Contractor shall remove the debt from any internal withhold/recoupment status.

Contractor shall apply each collection to principal and interest, based on the breakout as indicated on the Collection/Refund Spreadsheet and follow Collection/Refund Spreadsheet instructions. Contractor shall continue to accrue interest on the remaining principal balance of the debt.

Debts that are in a Treasury approved ERS and not yet classified to CNC shall be reported as current on the Forms CMS H/M 751. Debts in CNC classification shall remain in CNC and continue to be reported as delinquent on the Forms CMS C/MC 751. Debts that are in a Treasury

approved ERS shall be reported as current unless they are already classified as CNC. Debts in CNC classification shall remain in CNC and continue to be reported as delinquent.

60.7.8 - Excess Collections

There may be instances where amounts collected exceed the amount of the debt that was referred for cross servicing/TOP. As an example, an excess collection may result from Treasury and its PCAs receiving a collection and Contractor recouping the same debt by internal withhold, or when a portion of the debt originally referred is reduced due to a partial valid documented defense.

Excess collections are identified on the Collection/Refund Spreadsheet by showing a negative principal balance in the DCS Principal Balance column.

60.7.8.1 - Applying an Excess Collection

Contractor shall apply an appropriate portion of the collection to the debt in order to bring the balance to zero. The Collection/Refund Spreadsheet shall be annotated with the portion of the collection that was posted to the debt. Contractor shall then determine if the debtor has any other outstanding debts, including interest, to which the excess collection may be applied.

60.7.8.2 - If the Debtor Has Other Outstanding Debt

If the debtor has other outstanding debt, the excess collection shall then be applied to the oldest active debt first (then next oldest), that has not yet been referred to Treasury. If the only other outstanding debt is currently at Treasury, the excess collection shall then be applied to the oldest debt first. The breakout of principal and interest on the Collection/Refund Spreadsheet does not apply when the excess collection is applied to another outstanding debt. Contractor shall indicate on the Collection/Refund Spreadsheet the action taken and the way the collection was allocated to principal and interest on the other debt, and return the completed spreadsheet to CMS CO. If the collection is applied to other debt(s), the Contractor shall first update the DCS with the DCS Collection Type Code of AD to zero the negative balance of the debt where the excess collection is identified. If the excess collection is applied to another debt currently at Treasury, Contractor shall use AD to post the excess collection to the other debt(s). The Contractor shall annotate the Comments screen to all affected debts in the DCS with the actions taken regarding the excess collection.

60.7.8.3 - If the Debtor Has No Other Outstanding Debt

If there are no other outstanding debts, the excess portion of the collection, after bringing the debt to a zero balance, shall be refunded. The amount of the refund shall be annotated on the Collection/Refund Spreadsheet. If the refund cannot be processed within the timeframe allotted for returning the Collection/Refund Spreadsheet, Contractor shall annotate the spreadsheet as

partially complete, return to CMS CO timely, and an additional 15 days shall be allowed for processing refunds. Once the refunds are processed, the completed Collection/Refund Spreadsheet shall be forwarded to CMS. A copy of the Collection/Refund spreadsheet, with annotations regarding the refund, shall be kept in the debtor file for audit trail purposes. The contractor shall make appropriate adjustments in DCS, as well as internal systems to reflect the refund activity.

60.7.8.4 - Additional Instructions for MSP Excess Collections

If the debtor is an Employer, and the payment creating the excess collection on a specific Employer debt is made by an Insurer, the Insurer is deemed to be acting as an agent of the Employer. If the amount paid exceeds the sum due on the individual debt for which payment was made, the excess monies have to be applied to the same combination of Employer/Insurer only. If there is no other outstanding debt for that same combination of Employer/Insurer, the Contractor shall issue a refund.

If an Employer has outstanding debts, and the monies were received from that Employer, the excess collection can be applied to other debts of the same Employer regardless of the Employer/Insurer combination. If there is no other outstanding debt for that Employer, the Contractor shall issue a refund.

