CMS Manual System

Pub. 100-05 Medicare Secondary Payer

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

Transmittal 22 **Date: DECEMBER 10, 2004**

CHANGE REQUEST 3293

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

I. SUMMARY OF CHANGES: When various Program Memorandums (PM) were incorporated in Pub.100-05, Medicare Secondary Payer Manual, they were not integrated in a fluent and coherent way. This change request integrates the existing instructions in a more logical way. Any substantive changes to the existing instructions are addressed in the business requirements. Where existing instructions have merely been reorganized, these "changes" are not addressed in the business requirements. All of the changes addressed in this summary are on chapter 7 section 10 and 60.

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 10, 2005
***IMPLEMENTATION DATE: January 10, 2005**

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	7/Table of Contents
R	7/10.10/Courtesy Copy of All MSP GHP-Based Recovery Demand Packages to the Employer's Insurer/Third Party Administrator (TPA)
R	7/10.10.1/Insurer/TPA Courtesy Copy Letter
R	7/60/Medicare Secondary Payer (MSP) Debt Referral, "Write-Off - Closed" Instructions and Debt Collection Improvement Act of 1996 (DCIA) Activities
R	7/60.1/Background
R	7/60.2/Debt Selection, Verification of Debt, and Updating of Interest
R	7/60.3/"Intent to Refer" Letter and Inquiries/Replies Related to DCIA Activities
R	7/60.4/DCS System, DCS Input, Debt Transmission, Documentation to Treasury
R	7/60.5/Actions Subsequent to DCS Input
R	7/60.6/MSP DCIA Tracking Report for Referral/Collection

R	7/60.6.1/Monitoring Debts Excluded From the DCIA Referral Process
R	7/60.7/Financial Reporting
R	7/60.8/Compromise Requests and Extended Repayment Agreement Requests, and Waiver of Interest Requests
R	7/60.9/Miscellaneous Questions and Answers
R	7/60.10.1/Exhibit 1 - DCIA "Intent to Refer" Letter
R	7/60.10.1.5/Exhibit 1E - Enclosure for DCIA "Intent to Refer" Letter to Employer, Insurer, Third Party Administrator, Group Health Plan (GHP), or Other Plan Sponsor
D	7/60.10.2/Exhibit 2 – Instructions for the Required Format and Content of the Monthly MSP DCIA Status Report for Referral/Collection
R	7/60.10.3/Exhibit 3 – Treasury Address

***III. FUNDING:**

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-05	Transmittal: 22	Date: December 10, 2004	Change Request 3293

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

I. GENERAL INFORMATION

A. Background: The DCIA requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center for cross servicing and/or offset. The CMS is mandated to refer all eligible debt, over 180 days delinquent, for cross-servicing, including the Treasury Offset Program (TOP). Pub. 100-05, Medicare Secondary Payer, chapter 7, sections 10 and 60 addressed these issues. Due to revisions in Pub.100-06, Financial Management Manual, and Treasury's expansion of the DCIA exclusions from referral (Treasury's Cross-Servicing Technical Bulletin dated February 13, 2004, Number 04-03), some instructions addressed in Pub. 100-05, manual needed to be revised and/or deleted. Also when various Program Memorandums were incorporated in the Pub.100-05, MSP Manual, they were not integrated in a fluent and coherent way. This change request integrates the existing instructions in a more logical way. Any substantive changes to the existing instructions are addressed in the business requirements. Where existing instructions have merely been reorganized, these "changes" are not addressed in the business requirements. All of the changes addressed in this summary are on chapter 7, sections 10 and 60.

B. Policy: The CMS is required to refer all eligible debt to Treasury for cross servicing and/or offset. The CMS is mandated to refer all eligible debt, over 180 days delinquent, for cross-servicing, including the TOP.

C. Provider Education: None.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3293.1	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	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	to that insurer/TPA for that employer.									
3293.2	Contractors shall accept debt specific authorization as valid until the debt is closed (vs. the prior instruction of validity for 1 yr).	X	X	X	X					
3293.3	Contractors shall receive updated information on DCIA "Bankruptcy" exclusions, "Litigation" exclusions, and "CMS Identified Exclusions" through the RO MSP Coordinator.	X	X	X	X					
3293.4	Contractors shall exclude from referral to Treasury debts of $100 or less (principal & interest) where no Tax Identification Number (TIN) is available.	X	X	X	X					
3293.4.1	When the debt is $100 or less (principal & interest) and no TIN is available, the contractor shall search its database to identify if there is a TIN for a debtor of the same name and address.	X	X	X	X					
3293.4.2	If a TIN can be matched to the debtor, the contractor shall follow the Debt Collection System (DCS) referral process in section 60.4.	X	X	X	X					
3293.4.3	If the contractor is NOT able to identify the TIN of the debtor by searching their database, the contractor shall document efforts taken to find the TIN and shall report the debt as an Exclusion until further notification from their RO MSP Coordinator.	X	X	X	X					
3293.5	REMINDER: 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 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.	X	X	X	X					
3293.6	Contractors who are not current in their DCIA workload as defined in section 60.4, NOTE #3 shall follow all specific time frames set forth in the DCIA instructions.	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3293.7	Contractors shall interact directly with Treasury in resolving a Treasury Action Form (TAF).	X	X	X	X					
3293.7.1	Contractors shall seek assistance from their RO DCIA point of contact when they have trouble in resolving the TAF of a debtor to answer to Treasury.	X	X	X	X					
3293.8	CLARIFICATION--Contractor shall notify Treasury of their decision on the TAF via fax or mail.	X	X	X	X					
3293.8.1	CLARIFICATION-- The decision on a particular TAF must include rationale.	X	X	X	X					
3293.8.2	Contractor shall not send back the case documentation to Treasury when they respond to the TAF.	X	X	X	X					
3293.9	CLARIFICATION—The contractor shall provide a copy of the TAF decision to their RO MSP Coordinator.	X	X	X	X					
3293.10	Contractors shall no longer submit the recall reports to PSC. They will be transmitted automatically by CO.	X	X	X	X					
3293.11	Contractors shall no longer submit the Monthly DCIA Report from section 60.6.	X	X	X	X					
3293.12	Contractors shall review all exhibits in section 60.10 for wording changes and implement the necessary corrections.	X	X	X	X					
3293.13	Contractors shall use the address specified in section 60.10.3 when sending case files to Treasury. (Contractors were previously advised of this address by e-mail and conference calls.)	X	X	X	X					
3293.14	**Contractors shall make the following changes to section 60.10.5: 1) Add "DCIA" to the title of this section; 2) Change "report identification number" to "claim identification number" in the bullets in Nos. 2, 3, 4, 5, and 7.**	X	X	X	X					

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3293.15	**CLARIFICATION—Contractors shall exclude from referral all beneficiary debts where the beneficiary is deceased and the estate closed.**	X	X	X	X					

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: 1) CR 3163 updates language concerning the calculation of interest for the letter in section 60.10.1 We note that this update has not yet been made to the IOM.

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

***Effective Date:** January 10, 2005 **Implementation Date:** January 10, 2005 **Pre-Implementation Contact(s):** Deborah Pujals 410-786-8096, dpujalskeyser@cms.hhs.gov **Post-Implementation Contact(s):** Deborah Pujals 410-786-8096, dpujalskeyser@cms.hhs.gov	**Medicare contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Secondary Payer (MSP) Manual

Chapter 7 - Contractor MSP Recovery Rules

Table of Contents

(Rev. 22, 12-10-04)

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

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

All Medicare contractors currently initiate Data Match and Non-Data Match GHP-based recoveries of mistaken payments to the employer *(considered the debtor if they received the original demand)* if the employer is known. In order to facilitate employer efforts *in* respond*ing* 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 (10.10), the term "demand package" also includes the "intent to refer" package. Please refer to the definition of "debtor" and "current debtor" in section 60.2. 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 *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. The copy *to the employer's insurer/TPA* does not need to be sent certified mail. Send *the* copy to the address *shown* on the Common Working File (CWF) MSP Auxiliary File.

   - 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.

   - In the event the insurer/TPA copy is returned to the contractor as "undeliverable," do not attempt to find a better address.

   - *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 RO MSP Coordinator)*

2) *U*se *a cover letter* (*see 10.10.1)* 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) *M*aintain copies of all letters and demand packages sent to employers and insurers/TPAs within the case file.

