CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13071	**Date: March 13, 2025**
	Change Request 13895

SUBJECT: Updates to the Internet Only Manual (IOM) Publication100-06 Chapters 3 Overpayments and 4 Debt Collection

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to clarify multiple sections in the IOM publication 100-06 chapters 3 and 4. This also updates the following sections:

- Establishing an Extended Repayment Schedule (ERS) - (formerly known as an Extended Repayment Plan (ERP), and

- Debts RTA by Treasury as Uncollectible (RU) or Out of Business (RN)

EFFECTIVE DATE: April 11, 2025
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 11, 2025

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/170.5/Provider Offers to Settle on Compromise Basis
R	4/20/Demand Letters
R	4/30.2/Rates of Interest
R	4/50/ Establishing an Extended Repayment Schedule (ERS) - (formerly known as an Extended Repayment Plan (ERP)
R	4/70.17.2/Debts RTA by Treasury as Uncollectible (RU) or Out of Business (RN)

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to

be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-06	Transmittal: 13071	Date: March 13, 2025	Change Request: 13895

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- Establishing an Extended Repayment Schedule (ERS) - (formerly known as an Extended Repayment Plan (ERP), and
- Debts RTA by Treasury as Uncollectible (RU) or Out of Business (RN)

II. GENERAL INFORMATION

A. Background: CMS periodically reviews the IOM to ensure that all policy is interpreted as intended. This CR updates policy regarding compromises and directs all inquiries to the compromise mailbox. In addition, updates to the delinquent and default definitions have been clarified along with Returned to Agency (RTA) instructions for non-HIGLAS (Healthcare Integrated General Ledger Accounting System) users have been explained.

B. Policy: This CR clarifies and updates to chapter 3 section 170.5 and chapter 4 sections 20, 30.2, 50, and 70.17.2 of the IOM publication 100-06.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
13895.1	The MAC shall forward compromise offers to cmsdebtresolution@cms.hhs.gov.	X	X	X	X					
13895.2	The MACs shall scan or copy all overpayment letters into the internal system for non-HIGLAS users and HIGLAS users shall use the Tool (Paper Clip) to include a copy of	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	manual letters.									
13895.3	The MACs shall be aware of the updates made to IOM publication 100-06 chapter 4 section 30.2 regarding interest rate charges.	X	X	X	X					
13895.4	The MACs shall be aware of the definition addition of delinquent and a defaulted ERS.	X	X	X	X					
13895.5	The MACs shall continue to monitor approved ERSs for continued eligibility throughout the term of the installment schedule.	X	X	X	X					
13895.6	The MACs shall send a notice of default to the provider, suspend the ERS agreement, and immediately resume normal debt collection procedures within five (5) business days.	X	X	X	X					
13895.7	The contractor not utilizing HIGLAS shall re-refer to Treasury all debts RTA'd as RU/RN that are: • Less than or equal to \$500,000 (principal balance) and less than 3-years old; or • Greater than \$500,000 (principal balance) and less than 6-years old.									HITECH
13895.7.1	The contractor not utilizing HIGLAS shall not re-refer the debts to Treasury, if Treasury returns these same debts before									HITECH

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the 3 or 6-year age after they have been re-referred one time.									

IV. PROVIDER EDUCATION

None

Impacted Contractors: None

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

Medicare Financial Management Manual
Chapter 3 - Overpayments

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(Rev. 13071; Issued: 03-13-25)

170.5 -Provider Offers to Settle on Compromise Basis
(Rev. 13071; Issued: 03-13-25; Effective: 04-11-25; Implementation: 04-11-25)

An overpaid provider may offer to compromise an overpayment. The MAC shall forward compromise offers to ***cmsdebtresolution@cms.hhs.gov*** *only when the provider applies for an ERS and discontinues the approval process after asserting an inability to make the proposed monthly payments; the provider is approved for an ERS and asserts difficulty with making monthly payments; or the provider advises the MAC of closing or has closed the business.*

Medicare Financial Management

Chapter 4 - Debt Collection

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20 – Demand Letters

(Rev. 13071; Issued: 03-13-25; Effective: 04-11-25; Implementation: 04-11-25)

There are two overpayment demand letters, an Initial Demand Letter and an Intent to Refer Letter (ITR) (this does not include notification letters or response letters) used in the debt collection process. The purpose of an overpayment demand letter is to notify the providers and suppliers of the existence and amount of an overpayment, and to request repayment. Every demand letter, regardless of the cause of the overpayment or the status of the provider or supplier, shall meet certain requirements as to form and content.