60.7.9 - Financial Reporting for Collections Received on Debts from Cross-Servicing

Contractor shall follow the instructions as outlined in Publication 100-06, Medicare Financial Management Manual, Chapter 5, section 270. Contractor shall report and post all activities related to these debts according to CMS guidelines and instructions.

60.8 - Financial Reporting

Contractor shall document all accounting actions taken on any debt, whether the debt is actively being collected by the contractor or by Treasury/PCA/TOP. Contractors shall follow all applicable financial reporting requirements defined in Pub. 100-06 Chapter 4 -5, and Section 70 in this document. Further instructions will be published to address contractor requirements in documenting, updating and reporting debts collected by Treasury/PCAs or through TOP. Until instructions are issued, contractor shall **TAKE NO ACTION** to update their financial systems to reflect collections by Treasury/PCAs or through TOP.

70 - MSP Accounts Receivable (AR) Procedures

70.1 - General

Contractor has primary responsibility for collecting all MSP debts and are expected to pursue recovery of all accounts receivable (AR) to the fullest extent possible, regardless of the identity of the debtor. Contractor shall follow all financial reporting requirements contained in Pub. 100-06, Chapter 5. However, when AR's cannot be collected, an appropriate write-off is required.

The criteria for selection of MSP “currently not collectible” (CNC) or “Write off closed” categories and the specific instructions for implementation will be different from the non-MSP due to the differing natures of MSP and non-MSP debt. As with non-MSP AR, MSP AR that fall within either category of write-off will no longer be considered an active AR for financial statement reporting purposes; however, subsequent contractor action will differ depending on the write-off classification.

70.2 - Reclassification to CNC

Contractor shall follow instructions regarding the recommendation for CNC reclassifications and the line item reporting of CNC MSP debt contained in Pub. 100-6, Chapter 5, Sections 310 and 400.

70.3 - “Write-Off - Closed” for MSP AR

70.3.1 - Identification of MSP Write-Off Closed Accounts

Generally, Medicare contractor may recommend write-off closed on debt which is being reported as part of their ending AR balance. ARs that have been **transferred** to ROs for referral to other agencies or entities such as the Department of Justice or Office of General Counsel will be addressed by the ROs. MSP AR with CO locations will be addressed by CO. ARs that have been **referred** to another location, without transfer, remain the responsibility of the contractor.

NOTE: These instructions apply only to established ARs (e.g., a recovery demand letter has been issued). They shall **not** be used to close MSP liability/no-fault/workers’ compensation leads where no settlement, judgment or award exists and no recovery demand has been issued.

70.3.1.1 - Write-off closed Definition

The definition of “write-off closed” refers to an AR on which collection activity and servicing of the debt has been terminated. The contractor maintains records of the debts written off as “closed.” However, the debts are not to be used for future offset or interest accruals.

70.3.2 - Bases for Termination of Collection

Title 42 CFR 401.621 sets forth several bases for the termination of collection action on debts. The criteria set forth in this instruction for write-off closed are based upon CMS’ consideration of a combination of the bases set forth in this regulation rather than any single basis. In some situations, an AR could be written off as “closed” as of six years from the original demand date solely based upon the statute of limitations for initiating litigation. In other situations, this would not be true because the statute may have been suspended for some period or started a new due to a particular event, but CMS may have still determined that write-off as closed is appropriate

because of the likelihood of recovery and/or the cost of recovery, age, or the application of some other factor. In other instances CMS may determine that collection action beyond 6 years is appropriate, in part due to the governments offset authority.

70.3.3 - Criteria for MSP Based Debts to Qualify for Write-off Closed

In accordance with the Debt Collection Improvement Act of 1996 (DCIA), MSP AR which are 180 days delinquent must be referred to the Department's Program Support Center (PSC) for cross-servicing, which includes referral to the Treasury Offset Program. Where a contractor has issued a 60-day notice of CMS' intent to refer the AR to the PSC, the AR may not be recommended for write-off closed until the AR has been referred to the PSC and after lengthy recovery attempts Treasury returns the debt to agency (CMS). At the time of the return to agency, CO will determine which referred debts shall be written off as closed and shall notify the Contractor as appropriate.