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

- If the insurer/TPA is acting as an agent of the employer, the contractor must address correspondence to the employer with a copy to the insurer/TPA. The *insurer/TPA* cover letter *(see 10.10.1)* sets forth the documentation required when an insurer/TPA wishes *act as an agent* to resolve a debt on behalf of its client, an employer debtor.

- If an insurer/TPA submits payment or an alleged valid document defense but has not submitted documentation establishing its authority to act on behalf of the employer to resolve the debt, responses should be addressed only to the employer. *You may accept the payment and/or evaluate any documentation or defense provided, but you **cannot** share information about the case with the Insurer/TPA without the authorization.*

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

Contractors *shall* use extra care when evaluating defenses submitted by the insurer/TPA when the debtor is the employer. This is because a defense raised by the insurer/TPA might be valid if the insurer/TPA were being pursued with respect to the debt, but invalid as a defense for the employer. For example, the insurer might respond that it did not provide coverage during the period in question; or the TPA might respond that its contract was not in effect during the period in question. While proper documentation could establish these as defenses for the insurer *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. Contractors *shall* continue to evaluate alleged defenses and accompanying documentation as addressed in §60.10.1.5.

10.10.1 – Insurer/TPA *Courtesy Copy* Letter

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

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

Insurer/TPA City, State, Zip

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

Dear Insurer/TPA:

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

If you are to act as the agent of the employer in resolving this matter, please obtain specific authorization from the employer to do so. The authorization must be on employer letterhead and must specifically authorize the Centers for Medicare & Medicaid Services, its Medicare contractors, their employees and agents, and the Department of the Treasury and its employees, contractors and agents to disclose *until the debt is closed*, any and all information related to a debt identified in an MSP recovery demand letter dated (date of demand letter) from (name of entity sending demand letter) regarding the following Medicare beneficiaries (beneficiary names and Health Insurance Claims Numbers). It must also specifically authorize the insurer/TPA to resolve the identified debts on the employer's behalf. A copy of the authorization must be included in any communication to any of the named entities (to which the disclosure authorization applies) regarding this debt if you wish to be copied on the reply to the employer.

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

Sincerely,

(Name of MSP Manager)

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

60 - Medicare Secondary Payer (MSP) Debt Referral, "Write-Off - Closed" Instructions and Debt Collection Improvement Act of 1996 (DCIA) Activities

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

MSP DCIA activities include all GHP-based debts, including those where the debtor is the provider, physician, other supplier, or beneficiary *that received a primary payment from both the*

GHP and Medicare. MSP DCIA activities also include liability and no-fault-based debts of all types for all debtors, as well as workers' compensation-based debts for all debtors.

60.1 - Background

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer eligible delinquent debt to a Treasury designated Debt Collection Center (DCC) for cross servicing and/or offset. The CMS is mandated to refer all eligible debt, over 180 days delinquent, for cross-servicing, which includes the Treasury Offset Program (TOP).

The CMS has the option of referring such debt before it is 181 days delinquent, but is required to refer all eligible debt that is over 181 days delinquent. Over 181 days delinquent means 181 days or more after the payment due date stated in the recovery demand letter.

For purpose of DCIA debt selection/*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 a*n outstanding* debt *for which any of the following: (1) full payment has not been made, (2)* no response from the debtor regarding the debt, *(3)* no valid documented defense to the debt. All validated debt for which no valid defense has been presented to the contractor with full supporting documentation is considered to be legally enforceable.

The DCIA states that certain debts such as those in bankruptcy or in litigation of which the United States is a party, are not eligible for referral.

The DCIA process for MSP debts involves:

1. Selecting debts based on specific criteria;
2. *Verifying* these debts as valid;
3. Updating interest accruals;
4. Sending an "intent to refer" letter which contains specific language regarding the DCIA;
5. Dealing with inquiries and replies related to these activities;
6. Inputting debt information into the Debt Collection System (DCS) for electronic transmission to the PSC, as appropriate;
7. Coordination with Central Office (CO), RO, and any other entity, as appropriate; and
8. Related reporting activities, including all financial statement and debt management activities.

Additionally, Medicare contractors remain responsible for all other associated systems updates and associated accounts receivable activity.

The ultimate goal is that on or before any MSP debt is 181 days delinquent, it will have been referred for further collection activity. *T*he "intent to refer" letter *shall be* routinely issued as soon as a debt is delinquent.

60.2 - Debt Selection, Verification of Debt, and Updating of Interest

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Medicare contractors will select debts from their existing debt inventories for DCIA debt referral. The referral process for MSP debts involves selecting debts based on specific criteria, in order to certify these debts as valid.

For purposes of debt selection and referral, any dollar threshold includes both outstanding principal and outstanding interest. Also, because some Medicare contractors record their accounts receivable (AR) at the claim level (Example: 5 claims in a demand = 5 ARs) and others record them at the demand level (Example: all claims for a particular beneficiary = 1 AR), it is important that Medicare contractors have a common understanding of how the term "debt" is used in this instruction.

- For group health plan (GHP) based debt where the demand was issued to the employer, insurer, third party administrator, GHP, or other plan sponsor, the debt includes all of the claims in a demand letter to a debtor for a particular beneficiary even if a single cover letter has been issued to the debtor for multiple beneficiaries' claims.

- For duplicate primary payment recovery demands to a provider or supplier (including physicians), the debt includes all claims in the recovery demand letter regardless of the number of beneficiaries involved.

- For GHP-based recovery demands to a beneficiary, the debt includes all claims in the recovery demand letter. (Medicare may only make such recoveries when Medicare made its payment directly to the beneficiary and the insurer paid the beneficiary.)

- For liability, no-fault, and workers' compensation, the debt includes all claims in the recovery demand letter.

Additionally, "debtor" is defined as an individual or entity to whom/which the last recovery demand was issued. Where the demand was issued to an individual in their capacity as legal counsel or representative of any type, the debtor is the beneficiary, provider/supplier (including physician), or other individual or entity being represented. Where recovery is being pursued from the attorney or other representative in his/her own right, the debtor is the attorney or other representative.

"Current debtor" is a way of referring to the debtor for the most recently issued demand letter. It does not change the fact that other individuals/entities may have legal obligations with respect to

the debt, including any other individual or entity that may have previously received a demand letter. Where an individual such as an attorney received the last demand letter **in his/her capacity as a representative**, the individual/entity being represented is the current debtor.

Current debt selection criteria are as follows:

- Debts may be for Part A and/or Part B services.
- Debts must be delinquent.
- Debts may be Data Match (DM) or non-DM GHP-based debts regardless of who the debtor is.
- Debts may be liability, no-fault, or workers' compensation based regardless of who the debtor is. Contractors *shall* remember that liability and no-fault insurance include automobile liability insurance and automobile no-fault insurance as well as other types of liability and no-fault insurance.

In addition to the above selection criteria, once a single debt for a particular debtor has been selected, all debt for a particular debtor that does not fall under a specific exclusion may be selected and referred. The **CO encourages Medicare contractors 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 contractors should routinely consider *grouping* for GHP-based debts; however it is less likely to be an *option* for liability, no-fault or workers' compensation-based debts.

Debts always excluded from referral include *(See Medicare Financial Management Manual, chapter 5, Financial Reporting)*:

- 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]. (See section 80.)*
- Debts under a fraud and abuse investigation, if the contractor has received specific instructions from the investigating unit (i.e., Office of Inspector General or Office of Genera Counsel) not to attempt collection,
- Debts in litigation *[Information on current litigation exclusions will be updated through your RO MSP Coordinator. Additionally, contractors shall notify their RO MSP Coordinator of any litigation involving an MSP debt, which is brought to their attention.*

*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 only entity which 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 *and completely documented* request for a waiver or compromise *(i.e., all necessary information to make a waiver and compromise decision has been supplied to the contractor)*

- Debts less than $25.00 (principal and interest)

- *Debts of $100.00 or less (principal and interest) where **NO** Tax Identification Number **(TIN)** is available. See NOTE below and* section 70.7 for additional discussion.