Below is a detailed list of the requirements for the basic overpayment demand letters to use in various overpayment situations (it is not all-inclusive).

Non-Cost Report Overpayment Demand Letters:

1. The initial demand letter shall be sent to the provider or supplier within 7 calendar days of the determination of the overpayment.
2. The letters shall be labeled either Initial Demand Letter or The Intent to Refer Letter (ITR).
3. *All letters shall be scanned or copied into the internal system for non-HIGLAS users and HIGLAS users shall use the Tool (Paper Clip) to include a copy of manual letters.*
4. The initial demand letter shall be sent by first class mail, secured email, or fax.
5. The initial demand letter is an explanation of the nature of the overpayment, how it was established, a bankruptcy notice, and the amount determined.
6. The initial demand letter includes language to request the provider or supplier to submit a refund or arrange for immediate recoupment or file an appeal (with exception of Requests for Anticipated Payment (RAP) claims that shall not receive appeal rights, see 100-06 Chapter 3 Section 200.1.2).
7. The initial demand letter offers the provider or supplier the opportunity to apply for an Extended Repayment Schedule (ERS) if repayment of the debt will cause financial hardship. (An ERS shall be analyzed using the criteria set forth in Chapter 4, §50. Any approved ERS would run from the approval date.)
8. If payment in full is not received within 30 days, interest will be charged.
9. The initial demand letter includes Debt Collection Improvement Act (DCIA) Intent Language for referral to the Treasury Department for cross servicing.
10. The ITR letter is sent to the provider or supplier at least 60 days after the date of the initial, final

or revised demand letter, if it is not in a status excluded from debt referral, and shall include the initial demand letter number.

11. All correspondence, including demand letters, addressed to a provider or supplier in bankruptcy proceedings, shall be submitted to the Regional Office (RO), which has the lead in the bankruptcy proceedings, for approval prior to release.

Cost Report Overpayment Demand Letters:

1. When a provider files a cost report without payment for the amount due from the provider, the contractor shall send a demand letter to the provider. The demand letter shall inform the provider that the contractor will recoup (reduce or withhold) Medicare payments if it does not receive the overpayment amount, or a request for a repayment schedule along with the first month's payment within 15 days of the date of the demand letter.

2. In the situation of an unfiled cost report, the cost report reminder letter serves as sufficient notice that future Medicare payments (interim payments) will be suspended if the overpayment amount is not received on or before its due date.

3. In addition to the suspension of future Medicare payments for failure to file a cost report, contractors shall deem all interim and lump-sum payments made for the fiscal period and all interim and lump-sum payments made in a subsequent period as an overpayment. These overpayments shall be immediately due and payable to CMS if the cost report is not received timely.

4. The contractor shall ensure that recoupment of Medicare payments does not start until the cost report demand letter is generated.

5. The initial cost report demand letters may be delivered certified mail, electronic mail (e-mail), or through a secured portal and shall include a receipt confirmation.

6. The initial cost report demand letters shall be sent to the provider or supplier on the 7th day after the due date or extended due date of the cost report, if not received.

7. The initial cost report demand letters shall include the explanation of the overpayment determination and the amount due or Notice of Program Reimbursement (cost report).

8. *All letters shall be scanned or copied into the internal system for non-HIGLAS users and HIGLAS users shall use the Tool (Paper Clip) to include a copy of manual letters.*

9. The provider or supplier may submit a cost report, make a refund, arrange for immediate recoupment, or request an ERS, as applicable.

10. The percentage of withhold shall be indicated whenever an adjustment (reduction or suspension) of interim payments has been imposed.

11. The cost report letters shall offer the provider the opportunity to apply for an ERS if repayment of the debt will cause financial hardship. (An ERS shall be analyzed using the criteria set forth in Chapter 4, §50. Any approved ERS would run from the approval date.)

12. The cost report letters shall include DCIA Intent Language for referral to the Treasury Department for cross servicing.

13. The ITR letter shall be mailed to the provider 60 days after the date of the Initial Demand letter, if it is not in a status excluded from debt referral.