No debt shall be recommended for write off closed without having first been referred for cross-servicing and subsequently returned to agency (CMS) by Treasury, unless one of the exceptions set forth below exists. Regardless of the existence of an exception, an approval for write off closed will not be granted in all instances.

With the above limitations, debts which can be recommended for write off closed without having first been referred to Treasury for cross-servicing are: 3) Debt equaling \$100 or less (principal and interest) in which there is no Tax

- 1) Debt is less than \$25 (principal and interest), WO1 (to be used as reason for recommending write off closed) See also section 70.7 for additional requirements for this write off closed situation.
- 2) Debt in which the debtor is deceased, WO2 (to be used as reason for recommending write off closed) **Remember that the deceased beneficiary is not the debtor in a wrongful death action.

Identification Number (TIN) and development for the TIN has been unsuccessful. WO3 (to be used as reason for recommending write off closed.)

- 4) Debts that are discharged/forgiven by the bankruptcy court are to be recommended for "write-off – closed", WO4 (to be used as reason for recommending write off closed.)

NOTE: Debts excluded from cross-servicing do not qualify for write off closed without having either RO or CO approval.

Litigation, CMS Identified Exclusion and Pending Bankruptcy

Debtors currently excluded from consideration for write-off closed due to litigation in which the Department of Health and Human Services/CMS is a party or debts excluded due to a “CMS Identified Exclusion” will be communicated to Contractors via a joint signature memorandum.

Debts involved in a pending bankruptcy cannot be recommended or approved for write-off closed. If there are questions about the documentation regarding discharge, contractor shall consult their RO.

All debts which are excluded from DCIA referral due to litigation or a CMS identified exclusion are also subject to exclusion from write off closed absent specific instructions.

MSP Beneficiary Debt

For MSP beneficiary debt, Medicare may recoup from (1) future Medicare paid claims where the payment is issued directly to the beneficiary, or (2) the beneficiary’s Social Security (SS) benefit payments. However, as a practical matter, this is generally an insufficient manner of recovery, particularly as the Social Security Administration (SSA) does not generally accept the referral of debts less than \$1,000. Additionally, beneficiaries often delay consideration of repayment until all appeals have been exhausted. Therefore, before recommending a beneficiary debt for write-off closed, the contractor shall follow appropriate debt referral procedures. In the event the debt is actively being appealed, respond to the appeal. After the appeal has been completed, if there remains a balance owing, refer the debt to Treasury for cross-servicing after issuance of a proper “intent to refer” letter.

Write-Off Closed of Less than Full Amount is Not Permitted

Contractor may not recommend write-off closed of less than the full amount of an outstanding “debt.””

70.3.4 - Data Requirements and Format for Recommendations to the RO for Write-off Closed (see 70.3.3 exceptions)

1. ARs recommended for write-off closed require the submission of the following information to the contractor’s RO MSP coordinator by the first day in the second month following the end of the quarter in which the debt met the criteria for write-off closed.

- Contractor name and number;
- Contractor mailing address;
- Contractor contact person/phone number/fax number/e-mail address;
- Type of MSP Debt (GHP or non-GHP (this includes liability, no-fault, and workers’ compensation));
- Beneficiary Health Insurance Claim Number (HICN);

- Beneficiary name;
- Name of debtor;
- Existing AR amount (principal and interest listed separately, as well as a total amount for principal plus interest; HI/SMI must also be listed and reported separately);
- Basis for recommendation (WO1, WO2, WO3, WO4)
- TIN for debtor, if available. There must always be a TIN for a provider, physician or other supplier or beneficiary debt. (The TIN is the Employer Identification Number (EIN) or Social Security Number (SSN));

NOTE 1: The debtor is the individual or entity to whom/which the last recovery demand was issued. Where the demand was issued to an individual in his/her 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.