***NOTE**: Contractors shall recognize that there are **two** types of "threshold" considerations in order to refer debts to Treasury:*

- Debts less than $25 (principal and interest) are excluded from referral. See section §70.7

- *Debts of $100.00 or less (principal and interest) where **NO** Taxpayer Identification Number (TIN) is available must **NOT** be referred to the Cross-Servicing Program [Cross-Servicing Technical Bulletin dated February 13, 2004 (Number 04-03)] (Treasury will only accept debts of $100.00 or less (principal and interest) if the TIN is provided)*

*For debts of $100.00 or less (principal and interest) and having **NO TIN**, contractors 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 DCS referral process (See section 60.4). If the contractor is NOT able to identify the TIN of the debtor by searching their database, document efforts taken to find the TIN and the debt needs to be reported as a "CMS Identified Exclusion" until further notification by the contractor's RO MSP Coordinator. Contractors are 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).*

Medicare contractors must check the Common Working File (CWF) for any status changes prior to sending the "intent to refer" letter and include a screen print of the CWF information in their case file. This review is to enable contractors to close debt, where appropriate, if the MSP record has been updated or terminated. For liability, no-fault, and worker's compensation debts, Medicare contractors must verify that a demand was properly issued (there was a settlement, judgment, or award), but they do not need to check CWF before sending the "intent to refer" letter. Additionally, where a provider, physician, or other supplier overpayment is the result of a duplicate primary payment, it is not necessary to check CWF. The demand should not have been issued unless insurer information has already confirmed the existence of a duplicate payment. For all types of debts, contractors must also check to see if any correspondence, checks and/or adjustments have come in that will change/alter the debt owed to Medicare before issuing the "intent to refer" letter. This includes ensuring that all associated payments/checks have been posted.

If a debt has been referred to the Social Security Administration (SSA), for collection, the Medicare contractor must recall the debt from SSA and make adjustments for any amounts collected by SSA before issuing the "intent to refer" letter.

Additionally, contractors must check their internal systems for an updated debtor address before sending the DCIA "intent to refer" letter. This information must be reviewed and the case file updated before an "intent to refer" letter can be issued. Contractors are reminded that MSP periods for beneficiaries enrolled in "union plans" are not routinely placed on CWF. If the GHP on the original demand has a "union plan," the lack of CWF information for the debt would not be sufficient to invalidate the debt.

Contractors are also reminded that if one or more of the claims in a specific debt were covered by a MSP GHP settlement (such as the Blue Cross Blue Shield Association settlement or the Provident settlement), those claims released in the settlement may not be included in the intent to refer letter and must be handled appropriately.

Any changes to status codes should be updated in **all** associated systems and interest accruals should be brought up to date while performing the debt validation process. This includes updates to internal systems and/or spreadsheets so that Medicare contractors can easily ascertain from their systems and/or spreadsheets what stage of the DCIA referral process a particular debt is in.

On DM debts, Medicare contractors will change the status code of the debt on the Mistaken Payment Recovery Tracking System (MPaRTS) at the time the "intent to refer" letter is sent, as well as when the debt is referred to the PSC. The status code on MPaRTS when the "intent to refer" letter is sent is "IL." The status code on MPaRTS when the debt is referred to the PSC is "PS."

60.3 - "Intent to Refer" Letter and Inquiries/Replies Related to DCIA Activities

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

All debts, which *become* 181 days delinquent, *shall be* resolved or have the applicable "intent to refer" letter issued.

Debts for which an "intent to refer" letter has already been issued will not be removed from the DCIA process solely because they now meet the criteria for recommending "write-off - closed." The DCIA requires agencies to inform the debtor of the agency's intent to refer the debt, and to provide the debtor with information regarding the referral process. Medicare contractors will send "intent to refer" letters via certified mail, return receipt requested, containing DCIA specific language, to the "current debtor." For liability, no-fault, and worker's compensation cases, the "intent to refer" letter should be addressed to the beneficiary where the beneficiary is the debtor, with a copy to the beneficiary's attorney or other representative (if applicable). See the definition of "debtor" in §60.2 above.

Use of the "intent to refer" letter is mandatory (including a copy of the last demand letter and all attachments to the demand letter). (See s*ection 60.10.1,* "DCIA 'Intent to Refer' Letter" and *section 60.10.1.5,* "Enclosure for "DCIA 'Intent to Refer' Letters for GHP-based employer, insurer, third party administrator, GHP or other plan sponsor debts.")

The "intent to refer" letter explains the referral process and the debtor's rights. Exhibit 1E explains the proper way for an employer, insurer, third party administrator, GHP, or other plan sponsor to document a valid defense for a GHP-based debt. The additional information in this enclosure will assist both the debtor and Medicare contractors by reducing the need for discussion and inquiries regarding what an employer, insurer, third party administrator, GHP, or other plan sponsor must submit to establish a valid documented defense for a GHP-based debt. (The "intent to refer" letter and the enclosure in Exhibit 1E must be generated without standard system changes. For most Medicare contractors this would mean PC-based generated letters.)

NOTE: When the "intent to refer" letter is issued and the amount of the debt has been previously reduced from the original demand letter, the demand packet must be appropriately annotated to explain the difference. The debtor must be able to understand the figures referenced in the "intent to refer" letter. Consequently, screen prints or other annotations to the case file are insufficient.

If a Medicare contractor receives a response to the "intent to refer" letter which challenges the amount of the debt, it must reply using the appropriate letter [*see section 60.10* (Exhibit 1B, 1C, or 1D)]. (These letters must be generated without systems changes. For most Medicare contractors this would mean PC based generated letters.) Where a debtor establishes that the debt or part of the debt should not be referred to *Treasury* due to one of the exclusions such as a pending appeal, the Medicare contractor must inform the debtor of the amount that remains subject to referral. (The response should indicate what amount will be excluded from referral at

this time and what amount continues to be subject to referral.) These response letters must be issued within 15 days of receipt of the debtor's reply.

If the "intent to refer" letter *to the debtor* is returned stamped "Undeliverable Mail," Medicare contractors should make one effort to locate a better address (for example; by calling directory assistance to obtain a phone number for the debtor *and calling the debtor*). Once the better/new address is obtained, contractors must re-issue the "intent to refer" letter with a new issuance date and must ensure that CWF is updated, including any necessary ECRS transmission. If this limited development effort does not result in a new address, Medicare contractors must document this development in the case file. Next, they must staple the envelope to the returned "intent to refer" letter and file it in the case. The debt can then be referred to the PSC/Treasury immediately for further collection activity.

If the certified mail delivery *to the debtor* is "refused", the contractor must re-mail the *original* "intent to refer" letter, by regular mail, within 7 calendar days of receiving the refusal. Contractors should retain documentation of the refusal and annotate the file to show the date the letter was re-mailed.

If the certified mail delivery *to the debtor* is returned as "unclaimed", contractors will follow the same procedures as they would for "refused" mail.

As stated in §60.2, once a single debt for a particular debtor has been selected, all debt for that debtor that does not fall under a specific exclusion may be selected and referred. Additionally, Medicare contractors are encouraged to at least select all of the debt for a particular debtor that was included in a particular demand letter without regard to the amount involved in the other debts (other than the $25.00 minimum threshold for referral.) There must be a separate "intent to refer" letter for each debt as well as an instructional cover sheet **for each package** of "intent to refer" letters when multiple "intent to refer" letters are sent to the same debtor at the same time. (See *section 60.10.1.1* for the instructional cover sheet. This sheet must be generated without standard system changes. For most Medicare contractors this would mean a PC based generated document.) Multiple debts may **not** be aggregated or otherwise combined in a single "intent to refer" letter. "Intent to refer" letters must be debt specific. Input into the DCS must also be debt specific. (See §60.2 for the definition of "debt" for purposes of these instructions.)

Medicare contractors *shall* answer *all* inquiries resulting from the DCIA "intent to refer" letter. These inquiries *shall* be handled in the same manner as any DM, non-DM, liability, no-fault, or workers compensation inquiry.

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 must evaluate whether any 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.*

60.4 - DCS System, DCS Input, Debt Transmission, Documentation to *Treasury*

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Treasury is the current designated DCC for MSP debts 181 or more days delinquent. However, MSP debts will continue to be referred to the PSC, as the PSC is still responsible for completing the referral process to Treasury cross-servicing and TOP. Medicare contractors may still have some contact/interaction with the PSC (or its contractor, OSI) with respect to debts previously referred to the PSC.

This change has no effect on contractor processes, including DCS input and/or updating. However, Medicare contractors will now interact directly with Treasury *in resolving Treasury Action Forms (see section 60.5) and with RO MSP Coordinator to assist with troublesome DCIA issues or issues with a particular debtor,* as well as the PSC. Consequently, the paragraphs below may continue to reference the PSC even where Treasury is the responsible entity for newly referred debts.