30.2 - Rates of Interest

(Rev. 13071; Issued: 03-13-25; Effective: 04-11-25; Implementation: 04-11-25)

The interest rates on overpayments and underpayments are determined in accordance with regulations promulgated by the Secretary of the Treasury and is the higher of the private consumer rate or the current value of funds rate prevailing on the date of final determination. Interest accrues from the date of the initial request for refund and is assessed for each 30-day period, or portion thereof, that payment is delayed after the initial refund request.

The private consumer rate, historically higher than the current value of funds rate, is subject to quarterly revision. The Department of the Treasury certifies the revised rate to the Department of Health and Human Services on a quarterly basis. Medicare contractors will be receiving subsequent quarterly updates of the new interest rate for Medicare overpayments and underpayments through a recurring update notification. Interest assessed for both late payments and installment payments is computed as simple interest using a 360-day year. Simple interest is interest that is paid on the original principal balance and after each payment interest accrues on the remaining unpaid principal balance. Interest charges will not be prorated daily for overdue payments received during the month (e.g., 10, 15, or 20 days late). Interest is assessed for the full 30-day period. The interest rate on each of the final determinations will be the rate in effect on the date the determination is made.

If periodic but unscheduled payments or credits are made in different calendar quarters, the quarterly rate prevailing at the time of the final determination is charged and remains the same until the debt is liquidated. Interest must be recalculated based on the outstanding balance at 30-day intervals from the date of final determination.

Per The Debt Collection Improvement Act of 1996, the interest rate charged on overpayments repaid through an approved extended repayment schedule is the rate that is in effect for the quarter in which the determination was made. The rate remains constant unless the provider defaults (i.e., misses one consecutive installment payment following a delinquent status) on an extended repayment agreement. When the provider defaults on such an agreement, interest on the balance of the debt may be changed to the prevailing rate in effect on the date of the default if that rate is higher than the rate specified in the agreement.

50 - Establishing an Extended Repayment Schedule (ERS) - (formerly known as an Extended Repayment Plan (ERP)

(Rev. 13071; Issued: 03-13-25; Effective: 04-11-25; Implementation: 04-11-25)

For purposes of these instructions, the term Provider, Physician and other Supplier will be referred to as "Provider."

For purposes of these instructions, the term Medicare Administrative Contractor (MAC) may be referred to as "Contractor."

For the purposes of these instructions, the following definitions apply; See 42 C.F.R. §401.607(c)(2) and (3) *and The Debt Collection Improvement Act of 1996*:

Hardship exists when the total amount of all outstanding overpayments (principal and interest) not included in an approved, existing repayment schedule is 10 percent or greater than the total Medicare payments made

for: (1) the cost reporting period covered by the most recently submitted cost report; or (2) the previous calendar year for a non-cost report provider (see below 'additional factors to consider' when determining eligibility).

Extreme Hardship exists when a provider qualifies as being in "hardship" as defined in the previous paragraph and a 36 month to 60 month extended repayment schedule (ERS) is deemed eligible for approval consideration by Medicare.

Delinquency *is when a full installment payment is not made by the due date or the end of the "grace period" as established in a loan or repayment agreement, in the case of a debt being paid in installments. The date of delinquency is the payment due date.*

Default *is when an ERS is deemed delinquent, and a consecutive full installment payment is not made by the due date as established in a loan or repayment agreement.*

Additional Factors to Consider:
The contractor shall evaluate the request, based on the definitions written above, in conjunction with the requirements found in sections 50-50.3 of this chapter. For a provider whose situation does not meet the definitions written above, the contractor shall evaluate the ERS request based on the requirements found in sections 50-50.3 of this chapter and consider the information in (i) – (iii) below, when deciding whether to grant an ERS. *If granted, the MAC shall continue to frequently monitor if the provider continues to qualify for the ERS throughout the term of the installment schedule.*

The contractor shall determine the number, amount, and frequency of installment payments based on the information submitted by the debtor and on other factors such as:

(i) Total amount of the claim (overpayment);
(ii) Provider's ability to pay; and
(iii) Cost to CMS of administering an installment agreement.

The contractor shall document evaluation factors, including communication with CMS, used during the decision-making process.