Where the TIN is unavailable, the contractor's write-off closed recommendation shall leave this field blank.

1. Subtotals for GHP based AR vs. non-GHP based AR (liability/no-fault/workers' compensation) are required, and within GHP or non-GHP the AR shall be grouped together by each different basis for the recommended write-off closed action.
2. Write-off closed recommendations should be submitted in the form of a spreadsheet that includes the required contractor certification. The contractor's Chief Financial Officer (CFO) must sign recommendations for Medicare Operations. The CFO's signature constitutes his/her certification to all information/statements contained in the recommendation.
3. The contractor shall send recommendations for the approval of write-off closed to the RO MSP coordinator a diskette and hardcopy no later than the 1st day of the second month of each quarter (November 1, February 1, May 1, August 1). The CFO of Medicare Operations shall sign the hardcopy. Recommendations for write off closed may be sent electronically via secured software only.
4. The contractor shall include a preprinted address label with the hardcopy for the return of approved write-off reports.

70.3.5 - Write-Off Closed Notifications from CO for Debts Which Have Been Returned by Treasury or Recalled by CMS and CO Has Determined that No Further Collection Attempts are Appropriate

1. For such debts - Changes shall not be made to the AR on any systems (contractor systems or other systems which contractor have responsibility for updating) for write-off closed

until the contractor has been notified, in writing by CMS CO. A listing of write-off closed action notifications will be sent to the contractor by the CO. Receipt of this notification authorizes the contractor to write-off the AR as closed, and update the AR and associated case in all appropriate systems.

2. For such debts - CMS write off closed notifications shall be retained by the contractor and be available upon request (for the Office of Inspector General or any other internal or external review organization) in accordance with retention procedures. Contractor are also reminded that, under the Department of Justice's requested records freeze, all records must be retained indefinitely.

70.3.6 – Write Off Closed Approval Process for Section 70.3.3 Recommendations to the RO

1. For such debts - Changes shall not be made to the AR on any systems (contractor systems or other systems which contractor have responsibility for updating) for write-off closed until written approval by the CO is received.
2. For such debts - Receipt of this approval authorizes the contractor to write-off the AR as closed, and to update the AR and associated case in all appropriate systems. Where the CO does not approve a recommended write-off closed for a particular debt, the CO will annotate this clearly on the returned form.

70.3.7 - Financial Reporting for MSP Write-off Closed

The following reporting is required for write-off closed of debts by contractor:

1. Associated "interest" for write-off closed - Contractor shall use the amount of interest currently carried on their financial reports or tracking systems. If a contractor's system has not automatically updated interest, the contractor shall **not** calculate and update interest. (See previous CRAF instructions in Pub. 10006)
2. On Form CMS-M751 and MC751, the amount that CMS has approved for write-off closed, including principal and interest, is recorded on line 6a (M751) and line 4d (MC751), bad debt. The CMS CO or RO written approval for write-off closed is sufficient support for the subsequent write-off, including any increase in the interest, as long as the principal remains the same.
3. The contractor shall document in the remarks section of Form CMS-M751 and MC751 each quarter the amounts (principal and interest) that were written off as closed as a result of implementation of these instructions.

Contractor shall also perform all other appropriate actions in connection with closing a case.

70.4 - RO/CO Responsibilities and Time-frames for Approvals and/or Recommendations

70.4.1 - Write-Off Closed Notifications from CO for Debts Which Have Been Returned by Treasury or Recalled by CMS and CO has Determined that No Further Collection Attempts are Appropriate

CO receives reports from Treasury identifying debts that have been “returned to agency.” CO will notify contractor of their agency returns via a debt specific report no later than the subsequent quarter in which Treasury notifications have been received, after CO has implemented the “return to agency” process with Treasury.