NOTE: It is important to remember that all instructions in this section to update applicable systems include Medicare contractors' internal systems, databases and spreadsheets, as well as the standard contractor systems, because many aspects of MSP recoveries/debts are not tracked on the standard systems. This is especially true for liability, no-fault, and workers' compensation-based debts.

Debts eligible for referral to the PSC, *for which correspondence has been received,* must be input into the DCS *if appropriate* within 10 calendar days *after correspondence is worked* or *within one business week* the 61st day after the "intent to refer" letter is issued, **whichever is later**. Debts may **not** be referred to the PSC until 61 day*s have passed since the issuance of the ITR*, except for undeliverable "intent to refer" letters where the Medicare contractor is unable to locate a better address. Consequently, there will be some instances where the Medicare contractor has worked the incoming correspondence but must hold the debt/delay input to the DCS system until the 61st day. Medicare contractors must also update all other systems, as appropriate, within 10 calendar days of working the correspondence and/or posting any checks received (this includes MPaRTS, where applicable).

NOTE: *As long as* a Medicare contractor is current with its DCIA workload, it may use the *standard* 45-day correspondence time frame to work its DCIA correspondence workload. "Current" means that all eligible delinquent debt is routinely referred on or before the date it becomes 181 days delinquent. *Contractors who are not current in their DCIA workload shall follow all specific time frames set forth in the DCIA instructions. Contractors using this 45 standard must complete all associated systems updates (other than DCS input) within 45 days of receipt of the correspondence or within 10 days of resolving the correspondence, whichever is earlier.*

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

- The DCS database is accessed through the CMS Data Center and is limited to authorized users.

Instructions for DCS access and data entry are included in the DCS Manual, which has already been provided to Medicare contractors. These instructions:

- Provide step-by-step guidance on entering a debt into the system;
- Define each field in the system;
- Provide directions on how to handle and enter various situations which may occur during the DCIA process; and

Once the debt has been input into the system for referral, a copy of the "intent to refer" letter with all attachments and/or enclosures, **must** be forwarded to the Treasury in *Homewood*, Alabama within 7 calendar days from the date of input. The address for debtors to mail information to Treasury is contained in s*ection 60.10.3*.

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 enters that a collection occurred and/or a valid documented defense was received; from whom; how much the debt balance was at the time of the "intent to refer" letter; the amount of any collection; and the resulting balance being referred. It annotates the balance to show principal amount, interest amount, and total amount.

60.5 - Actions Subsequent to DCS Input

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

NOTE: As indicated in §60.4, the fact that the PSC will only be the referral point for debts being sent to Treasury for cross-servicing and TOP rather than the entity responsible for actual cross-servicing should have no impact on contractor activities at this time other then the fact that supporting documentation is now mailed to Treasury rather than the PSC. Consequently, the paragraphs below may continue to refer to the PSC even where Treasury is the responsible entity for newly referred debts. Further instructions will be issued when there is more detail available and/or if there are any changes contractors need to make in their activities (including reporting).

Once a debt is referred to the PSC/Treasury, collection efforts by the Medicare contractor, the RO, and/or CMS must cease. However, referred debts must still be maintained in the Medicare contractors' internal systems *(such as debt tracking)* and interest must continue to accrue. The

CO, via the RO, furnishes Medicare contractors with routine reports of debt transmitted to *Treasury (These are the DCS snapshots)*.

If Treasury or an entity on its behalf recovers on an MSP debt, Treasury will notify the PSC who notifies the Medicare contractor via CO and the RO *(instructions are in process as of 7/28/04)*. If a debt is returned due to a lack of collection subsequent to referral, CO will need to make a determination concerning any further action on the debt. (Until that decision is made, the debt remains on the Medicare contractors' internal records, remains on contractor systems, and is reported on Form CMS-750 (Statement of Financial Position"), Form CMS-751 (Status of Accounts Receivable), and Form CMS-M751 (Status of MSP Accounts Receivable") (Form CMS 750/751 reports).)

Medicare contractors may receive telephone inquiries/questions on debts that have already been referred to *Treasury*. Medicare contractors identify which letter (PSC, PSC contractor, Treasury, Treasury contractor, or Medicare contractor) the caller has and help the caller. If the caller/debtor wants to pay Medicare back or send correspondence and they have received a letter from an entity responsible for cross-servicing, then the Medicare contractor instructs the caller to send the check or correspondence to the entity which issued the letter, not the Medicare contractor. In addition, if an inquiry from a government entity responsible for some aspect of the referral process (or from another entity under contract for these purposes) calls for assistance on the debt, the Medicare contractor shall help them.

The general rule once a debt has been referred to the PSC/Treasury is as follows:

- In all instances where a debt is eliminated or reduced by collection and/or the establishment of a valid documented defense, the Medicare contractor is responsible for updating the DCS *and all applicable systems*.

- If a cross-servicing entity receives any partial or full collections for debts that have been referred, PSC 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 detail how the collection was applied *(see section 60.70).*

- If the Medicare contractor discovers an error, *receives a repayment* (by check or internal offset), receives information establishing a valid documented defense, or receives information that would exclude all or part of a debt from DCIA referral, ***they shall update the DCS*** *Data Entry Screen, as appropriate and document the reason for the recall* ***appropriately.*** ***Contractors no longer need to send the recall reports to the PSC. These updates will be transmitted automatically to PSC by CO.*** If a collection is received, the contractor updates the Collection Screen. DCS updates must be done within 15 calendar days. *(For further instructions about the DCS system, see the DCS Manual.)*

- When a Medicare contractor receives information from a government entity responsible for some aspect of the referral process for cross-servicing/TOP (or from another entity under contract for these purposes) that conflicts with what it has in-house, it checks CWF for current MSP Auxiliary File information. If the information the Medicare contractor receives from the PSC and/or an entity under contract to the PSC is consistent with the information on CWF, then no further action is required. If the information the Medicare contractor receives from the PSC and/or entity under contract to the PSC conflicts with the CWF MSP Auxiliary File data and it is not within the Medicare contractor's authority to resolve, the contractor sends an Electronic Control Response System (ECRS) *CWF referral* to the Coordination of Benefits (COB) Contractor. The COBC investigates the query to resolution and updates the MSP record, as appropriate. *C*ontractors should be aware that Treasury also contracts with outside entities for cross-servicing activities (Contractors received notification from their ROs of the private collection agencies currently under contract *by* Treasury.)

- If a cross-servicing entity discovers an error, receives information that establishes a valid documented defense, or receives information that would exclude all or part of a debt from DCIA referral, the Medicare contractor will be notified by The CO and/or the regional office (RO) via The Treasury Debt Management Services Action Form (*TAF*). The *TAF*, along with supporting documentation, is sent to CMS by Treasury for *a decision.* The CMS then forwards the *TAF* on to the appropriate Medicare contractor. 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 contractors are responsible for updating all systems, including Debt Collection System (DCS) and CFO tracking systems, if the decision so warrants within 30 calendar days. Medicare contractors will notify Treasury of their decision *either via fax or mail (Treasury needs the decision and its rationale; contractors shall* ***not*** *send back the case documentation). This notification of the contractor's decision* must include the *applicable* Debt Management Service Center Number in their response (the number is located at the top left of the *TAF*). The contractor *shall* provide a copy of *all* the *TAF* decisions to their RO *MSP* Coordinator to assist the RO in *its* oversight role.

- *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.*

- *If a debtor calls the contractor for information on a debt/case already referred to Treasury (in DCS), the contractor shall tell the debtor to contact Treasury. No information should be given since the DCS and internal systems of the contractor are* ***NOT*** *updated with Treasury's information.*

Specific instructions for DCS input and recalls are included in the DCS Manual and are updated on a continuing basis.

NOTE: *If* a debt is recalled/returned from *Treasury* due to a bankruptcy *notification*, the Medicare contractor *shall follow bankruptcy procedures in Section 80.*

60.6 - MSP DCIA Tracking Report for Referral/Collection

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Due to an expansion of the line items reported for the standard CFO reports, the Monthly DCIA Reports are no longer required.