A provider is expected to repay any overpayment promptly. If repaying an overpayment within 30 days would constitute a "hardship" on the provider, a request for an ERS should be submitted immediately. However, if the overpayment is outstanding and not referred to Treasury, the provider shall request an ERS beyond 30 days, and the contractor shall review that request. Instructions on how to apply for an ERS shall be available on the contractors' website for provider reference. Medicare demand letters shall refer providers to the contractors' website for detailed ERS instructions. Contractors shall include in the ERS instructions a form in which the provider can elect to have their underpayments or manual refunds automatically applied to their overpayment (see section B below). Providers shall be given the option to request a paper copy.

A. The following steps shall be implemented upon receipt of an ERS:

1. A provider shall submit a signed ERS request which includes:

   i. the specific overpayment for which an ERS is being requested;
   ii. the number of months requested;
   iii. CMS required documents (see sections 50.1-50.2) and a good faith payment equaling one month's payment of the providers requested terms with its request (ex. 36 month request = 1/36th minimum). Good faith payments shall not be considered monthly payments for the MAC approved ERS, but instead, shall be applied to reduce the overall balance of the

overpayment.

This is what constitutes a complete ERS.

2. Contractors shall evaluate all providers' requests for an extended repayment schedule up to 60 months, and shall only approve/disapprove ERS requests up to 60 months.

3. Contractors should consider ERS requests for 6-15 months on a case-by-case basis. Approval should only be for cases where it is clear that the debt can be repaid in this short period. Requests for 6 -15 month ERSs do not require submitting financial documentation if the provider meets the hardship qualifications and does not fall within a scenario found in section 50.3(1).

4. When deemed appropriate, contractors may refer ERS requests that need additional guidance to the Regional Office (RO), along with a recommendation.

5. The RO will evaluate ERS requests as needed or requested by the contractor for further direction. (see 42 CFR 401-607(c)(2)(vi)).

6. CMS Central Office (CO) will evaluate ERS requests as needed or requested by the RO.

7. All ERS requests shall be reviewed and evaluated for approval, disapproval, or referral to RO/CO within 30 calendar days of receipt of the complete request.

8. Providers may request for an ERS under 16 months without submitting financial documentation if they meet the hardship qualifications and do not fall within a scenario found in section 50.3(1).

9. The Provider shall submit financial documentation for ERS request 16 months or longer.

10. The contractor shall determine eligibility qualifications and the duration of the ERS based on its review of the provider's documentation and any other information acquired (such as fraud information, claims data, overpayment history, etc.).

11. If an ERS is approved and a provider misses one consecutive installment payment following a delinquent status, the provider is in default. (refer to 42 CFR §401.607(2)(v) *and The Debt Collection Improvement Act of 1996*). Delinquent loan status is when a provider misses one installment payment. Default loan status is when a provider misses one consecutive installment payment, following a delinquent loan status. The contractor shall send a notice of default to the provider, suspend the ERS agreement, and immediately resume normal debt collection procedures *within 5 business days*.

12. The contractor shall consider a providers' request to reinstate the ERS, even after default. If reinstated, the provider shall be required to submit new documentation to determine eligibility. The contractor shall determine to reinstate the original ERS agreement or revise the schedule, if approved. If revised, the contractor shall ensure that the revised terms do not extend the original and revised schedule beyond 60 months. The ERS will be closed with no reopening, if the provider were to default again on the reinstated request.

13. The contractor should not grant an ERS to a provider where there is a previously defaulted ERS that was not resolved (reinstated, paid up to date, or paid in full).

14. *If the provider applies for an ERS and discontinues the approval process after asserting an inability to make the proposed monthly payments; the provider is approved for an ERS and asserts difficulty with making monthly payments; or the provider advises the MAC of closing or has closed the business; they may be considered for a debt compromise. MACs shall refer these debts to cmsdebtresolution@cms.hhs.gov immediately, for further review.*

B. The following steps shall be implemented when reviewing and establishing an ERS:

1. If a complete ERS request and a good faith check payment (see note a. below) are received, the contractor shall start reviewing the request immediately. The contractor shall accept the good faith payment(s) and suspend any recoupment during the review of the ERS.

2. Contractors shall review the complete ERS package to make a final decision within 30 calendar days of receipt. If the contractor needs additional time to review an ERS request, it shall work with their RO to determine a reasonable timeframe to complete.