NOTE: There will be instances when debts will be “returned to agency” due to unresolved issues. “Return to agency” status is not a guarantee that the debt will be approved for write-off closed.

70.4.2 – Write Off Closed Approval Process for Section 70.3.3 Recommendations to the RO

CO is responsible for approval or denial of all recommendations for write-off closed for MSP AR made based upon the criteria set forth in 70.3.3.

When in receipt of a write off closed recommendation for a debt in which the debtor is deceased the CO will determine the category of the debt. For example, wrongful death, Medical malpractice, etc. Prior to approval the CO will also determine if the estate is closed. Debts shall not be closed when the debtor is deceased and the estate is still open or for a wrongful death matter where the wrongful death settlement, judgment or award is awarded to other than the beneficiary’s estate.

NOTE: CO has approval authority within the limits of their delegated Federal Claims Collection Act (FCCA) authority. In addition to limitations on the dollar amounts that CO may approve, CO FCCA authority does not include third party payer debts of any kind.

CO approval must be by the ARA for Financial Management. CO must complete their review of contractors’ recommended write-offs and return their approval or denial of such write-offs by the 1st of the last month of each quarter (December 1, March 1, June 1, September 1). CO may return an electronic copy annotated to show approval or denial by the CO for Financial Management in order to meet the required time frame for approval, but this must be followed by a hardcopy that was signed and dated by the ARA for Financial Management, within the required time frame.

CO does not approve a recommended write-off closed for a particular AR, the CO must annotate this clearly on the returned form. This information must be clearly shown on both any advance electronic copy of the approval as well as the hardcopy signed by the ARA for Financial Management.

70.5 - Elimination of Automated/Systems “Write-off - Closed” Actions for MSP AR; Reminder Regarding Zero “Backend Tolerance” for MSP AR

Some contractor and/or standard systems include automated write-off closed actions for certain MSP AR based upon the outstanding amount of the AR (often referred to as a “backend

tolerance”), the age of the AR, or other criteria, without specific CMS approval of the write-off of individual AR. All such automated write-off closed actions shall cease. Contractor are prohibited from performing any manual write-off closed actions without specific approval for such actions. MSP AR write-off closed actions may take place only after recommendation for write-off closed is made to CMS CO and written approval for such write-off is received by the contractor or notification is received directly from CO. Reduction of the outstanding principal below a certain amount does not automatically justify a write-off closed action nor does the age of an AR, by itself, always justify a write-off closed action. Changes must be made to both the contractor systems, where necessary.

NOTE: The CMS has not approved an automatic write-off closed action, automated or otherwise, for any type of AR MSP. Therefore, contractor shall not use their systems to perform write off closed actions.

70.6 - Date for Establishment of MSP AR

MSP ARs must be established as of the date of the recovery demand letter or the payment receipt date (see instructions for voluntary/unsolicited refunds within Pub. 100-06 Chapter 5 Section 411).

Contractor shall not delay establishment of the AR until payment is received.

70.7 - Additional Instructions for “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.
- Where an initial demand letter is for less than \$25.00 and there is no response within 60 days, contractor shall not recommend the debt for write-off closed on the next quarterly write-off closed report sent to the CO.
- Contractor shall reply to any response, with the exception of a debt balance less than \$1.00, to a demand letter.
- 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 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 CO, unless the debt has already been referred to Treasury for cross-servicing.

70.8 - Exhibit 1 - MSP Accounts Receivable: Contractor Recommendation for "Write-Off - Closed"

Contractor Name and Number: Contractor Contact Person/Phone/Fax/E-mail Address:

Contractor Mailing Address:

Type of MSP Debt	Beneficiary HICN	Beneficiary Name	Debtor Name	Outstanding Principal Balance (HI)	Outstanding Interest Balance (HI)	Outstanding Principal Balance (SMI)	Outstanding Interest Balance (SMI)	Total Principal and Interest	Reason Code	TIN of Current Debtor

(Provide totals for each column if applicable)

Chief Financial Officer (CFO) of Medicare Operations: (signature required) My signature constitutes certification that all CMS specified criteria for write-off closed are met.