60.6.1 - Monitoring Debts Excluded From the DCIA Referral Process

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Medicare contractors monitor and report on debts that were selected for potential referral but met one of the exclusions to the DCIA referral process. Contractors monitor and determine any change in the status of such debts, which would lift the exclusion and make the debt subject to referral (for example, if a debtor loses an appeal and still refuses to make payment or if CMS eliminates a litigation exclusion or a CMS-identified exclusion). *[Information on current litigation exclusions and on current "CMS Identified Exclusion" will be updated through your RO MSP Coordinator]*.

60.7 - Financial Reporting

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Medicare contractors are responsible for the financial reporting of all Accounts Receivables (AR) throughout the DCIA process. The AR for debts referred to the PSC remain on Medicare contractors' internal records, remain on contractor systems, and are reported on Form CMS-750 ("Statement of Financial Position"), Form CMS-751 (Status of Accounts Receivable), and Form CMS-M751 ("Status of MSP Accounts Receivable") and Form CMS-MC751 for MSP "Write-Off - Currently Not Collectible Debt" (collectively known as Form CMS-750/751 reports).

NOTE: Medicare contractors *shall* refer to chapter 5 of Pub.100-06 Medicare Financial Management Manual (concerning the preparation and submission of Contractor Financial Reports (Form CMS-750 and 751) *and chapter 4, section 70* and follow the instructions contained therein when doing any financial reporting for DCIA activities.

Medicare contractors continue to accrue interest on a debt after the debt is entered into the DCS system. Although the DCS does not reflect this additional interest unless/until DCS is updated in

connection with a collection, *Treasury* takes the continuing accrued interest into account in its recovery effort. Also, although the private collection agencies under contract to Treasury do not take additional interest into account, contractors *shall* continue to accrue interest regardless of the referral location of the debt.

When Treasury *or one of its PCA's* receive payment, CMS is notified and receives payment through IPAC. Medicare contractors are responsible for all associated AR actions once they receive collection information from CO via *the Collection Reconciliation/Acknowledgment Form (CRAF)*. Medicare contractors *shall* complete all associated AR actions within the same quarter that they receive notification of *a collection via the CRAF*.

Upon contractor determination of an Action Form, contractors must update all financial reporting systems to reflect appropriate adjustments (CFO reported actions) due to approved valid documented defenses. Contractors *shall* await CO notification *via the CRAF* prior to reporting collections received by Treasury.

Medicare contractors must maintain detailed support for all information reported on *their CFO Report.*

60.8 - Compromise Requests and Extended Repayment Agreement Requests, and Waiver of Interest Requests

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Compromise requests should be rare. Additionally, third party payer debts are unlikely to meet the regulatory criteria for consideration of a compromise. Any compromise requests must be in writing and must state the reason why the debtor believes a compromise should be *granted*. If a verbal request or a written request which does not state a reason for the requested compromise is received, the Medicare contractor should inform the requestor of these requirements, state that no action will be taken on the compromise request until these requirements are met, and refer them to the compromise criteria set forth in 42 CFR 401.613. Written compromise requests that state the reason for the requested compromise must be forwarded to the RO, within 15 days of receipt by the Medicare contractor. The Medicare contractor must send a copy of the case file and must include any supplemental information or documents furnished by the debtor. The RO will make compromise decisions within its Federal Claims Collection Act (FCCA) authority. The ROs do not have the authority to compromise debts where the principal amount exceeds $100,000 or any third party payer debt (debtor is the insurer, employer, third party administrator, plan, or other plan sponsor) regardless of the amount. For debts exceeding $100,000 or any third party payer debt regardless of the amount, the RO reviews each case individually, writes a recommendation, and forwards a complete case file including a Claims Collection Litigation Report (CCLR), together with their recommendation to The CO to the Deputy Chief Financial Officer (through the Medicare Secondary Payer Operations Chief) for approval. Once the RO or CO, where

appropriate, makes a decision, the RO communicates the decision in writing to the debtor, with a copy to the Medicare contractor.

If the Medicare contractor receives a request from the debtor for an Extended Repayment *Schedule* (ERS) from a third party payer (insurer, employer, third party payer, GHP, or other plan sponsor), it must contact the RO. The RO, with the assistance and input of CO, handles these requests on an individual basis. Medicare contractors will handle extended repayment agreements for providers/suppliers (including physicians) or beneficiaries under existing procedures. *(Debtors who have entered into an approved ERS shall **not** have their debts referred unless they default on the agreement because a debt with an ERS which is **not** in default is **not** delinquent.)*

Medicare contractors have the authority to make waiver determinations under §1870 of the Act (a decision whether or not a provider, physician or other supplier is "without fault" with respect to an overpayment; a decision whether or not a beneficiary is "without fault" and recovery would either cause financial hardship or be against equity and good conscience). Where a partial or full waiver is granted, **no interest is due for the waived amount,** and the contractor must make a manual downward adjustment for the interest associated with the waived principal amount if this is not done automatically by the contractor's system. It is important to understand that this action is not a "waiver of interest" and that interest is **not** subject to waiver under §1870 of the Act. (Similarly, other situations where the contractor must adjust interest due to an error (for example, a debtor establishes that their liability settlement payment was actually received after the recovery demand letter was issued) do not involve a waiver of interest.) Contractors are also reminded that waiver under §1870 of the Act does not apply to MSP debtors other than providers, physicians and other suppliers, or beneficiaries.

In some instances, contractors have received a request for a waiver of interest rather than a request for compromise. This issue is not within the Medicare contractor jurisdiction. Any such request must be in writing, and must explain why the debtor believes that the interest should be waived. Such requests must be forwarded to the RO with a copy of the case file. 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.*

The MSP compromise requests, extended repayment agreement requests, and requests to waive interest sent to the RO should be sent to the attention of the RO MSP Coordinator.

60.9 – Miscellaneous Questions and Answers

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Q1. If we have an unprocessed Data Match (DM) case, is this part of the backlog that we should be working on with respect to the DCIA referral process? (We have not issued demand letters for these cases yet.)
A1. No. The DCIA referral process is *applicable only to* delinquent, established debt. A recovery demand letter must have been issued in order to establish the debt.

Q2. The language for the "intent to refer" letter indicates that a case ID number is part of the "debt identification number" and must be included on the letter for non-DM debts. Our non-DM debts do not have a case ID number. Do we need to assign case ID numbers to these cases or can we leave this information out of the "intent to refer" letter for non-DM debts? (We identify our non-DM cases by the Medicare HIC number.)
A2. No, you may not leave this information out. From the information in your question, the Medicare HIC number is what **you** use as a "case ID number" for non-DM cases. Therefore, you would use the HIC number as the case ID number in the "intent to refer" letter. Case ID numbers are how you identify a case (i.e., HICN, Report IDs, etc.).

Q3. Assume that: (1) We have a DM debt that is delinquent and has not yet been selected for the DCIA referral process/has not had an "intent to refer" letter issued; and (2) We receive a new DM tape which has another report ID for the same beneficiary. Do we keep the two cases separate for DCIA purposes (separate "intent to refer" letters, etc.) or do we somehow lump them together?
A3. You may not group them together in any manner. The information on the new DM tape is not a debt until a recovery demand letter is issued. Additionally, as stated in the instructions, multiple debts may not be aggregated or otherwise combined in a single "intent to refer" letter (see section III.). However, as further discussed in §60.3, Medicare contractors are encouraged to bulk mail all of the "intent to refer" letters for a particular debtor at one time, where possible.

Q4. Is assessment of interest/additional interest appropriate if the debt only had one demand sent, with no follow up demand letter?
A4. Yes, interest continues to accrue on the debt. As stated in the PM, the accrued interest amount needs to be updated (manually, if necessary) before the "intent to refer" letter is issued. The applicable interest rate is the rate in effect on the date the demand letter was issued.

Q5. Should the beneficiary be copied on the "intent to refer" letter?
A5. The only situation in which the beneficiary would be involved with an "intent to refer" letter is when the beneficiary is the debtor in question. In most instances this will involve a liability, no-fault or workers' compensation-based debt although it could involve a GHP-based debt. As stated in §60.3 above, for liability, no-fault, and workers' compensation debts, the "intent to refer" letter should be addressed to the beneficiary when the beneficiary is the debtor, with a copy sent to the beneficiary's attorney or other representative (if applicable). One reason

for sending the "intent to refer" letter directly to the beneficiary (where the beneficiary is the debtor) is that the beneficiary may have no ongoing relationship with the individual who was their attorney by the time the "intent to refer" letter is issued. It is crucial that the beneficiary realize that there is an outstanding matter against him/her as any further collection action or Treasury offset action will be taken against the beneficiary. See also, the discussion of the terms "debtor" and "current debtor" in §60.2.