3. If an ERS request is received with all documentation but no good faith payment, (see note a. below) the contractor shall immediately place the provider on 30% recoupment during the review of the ERS.

4. Contractors shall review the ERS documents in detail to determine if there are any other documents needed. If additional documents are needed the contractors shall request additional documentation.

5. If an incomplete ERS request is received, the contractor shall review the submitted documentation, determine and request all missing documents. If a good faith payment was not received, the MAC shall immediately place the provider on no less than 30% recoupment. If the contractor requests additional documentation and the information is not received by the 16th calendar day after the contractor's request, the contractor should close the request and resume normal collect activities.

6. Contractors shall review the ERS documents in detail to determine if there are any other documents needed. If additional documents are needed the contractors shall request additional documentation.

7. Contractors should extend an additional 15 calendar days to receive the documentation from the provider before closing the request. Upon receipt, the contractor shall complete its review of the additional documentation within 5 calendar days.

8. Contractors shall ensure that requesting additional documentation will not unnecessarily extend the decision-making period.

9. If the contractor needs additional time to conduct the review, they shall work with their RO to determine a reasonable timeframe to complete.

10. Contractors shall **NOT** refund any payments received or recouped that occurred while processing an ERS but shall apply such amount(s) to the outstanding overpayment(s) (apply to interest first then principal), unless CMS directs otherwise.

11. If the ERS request is approved, the contractor shall establish an ERS to recover the remaining balance of an overpayment.

12. Pre-accrued interest shall be recovered first before applying any payments to principal. Pre-accrued interest can either be recovered in one lump sum or over multiple months (not to exceed 3 months, unless directed by CMS), depending on a provider's ability to pay in full or over time.

13. Contractors shall ensure that interest continues to accrue on the overpayment until it is paid in full. While recovering the pre-accrued interest amounts, the contractor shall also recover the interest that continues to accrue on the outstanding principal balance.

14. Once the pre-accrued interest is paid in full, the ERS (recovering principal and accruing interest) shall begin.

15. Approved ERS requests will run from the ERS approval date.

16. If the ERS request is denied, the contractor shall continue with normal debt collection activities. Providers shall be permitted one additional ERS request for an overpayment, where a previous ERS was denied.

17. If both ERS requests are denied, any additional ERS requests for that overpayment (that a contractor deems should be considered) shall be forwarded to the RO for review.

18. Contractors shall include in the ERS instructions an option in which the provider can elect to have all of its underpayments or manual refunds automatically applied to its overpayment. Subject to section B below, a provider can rescind its consent to automatic recoupment or offset of underpayments and manual refunds, with further written notice to the contractor.

19. Any underpayments or manual refunds applied to an overpayment shall reduce the term of the ERS and shall not affect the installment amounts due under any amortization schedule.

20. Unless the provider has submitted a request asking the MAC to automatically apply underpayments and manual payments to the ERS payments, contractors shall not automatically apply an underpayment due to a cost report or a manual refund due to over collection to the ERS overpayment.

21. If the contractor determines a Medicare underpayment or manual refund after establishing an ERS, the contractor shall notify the provider in writing of the underpayment or manual refund.

22. The contractor shall permit the provider 15 calendar days following the date of notification to submit a request (with justification) to refund the underpayment.

23. If the provider does not respond in the required timeframe or has not submitted a form asking the contractor to automatically apply the underpayment or manual refund to the ERS payments, the contractor shall immediately apply this amount to the ERS payments (with the exception of #20 above).

24. If the provider responds timely, the contractor has 15 calendar days from the receipt date to determine if the provider's justification is in the best interest of the Medicare program. The contractor should either apply the underpayment or refund the amount to the provider.

25. If a provider does not submit such a justification, the contractor shall deny the request and shall immediately apply this amount to the ERS payments.

26. If the provider fails to provide accurate current financial information, including certifying that no material change has occurred, the contractor shall apply the underpayment or manual refund to the ERS.

27. If a refund request is denied, the contractor shall send written notice of the determination to the provider, explaining the rationale for the determination. The determination is not an initial determination and is not appealable.