Associate Regional Administrator/Division of Financial Management: (signature required) _____

Concur _____ Non Concur Date of Referral to RO: _____ Date of RO decision:

_____ Date/quarter when approved AR are written-off as closed: _____

80 – Federal Bankruptcy/State Insurer Liquidation Actions and Medicare Secondary Payer (MSP) Debt

Action must be taken to safeguard the Medicare Trust Funds when an MSP debtor files a Federal bankruptcy petition (voluntary); creditors of an MSP debtor petition the bankruptcy court to

order the MSP debtor bankrupt (involuntary); or an MSP debtor is ordered liquidated by a State government.

80.1 – Types of Federal Bankruptcy Proceedings

Types of Federal bankruptcy filings that may involve Medicare MSP debtors include:

1. **Chapter 7** – Debtors or creditors file under this chapter to obtain discharge of debtor's debts (liquidation). Companies that file under this chapter generally close. (the debtor ceases operations and disposes of the assets over a period of time). A court-appointed trustee accumulates the assets of the debtor, sells them and distributes the money among those whom the debtor owes (creditors).
2. **Chapter 9** - This type of bankruptcy involves municipalities such as a hospital district. This chapter provides for re-organization and debt restructuring to be developed and approved, much like Chapter 11.
3. **Chapter 11** – Debtor files under this chapter to re-organize his business. The purpose of this chapter is to restructure company finances so that the debtor can continue to operate. To emerge from Chapter 11 the debtor submits a "Reorganization Plan." This Plan indicates the amounts and schedules for payments to creditors. Creditors vote on the Plan and the bankruptcy court must confirm the creditors' decision. Recovery amounts may vary. The Bankruptcy Code provides for the discharge of any remaining debts.

Chapter 13 – Debtors are individuals (including sole proprietorships) with regular income. Generally the debtor must file a debt adjustment plan within 15 days after filing (it is better to file a proof of claim as early as possible after the filing date). This chapter allows the debtor to keep property and to pay debts over time, usually between three to five years.

80.2 – State Ordered Insurer Liquidations

The State may order insurers, incorporated or otherwise organized, that do business in that State to be liquidated under certain circumstances. Generally, this occurs following:

1. A determination by a State agency (e.g., Insurance Commission) that an insurer is insolvent or operating in financially hazardous manner; and
2. An order by a State Court that the insurer be liquidated. The assets of the insurer are sold and the proceeds are used to pay claims against the debtor as ordered by the Court.

80.3 – Importance of Various Dates in Bankruptcy/Liquidation Proceedings

The filing date (i.e., the date a petition of bankruptcy is filed with the U.S. Bankruptcy Court or the date a petition for insolvency (liquidation) is filed with the State courts) distinguishes “pre-petition” services from “post-petition” services. Events that occur **on or before** the petition date are pre-petition. Events that occur **after** the petition date are post-petition.

Initially, creditors file claims for pre-petition services. Creditors often update their pre-petition claims as additional debts are identified.

At various points during the process, the bankruptcy court may allow creditors to file claims for post-petition service.

Ultimately, a debtor will be discharged (released from the jurisdiction of the bankruptcy court). Generally the discharged entity is fully responsible for the debts arising from post-discharge services, unless the court makes other arrangements.

80.4 – Difference Between Automatic Stay, Relief, and Discharge

The “Automatic Stay” goes into effect when the bankruptcy petition is filed. It gives the debtor/entity a break from the creditors’ collection efforts. The “stay” is not permanent. In certain circumstances the creditor can ask for “relief” from the “stay.”

“Relief” from the “Stay” is petitioned by the creditor and shall be granted only by the court.