Q6. How is the Medicare contractor to determine if the debtor is in bankruptcy for potential referral where no response is received to the "intent to refer" letter? Similarly, how is the Medicare contractor to determine that a debtor is deceased if there is no response to the "intent to refer" letter?
A6. Absent proof to the contrary, assume that a debtor is not in bankruptcy and is alive.

Q7. (a) Why does the "intent to refer" letter include the amount of interest as of 30 days after the date of the "intent to refer" letter? Is this necessary since the debtor has 60 days to respond to the "intent to refer" letter? (b) When the "intent to refer" letters are sent, the interest is calculated to show the amount due 30 days and then 60 days from the date of the "intent to refer" letter. This does not always run true with the required accrual of interest because interest accrues from the date of the original demand letter to the debtor (and is due and payable as of the first day of each 30 day period). This means that there are instances where even if the debtor pays the amount specified in the letter, including interest, the amount paid is insufficient. How should the contractor handle this situation?
A7. To correct this, the revised "intent to refer" letter now requires Medicare contractors to tie the amount due back to the existing interest accrual dates rather than to the date of the "intent to refer" letter. This means that the debtor will have accurate information as to when the amount due changes/will change due to the accrual of additional interest. If a Medicare contractor has a situation where the debtor has paid the amount specified in the "intent to refer" letter, but this amount is insufficient solely because of the problem explained above, the contractor should adjust the interest downward by the additional amount accrued as of the date of repayment but not specified in the "intent to refer letter." This adjustment must be done before the check is posted to the account receivable because payment is applied to interest first and principal second. In the example given above, the contractor would need to adjust the interest due, downward.

Q8. What will we do if the insurer or employer responds to the "intent to refer" letter stating that they have already paid the provider, physician, or other supplier?
A8. Ask for proof of payment. The insurer or employer still owes any interest that accrued up until the date they paid the provider, physician, or other supplier. If they paid the provider, physician, or other supplier before Medicare issued its demand, then proof of such payment is a valid documented defense for the entire debt. However, if the insurer or employer paid the provider, physician, or other supplier after Medicare issued its demand letter, the employer or insurer still owes any interest which had accrued and was due at the time of the payment to the provider, physician, or other supplier. (Proof of payment may include a remittance advice, an EOB (explanation of benefits), cancelled checks and/or spreadsheets/computer print-outs on the

insurer's letterhead that establish that the insurer in fact paid the provider, physician, or other supplier.)

Q9. On the Debt Collection System (DCS) there is a field for the Taxpayer Identification Number (TIN). Is this a required field? What do we enter if a TIN is not available? When do we enter a Social Security Number (SSN) as a TIN?
A9. Yes, this is a required field if the TIN information is available. If the TIN is not available, the field must be left blank; a pseudo-number should **not** be entered. The TIN for a corporate entity is the Employer Identification Number (EIN). The TIN for an individual is an SSN.

Q10. How would a Medicare contractor enter a debt into the DCS system to be referred to the PSC/Treasury for the following scenario: The employer/insurer paid the provider/physician/supplier after Medicare issued its original demand letter, the employer/insurer still owes interest which had accrued and was due at the time of the payment to the provider/physician/supplier?
A10. This type of scenario/debt would be entered into the DCS following the DCS manual instructions with the following exceptions. On the Data Entry Screen the contractor *must* 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 *must* 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.

Q11. Contractors must annotate the demand package "appropriately" when the amount of the debt has been reduced from the amount in the original demand letter. Please explain what is meant by the term "appropriate"?
A11. The original demand package needs to be *annotated* to *reflect* the amount *still* owed and note on the packet why the amount has changed (due to a partial payment, adjustment, partial defense, Medicare primary for some, etc.). *Annotate which* claims *were* paid and *which* claims are still due. This annotated/marked up demand packet must be included with the "intent to refer" letter so that the debtor can see exactly what *activity has* occurred on their debt. A copy of this annotated/marked up packet must be included in the contractor's case file as an audit trail for the case file. Internal notes to the file or notes on a comment screen are insufficient because they do not clarify matters for the debtor.

60.10.1 - Exhibit 1 - DCIA "Intent to Refer" Letter

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

NOTE: *Medicare contractors shall remember that interest runs from the date of the original demand letter to the debtor. Although a particular debt will not be referred to Treasury or a designated DCC until the 60 day period in the "intent to refer" letter has expired, interest continues to accrue from the date of the original demand letter to the debtor during this period. The additional information about interest accrual is included in the letter so that the debtor will know how much they must repay if they do not make repayment immediately upon receipt of the "intent to refer" letter.*

DCIA "Intent to Refer" Letter
[Insert: Date]

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

Past-due debt owed CMS as of **[insert:date of "intent to refer" letter/this letter] :** $**[insert: total principal and interest]**
Date debt became past-due: **[insert:the 31st or 61st day after demand letter date depending on the type of debt and whether the demand letter set a 30-day time frame for repayment or a 60-day time frame for repayment]**
Date of Demand Letter previously sent: **[insert: date; Contractors, remember that this is the date of the demand to the debtor receiving this "intent to refer" letter.]**
Debt identification numbers: **[insert: Contractor number plus contractor case ID number for all MSP other than DM; contractor number plus MPaRTS Report ID number for DM]**

Taxpayer Identification Number (TIN): **[insert: EIN (or SSN for beneficiary debtors or other non-corporate debtors]**
Beneficiary's Name: **[insert]**
Beneficiary's HIC#: **[insert]**
[insert for liability, no-fault, workers' compensation "intent to refer" - Date of Accident/Incident: (insert date)]

NOTICE OF INTENT TO REFER DEBT TO THE DEPARTMENT OF TREASURY OR A DEPARTMENT OF TREASURY DESIGNATED DEBT COLLECTION CENTER FOR CROSS-SERVICING AND OFFSET OF FEDERAL PAYMENTS

(Note that it is possible that this letter is being sent to you by a Medicare contractor other than the one who issued the request(s) for repayment that is(are) attached to this letter. This situation would occur whenever one contractor has assumed responsibility for a particular workload from

another contractor (usually because the initial contractor is leaving or has left the Medicare program).)

The Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA)) has determined that you are indebted to the Medicare program for the amount shown above and that this amount is delinquent. The amount shown includes principal and interest. This debt arose under the Medicare Secondary Payer (MSP) provisions of the Social Security Act. The CMS has the right to collect this debt through offset of any payments due to the debtor. In addition, the Debt Collection Improvement Act (DCIA) of 1996 requires federal agencies to refer delinquent debts to the Department of Treasury and/or a designated Debt Collection Center (DCC) for collection through cross-servicing, including the Treasury Offset Program (TOP). Under TOP, delinquent federal debts are collected through offset from other Federal agency payments you may be entitled to, including the offset of your income tax refund through the referral of this debt to the Internal Revenue Service (IRS), and Federal benefit payments such as Social Security retirement or disability benefits. Treasury or a designated DCC uses various collection tools to collect the debts, including offset, demand letters, phone calls, referral to a private collection agency and/or referral to the Department of Justice or agency counsel for litigation.

The purpose of this notice is to inform you of our intention to refer your debt to Treasury/a designated DCC, under the provisions of the DCIA, Title 31 United States Code, Section 3711 to collect this debt. This referral will permit the Department of Treasury and/or a designated DCC to use the aforementioned means of collection as well as to permit administrative offset of payments you may be receiving from other federal agencies. During this collection process, interest will continue to accrue on the debt and you will remain legally responsible for any amount not satisfied through the collection efforts.

Please read the following instructions carefully as they may assist you in resolving this matter prior to referral. Add: **[insert - Contractors, insert the following sentence for "intent to refer" letters to insurers, employers, third party administrators, GHPs, or other plan sponsors: Please note that in addition to the information set forth below, we are enclosing more detailed information on how to review this debt, and proper documentation requirements for asserting that the debt is not past due or legally enforceable.]**

Challenging the Indebtedness:

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing to the address listed below. Additionally, you have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise this right, this office must receive a copy of the evidence to support your position. Please include a copy of this notice when corresponding with the agency regarding this matter. You must submit any evidence that the debt is not owed or legally enforceable within 60 days of the date of this letter. We will notify you within 30 days of receipt of the information of our determination as to whether the debt is still past due and legally enforceable. Failure to

present any evidence will result in the automatic referral of the debt to the Department of Treasury/a designated DCC for cross-servicing/offset actions.

Your debt will not be referred for further collection action if you make payment in full. Please be advised that payment of principal only is not considered payment in full and will not satisfy this debt. By law, partial payments are applied to interest first and then to principal.

The past-due debt owed to CMS as of **[insert: date of "intent to refer"/this letter]**, including interest accrued through **[insert: date of last day of the current interest period]**, is **[$]**. By regulation, interest is due and payable for each 30-day period as of the **first day** of that 30-day period. Be advised that interest is accrued monthly and is added to the balance of the debt. If the debt remains outstanding after **[insert specific date: date of last day of the current interest period]**, the amount of the debt, including interest, will be **[insert dollar amount]**. If no payment is received by **[insert date: date of last day of the next interest period (30 days from date of the last day of the current interest period)]**, the amount of the debt including interest will be **[insert: dollar amount, including interest]**; and if no payment is received by **[insert date: date of the last day of the third interest period (60 days from the date of the last day of the current interest period)]**, the amount of the debt including interest will be **[insert: dollar amount, including interest]**. Please make your check or money order payable to **[insert: name of Medicare Contractor - MSP Unit]**, include a copy of this notice and forward both to the address below.

[insert & instructions: "interest only debt" – If the outstanding debt is interest only, that debt does not accrue additional interest. "Interest only" debts generally happen when the employer or insurer paid the provider/supplier after the date of the demand. In these situations, contractors must delete the preceding paragraph (that is, starting with "The past due debt owed….") and insert the following paragraph in its place: Please be aware that if you paid the provider, physician, or other supplier for the claims at issue after Medicare issued its demand letter, you still owe any interest which accrued and was due at the time of the payment to the provider, physician, or other supplier. The past due debt of [insert: amount] owed to CMS is comprised entirely of interest. Please make your check or money order payable to [insert: name of Medicare Contractor – MSP Unit], include a copy of this notice and forward both to the address below.]

[insert & instructions: beneficiary GHP-based debt - If the debtor is the beneficiary and the debt is GHP-based debt, CMS does not charge interest to the beneficiary. In these situations, the contractor must delete the standard paragraph which includes information about interest (that is starting with "The past due debt owed....") and insert the following paragraph in its place: The past-due debt owed to CMS is [insert: amount of outstanding debt]. Please make your check or money order payable to [insert: name of Medicare Contractor - MSP Unit], include a copy of this notice and forward both to the address below.]

[insert: Name of Medicare Contractor - MSP Unit

Attention: Manager's Name
Address of Medicare Contractor]

Your check should also include the "debt identification numbers" as shown at the beginning of this letter in order to ensure that you receive proper credit for your payment.

If you cannot make the payment in full, you may be allowed to enter into an extended repayment agreement.

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

Information for Individual Debtors Filing a Joint Federal Income Tax Return: TOP automatically refers debts to the IRS for offset. Your federal income tax return is subject to offset under this program. If you file a joint income tax return, you should contact the IRS before filing your tax return to determine the steps to be taken to protect the share of the refund which may be payable to the non-debtor spouse.

If you have questions concerning this debt, extended repayment plans, and/or relating to the submission of evidence, you may contact:

[insert: Name of Contractor's Contact Person
Telephone Number of Contact Person]

If you call, please be sure that you have this letter available so that you can readily provide us with the identification information provided at the beginning of the letter.

Sincerely,

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

Enclosures:
Demand Letter
Claims Summary/Claims Facsimiles
[insert for GHP insurer, employer, third party administrator, GHP, or other plan sponsor debts only: Enclosure with supplemental information on resolving debts]
[insert where the beneficiary is the debtor and is represented - cc: attorney or other representative]

60.10.1.5 - Exhibit 1E - Enclosure for *DCIA* "Intent to Refer" Letter to Employer, Insurer, Third Party Administrator, Group Health Plan (GHP), or Other Plan Sponsor

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

Supplemental Guidance on Resolving MSP Debts for Employers, Insurers, Third Party Administrators, Group Health Plans (GHP's), and Other Plan Sponsors

The Centers for Medicare & Medicaid Services (CMS) (formerly the Health Care Financing Administration (HCFA) anticipates that the employer or insurer may ask its health insurance contractors (i.e., the group health plan (GHP) or any entity responsible for payment under the plan (employer, insurer, third party administrator (TPA), or other plan sponsor) to assist in resolving these Medicare Secondary Payer (MSP) debts. This is certainly acceptable. However, the employer, the insurer, and other health insurance contractors must recognize that the date of Medicare's original demand letter is the date applicable to any defense that the employer, insurer, or health insurance contractors may have to any portion of this debt. The date that the employer, insurer (or other entity to the demand letter was issued) elected to share MSP claims information with a particular health insurance contractor is not relevant.

The numbered sections below show what you must take into consideration and what documentation you must provide if you wish to assert that the debt is not past due or legally enforceable. If you determine that you can resolve the debt based upon the information in a particular section, you do not need to proceed to the next numbered section.

The numbered sections will reference proper documentation. When copies of "individual claims," demand letters, and report identification numbers are requested, you may use the copies we are providing you but the information of most importance is documentation to support your defense.

Number 1

Many employers and entities that process claims for employer group health plans (EGHPs) organize their records by the name and unique identifier of the employee to whom individual or family health insurance coverage is afforded. We provide information on the individual (in most cases the employee) to whom the health insurance was afforded. This information is the primary insurance that usually covers the individual beneficiary that received the medical services. We have observed that some employers and claims processors neglect to check the MSP Summary Data Sheet and mistakenly assume that the beneficiary is an employee. Historically, the majority of MSP recovery claims have involved services provided to spouses of employed individuals. The employer and any health insurance contractors that assist the employer in this effort must utilize the individual claim and the associated MSP Summary Data sheet to determine coverage at the time services were provided.

Number 2

The health plan information that Medicare provided in the original demand letters was, in almost all cases provided by the employer in response to Internal Revenue Service (IRS)/Social Security Administration (SSA)/CMS Data Match questionnaires. In other cases, the health plan information was obtained from the beneficiary, the insurer, or the provider/physician/other supplier that furnished services to the beneficiary. Thus, the information is presumed to be accurate as of the time it was provided. Many employers offer employees the opportunity periodically to choose among several available group health plans. Because CMS was not advised of changes in employees' group health plan choices, the group health plan Medicare identified as providing the health insurance may not be correct as of the date particular services were provided to an identified beneficiary.

The MSP debt is still valid as long as the Medicare beneficiary, entitled to Medicare on the basis of age or disability, had coverage under any employer plan based on their own or spouse's current employment status. (A disabled beneficiary may also have had coverage based on another family member's current employment status.) In the case of a beneficiary entitled to Medicare on the basis of ESRD (end stage renal disease), the debt is still valid if the beneficiary had coverage under any Employer plan on any basis. If you are unclear about your responsibility relative to ESRD, please call the Medicare contractor.

The original demand letters explain that interest is due on any debt that is not resolved timely (60 days from the date of the original demand letter) and advises the recipient of the applicable interest rate. Interest applies from the date of the demand letter for each *full*30-day period that the debt is unresolved. Accordingly, to resolve any MSP claim for which payment is due, the responsible entity (GHP, employer, insurer, third party administrator (TPA), or other plan sponsor) must pay both the principal due and the applicable interest. To assist the responsible entity in determining the amount due on any individual unresolved MSP debt and CMS in verifying that the correct payment has been made, the responsible entity should provide the Medicare contractor with the following information:

- A copy of the individual claim;
- Date of the original demand letter containing the claim;
- Associated *claim* identification number for that claim as provided in the demand letter;
- Explanation of how the principal payment was determined; and
- Explanation of how applicable interest was computed.

The responsible entity (employer, insurer, third party administrator (TPA), group health plan, or other plan sponsor) should contact the Medicare contractor with any question on the exact amount the responsible entity owes.