The “Discharge” from bankruptcy occurs at the end of the court process and closes the bankruptcy. It voids any judgment to the extent that it is a determination of the liability of a debtor/entity for a pre-petition debt. The effect of the discharge is to totally prohibit debt collection activities against the debtor as specified in the discharge papers by the court.

80.5 – Affiliates

Businesses (including insurance companies) often have complex legal structures. It is not uncommon for a business entity to have multiple subsidiaries using different business names, called “Affiliates.” A bankruptcy/liquidation proceeding may involve all affiliates or only certain affiliates. Affiliates, if any, should be listed on the bankruptcy petition. An affiliate is **not** automatically part of the bankruptcy unless the petition states that the affiliate **is** part of the bankruptcy.

81 – Notice of Bankruptcy/Liquidation

81.1 – Identifying MSP Based Debts for Entities in Bankruptcy/Liquidation

Identifying actual and potential MSP-based debts for insurers in liquidation as well as employers, insurers and other entities in liquidation, has become an ongoing process at CMS. As a result, Office of General Council (OGC) will make, with CMS consultation, a decision as to the pursuit of a Medicare claim as part of a bankruptcy proceeding. When Department of

Justice (DOJ)/OGC does pursue a claim on behalf of Medicare, contractor shall take the following actions:

Upon receipt of an email request from OGC regarding a specific bankruptcy/liquidation, CO will forward this email to its CMS Regional Office (RO) MSP Coordinators in order to allow them to gather information from all (or selected) contractor regarding debts where demand letters have been sent, as well as cases where the entity in bankruptcy/liquidation is involved (e.g., as the worker's compensation or liability insurer), but demands have not yet been sent. All due dates will be specified in CO's email requests.

The CMS anticipates that DOJ/OGC may periodically request updates and additional information and will try to get as much time as possible for ROs and contractor to gather and report such updated information.

Reminder: The RO that has jurisdiction for the state in which the debtor/entity files bankruptcy usually is the designated lead. Contractor will be notified of any exceptions as they occur.

CO will update and maintain a list of known bankrupt debtors and liquidated debtors, which CO will supply to the contractor via their MSP RO Coordinators.

81.2 – Contractor's Role

The contractor shall upon receiving its MSP RO Coordinator's email request take the following actions:

- 1) Shall identify all MSP debts/cases/ARs specific to the bankruptcy/liquidation debtor/entity.
- 2) Shall respond to its MSP RO coordinators by the due date specified in the email request
- 3) Shall copy and send all case files for debts as requested

Reminder: If during the course of other business, the contractor identifies additional debts/cases/A/Rs for a debtor/entity on a pending bankruptcy or adjudged bankruptcy, the contractor shall take appropriate action with respect to the debt and notify its MSP RO Coordinator of the updated information. Contractor shall capture the information on Attachment A. As questions arise for a particular case, the contractor shall refer such questions to its MSP RO Coordinator.

NOTE: When a bankruptcy notification is received from Treasury, via a Treasury Action Form, at the CO, CO will update the DCS to reflect the bankruptcy status. CO will fax the information back to the Medicare contractor. The Medicare contractor shall update its internal systems, report the bankruptcy for financial reporting purposes and make its MSP RO coordinator aware of the filing.

REMINDER: The Medicare contractor does not need to send a recall to the PSC, all updates to DCS are automatically referred to Treasury.

81.2.1 - Identifying MSP Based Debts of Entities in Bankruptcy/Liquidation at Contractor Site

Contractor must report any bankruptcy/liquidation information immediately to their MSP RO Coordinator, via telephone call, fax, or hardcopy. If a contractor receives notification of a bankruptcy/liquidation or potential bankruptcy/liquidation situation from other than CO or its MSP RO coordinator, the contractor must track on a spreadsheet and notify immediately its MSP RO coordinator. Contractor is responsible to ensure the MSP department is made aware of all non-provider/supplier bankruptcy/liquidation notifications received by the contractor.