Number 3

It is possible that a beneficiary, entitled to Medicare on the basis of age or disability, did not have coverage under any employer plan based on their own or a spouse's current employment status at the time the services were provided, because the individual or his/her spouse had retired or left employment. (A disabled beneficiary may also have had coverage based on another family member's current employment status.) If properly documented, the retirement or termination of the individual through whom the beneficiary had coverage is a valid defense to associated debts. Proper documentation would consist of the following:

- A copy of the individual claim;
- Date of original demand letter containing the claim;
- Associated *claim* identification numbers for that claim as provided in the demand letter;
- Identification of the individual through whom the beneficiary had coverage; and
- Certification of the date of retirement or termination of that individual.

We will consider all claims for which such a documented defense is provided and Medicare determines to be valid to be fully resolved.

Number 4

It is also possible that a beneficiary who has employer plan coverage that is obligated to be a primary payer may have had services not covered by the employer's plan. This would mean that the services are not the responsibility of the employer's plan. If properly documented, this would be a valid defense to the debt associated with those services. Proper documentation would consist of the following:

- A copy of the individual claim with the non-covered services annotated;
- Date of the original demand letter containing the claim;
- Associated *claim* identification number; and
- Copy of plan documents (e.g., Employee Services Handbook, Member Services Booklet, etc.) that establishes that the services are not covered under the plan with the applicable coverage terms annotated.

We will consider all claims for which such a documented defense is provided and Medicare determines to be valid to be fully resolved.

Number 5

It is possible that both Medicare and an employer plan made primary payment for the services identified on any unique MSP claim. If properly documented, an employer plan's full primary payment for the services on an MSP claim is a valid defense to the debt that had been associated with that claim. Proper documentation generally would consist of the following:

- A copy of the individual claim;
- Date of the original demand letter containing the claim;
- Associated *claim* identification number for that claim as provided in the demand letter;
- Explanation of how the prior primary payment was determined; and
- Proof of payment (e.g., copy of remittance advice).

If the employer plan is an HMO and the employer plan's full primary payment responsibility was resolved by a capitation payment to the provider, physician or other supplier that treated the Medicare beneficiary, proper documentation would consist of the following:

- A copy of the individual claim;
- Date of the original demand letter containing the claim;
- Associated *claim* identification number for that claim as provided in the original demand letter;
- Copy of the relevant portions of the HMO contract with the provider, physician or other supplier stipulating that the only payment obligation of the HMO was payment of a capitated amount;
- Proof that the capitated amount for the individual for the time period when the services were furnished was paid.

In these instances, Medicare will recover from the medical provider or supplier that received Medicare's payment.

Number 6

Most group health plans (GHPs) have established time limits during which claims must be submitted in order to qualify for payment. If a GHP or any entity responsible for payment under the plan (employer, insurer, third party administrator (TPA), or other plan sponsor ("responsible entities")) does not receive a claim within those time limits, the plan is not obligated to make payment (even if it would be obligated to make payment if the claim had been submitted prior to the expiration of the time limit). These time limits are typically called "timely filing" requirements. Applicable Federal law limits the ability of any responsible entity (including the employer/insurer/TPA/GHP/other plan sponsor) that received a demand letter to assert a timely filing defense to an MSP-based debt.

As a first point, the date of Medicare's original demand letter is the date applicable to any defense that the recipient of the demand letter, or any entity acting on its behalf may have to the debt or any portion of the debt. This is true regardless of which of these entities the original demand letter is issued to, and regardless of whether or not the demand is immediately shared among these entities. For example, the insurer may not establish a timely filing defense on behalf of an employer based upon the date the insurer received the demand letter from the employer. The insurer may only establish a timely filing defense for the employer based upon the date of the demand letter to the employer.

Additionally, two different rules are applicable to the MSP claims that comprise the Medicare debts. These rules are explained below.

The first rule applies to all services, regardless of the date those services were provided. The recipient of the demand letter (regardless of whether it is the employer/insurer/TPA or other responsible entity) does not have a valid timely filing defense if either the employer, the insurer, the TPA, or other responsible entity had knowledge within the plan's timely filing period that the services were provided. This knowledge could come from a variety of sources, but is often due to the receipt of a claim from a provider, physician or other supplier (or the plan member) which included the services at issue.

The second rule applies to services provided on or after August 5, 1997, and further restricts the use of a timely filing defense. The Balanced Budget Act of 1997 eliminated timely filing defenses for at least 3 years from the date of the service. For services on or after August 5, 1997, there is no timely filing defense if Medicare's original demand letter is dated within 3 years of the date of the service. This rule applies even if the plan's timely filing period is less than 3 years. (If the services were on or after August 5, 1997, and Medicare's original demand letter is not dated within 3 years from the date of the service, then the first rule applies.)

Under the first rule, proper documentation of a timely filing defense would consist of the following:

- A copy of the individual Medicare claim supplied with the demand letter with the services for which the defense is offered annotated by the entity asserting the defense;
- The date of the original Medicare demand letter containing the claim (and the associated report identification number for Data Match recoveries);
- A copy of plan documents that establish the timely filing period with the applicable provisions annotated; and
- A written statement by or behalf of the recipient of the demand letter that claims records of all responsible entities exist for the time period when the services were provided, were searched, and no record of the services being provided to the beneficiary were found.

Medicare considers all claims for which such a documented defense is provided to be fully resolved, subject to Medicare's subrogated appeal rights described in Step 7.

Remember that if a demand letter is sent to an employer and another responsible entity such as an insurer or TPA responds, the responding entity is assumed to be acting as the agent of the employer. In this situation, the date of the original demand letter to the employer is the date applicable to any asserted timely filing defense.

Number 7

When the entity that received the demand letter is a Third Party Administrator (TPA), the TPA will not be required to repay Medicare or provide a claim specific defense for services provided prior to August 5, 1997, if the TPA provides the following documentation:

- Copies of individual claims;
- Dates of original demand letters containing the claims;
- Associated *claim* identification numbers for those claims as provided in the original demand letters;
- Copy of the relevant portion of the contract with the employer or other plan sponsor stipulating that the entity was a TPA only.

Number 8

As explained in the original demand letter, in addition to its statutory recovery rights, Medicare also has subrogation rights. Medicare utilizes its subrogated rights to appeal a denial of payment due to a timely filing defense and/or seek waiver of the timely filing requirements to the same extent that the patient could appeal and/or seek such a waiver. Where there is a denial of payment based upon a timely filing defense, Medicare's original demand letter must be treated as a request for appeal of that denial. Similarly, if the right to seek a waiver of the plan's requirement exists, Medicare's original demand letter must be treated as a request for waiver. If such rights do not exist, a copy of the plan's documents that explain that such rights do not exist must be provided.

When a patient's rights to appeal a timely filing denial and/or to seek a waiver of the plan's timely filing requirements exist(s), the employer/insurer/TPA/GHP/other plan sponsor must apply the same criteria to Medicare's appeal and request for waiver as they would have had the appeal or waiver request been made by the patient. For example, if the timely filing requirement is always waived for the patient if the claim was not filed timely through no-fault of the patient, the employer/insurer/TPA/GHP/other plan sponsor must waive the timely filing requirements for Medicare. Accordingly, before a case can be closed with respect to a particular service (or services) due to presentation of a valid fully documented timely filing defense, the employer/insurer/TPA/GHP/other plan sponsor must furnish to the contractor a notification that the appeal and waiver requests have been denied and provide copies of any provision upon which the denial is based. (This documentation is in addition to the information previously described as necessary for a timely filing defense.)

60.10.3 - Exhibit 3 - Treasury Address

(Rev. 22, Issued: 12-10-04, Effective: 01-10-05, Implementation: 01-10-05)

The address for contractors to utilize when sending case files to Treasury and overnight deliveries is:

U.S. Department of Treasury
Attn: MSP Room
190 Vulcan Road
Homewood, AL 35209

The address for debtors to utilize when corresponding with Treasury is:

U.S. Department of Treasury
Financial Management Service
Debt Management Service Branch
P.O. Box 830794
Birmingham, AL 35283

Treasury's Phone Number: 1-888-826-3127

NOTE: The above address and telephone number are the only address and/or telephone number that contractors are to give to debtors.

Outsourcing Solutions, Inc. (OSI)'s Address:

OSI Collections Services, Inc.
P.O. Box 469
Owings Mills, Maryland 21117

Attn: Ms. Gemette Dorsey

OSI's Telephone Number: 1-800-234-3550 or (410) 602-6860
Fax Number: (410) 602-5375

Contact Person at OSI:
Ms. Gemette Dorsey