NOTE: Information sent by Internet e-mail to the RO is not secure. Contractor shall refrain from Internet e-mail communications, containing beneficiary information. Contractor may send the information via e-mail for corporate debtors - because the information is public.

When the contractor receives a defense to an MSP recovery demand letter and the entity in bankruptcy/liquidation is the debtor (as opposed to the debtor's insurer, for example), the contractor shall determine if the bankruptcy/liquidation is already known to CMS (generally from previous MSP RO Coordinator's requests). If it has been previously identified, the contractor shall follow prior guidance. If the bankruptcy/liquidation had not been previously identified, the contractor shall take the following actions:

- 1) The contractor shall request a copy of the petition for bankruptcy/liquidation from the debtor/entity.
- 2) If the contractor does not receive a copy of the filing, the contractor shall notify the debtor that the posed "defense" is not valid and the proper documentation must be submitted.
- 3) When the proper bankruptcy documentation is received, the contractor shall update all internal systems, DCS and Financial reports with the bankruptcy status.

NOTE: Please note that "defense" here does not invalidate the debt but merely refers to a defense to Treasury referral and our active pursuit of recovery through other venues other than the bankruptcy court. Also note that in no way does the bankruptcy notice alleviate the debtor of its responsibility to repay Medicare. All debts for pending bankrupt debtors remain open on the contractor's systems and financial reports.

- 1) Contractor shall cease new MSP recovery demand letters to the bankrupt debtor.

- 2) Contractor shall identify all existing open debts/A/Rs for that specific debtor. Do not refer any new debts to Treasury.
- 3) Contractor shall recall any debts that were previously referred to Treasury for that specific debtor.
- 4) Contractor shall report the debts on the contractor's financial statements within the appropriate bankruptcy detail line of the Form CMS-751 reports.

82 – Recovery Efforts and Managing Debts of Entities in Bankruptcy/Liquidation

NOTE: A bankruptcy/liquidation proceeding may be identified in numerous ways by a variety of organizations and brought to CMS' attention.

Pursuant to all types of bankruptcy/state ordered liquidation filed, contractor shall take the following actions:

1. Cease new MSP recovery demands for the debtor involved in bankruptcy proceedings, regardless of filing dates.
2. Recall from Treasury previously referred debts for the debtors. Do not do any further referrals to Treasury for these debtors.
3. Report the debt on the financial statements within the appropriate bankruptcy detail line of the Form CMS-751 reports.

NOTE: Once the bankruptcy has been finalized, consult with your Regional Office of the General Counsel before proceeding further.

NOTE: When a debtor/entity that is in Chapter 7 converts to Chapter 11 (an unusual occurrence), contractor must contact CO through their MSP RO Coordinator for further instructions.

NOTE: In the event that a contractor has or receives notice of Chapter 13 bankruptcy, the contractor and MSP RO Coordinator shall work with their RO OGC (There are many factors to be considered).

- State Ordered Liquidation

Contractor shall consult with your Regional Office of the General Counsel before proceeding further.

82.1 – Bankruptcy debts discharged by the U.S. Court/Liquidation debts discharged by State Court

Debts involved in a pending bankruptcy/liquidation cannot be recommended or approved for “write-off closed.” Debts that are discharged/forgiven by a U.S. Bankruptcy Court/State Court are to be recommended for “write-off closed” on the next quarter’s “write-off closed report.” If there are questions about the documentation requirements regarding discharge, the Contractor must obtain advice from the RO.

82.2 – Bankruptcy debts dismissed by the U.S. Bankruptcy Court

Occasionally, the U.S. Bankruptcy Court dismisses a bankruptcy action because the debtor does not qualify for bankruptcy or for some other reason. When there is a dismissal, with the advice of regional counsel, the RO and contractor can usually treat the case as if the bankruptcy action never occurred and continue the normal recovery process.

82.3 – Appeals Requests citing Bankruptcy Defense

The contractor shall refer all appeal requests with a bankruptcy defense to the RO.