NOTE(S):

a. Good faith payments are monthly payments submitted by the provider while an ERS is in review. They should equal one (1) month's payment of the providers requested terms; ex., 36-month request = 1/36th minimum good faith payment. Payments less than this amount are not considered a good faith payment. Payments shall continue to be submitted monthly while the ERS is being reviewed.

b. If under a 935 appeal, the provider shall continue to submit good faith payments or ERS installment payments. These payments are considered voluntary payments and not 935 recoupments.

70.17.2 - Debts RTA by Treasury as Uncollectible (RU) or Out of Business (RN)

(Rev. 13071; Issued: 03-13-25; Effective: 04-11-25; Implementation: 04-11-25)

The temporary HIGLAS RTA Status Code for all debts that are returned to agency as Uncollectible (RU) or Out of Business (RN) shall be systematically updated, by HIGLAS, to 'DR-RTN-CS' (Debt Returned from Cross-Servicing).

*The contractor **not** utilizing HIGLAS shall re-refer to Treasury all debts RTA'd as RU/RN that are:*

- *Less than or equal to $500,000 (principal balance) and less than 3-years old; or*
- *Greater than $500,000 (principal balance) and less than 6-years old.*

*However, if Treasury returns these same debts before the 3 or 6-year age after they have been re-referred one time, the contractor not utilizing HIGLAS shall **not** re-refer the debts to Treasury. The contractor's weekly RTA Report will allow the contractor to easily assess whether a debt qualifies for close-out or re-referral to Treasury.*

*(**For contractors utilizing HIGLAS:** HIGLAS functionality will systematically re-refer debts that have been initially RTA'd as RU/RN and do not meet the aforementioned age requirements.)*

For RU and RN debts with a combined principal and interest balance less than $25:

- Contractors utilizing HIGLAS shall allow the HIGLAS Auto Write-Off Program to identify these debts and systematically write them off.
- Contractors not utilizing HIGLAS shall submit for close-out review.

The contractors shall use the RTA report to research the RU or RN debts with a combined principal and interest balance greater than or equal to $25 in order to determine the current status or final disposition. The debts already in a recalled status are included so that the contractors will know that Treasury considers the debts uncollectible or out of business.

The contractors shall determine whether collection by litigation is a viable option for debts with a combined principal and interest balance greater than or equal to $25 showing a status code of RU or RN. If so, follow established procedures for referring the debts for litigation (See CMS Pub. 100-06, chapter 3, section 120).

The contractors shall also consider whether all other appropriate actions to collect debts with a combined principal and interest balance greater than or equal to $25 have been taken before recommending debts for Write-Off Closed (WOC), including the criteria listed below:

1. Have there been any collections or payments on this debt in the last year? If so, and the contractor believes further collections are possible, the contractor shall not recommend the debt for WOC, but shall continue collection efforts for MSP and Non-MSP debts.

2. Has the debtor submitted any Medicare claims in the last 6 months? If so, and the contractor believes further collections are possible, the contractor shall not recommend the debt for WOC, but shall continue collections efforts.
3. Is the debtor receiving Medicaid funds? If so, the contractor shall not recommend the debt for WOC. The contractor shall instead contact the CMS RO to institute an offset, and shall continue collection efforts.

4. If applicable, did the debtor undergo a Change of Ownership (CHOW) (a new owner who opts to receive automatic assignment of the old owner's provider/supplier agreement)?

   If so, the contractor shall determine if collection efforts were pursued from the new owner.

   (a) If so, the contractor shall recommend for WOC
   (b) If not, the contractor shall follow the normal policies and procedures for debts collection.

5. If applicable, did the debtor file any cost reports that the contractor has not yet settled?

   If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall await settlement of the cost report to determine whether it results in an underpayment. If it does result in an underpayment, the contractor shall apply any funds due to the provider/supplier to any outstanding debts first, before releasing any funds to the debtor

6. If applicable, does the debtor have any outstanding unfiled cost reports less than 1 year overdue?

   If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall await filing and settlement of the cost report to determine whether it results in an underpayment. If it does result in an underpayment, the contractor shall apply any funds due to outstanding debts first, before releasing any funds.

7. If applicable, does the debtor have any funds in suspense due to an unfiled cost report? If so, and the provider/supplier has been terminated from the Medicare Program, the contractor shall apply the funds in suspense to recover the debt or any other outstanding debts for the provider/supplier.

8. If applicable, does the debtor have any claims or cost reports subject to re-opening?

   If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall wait until the expiration of the reopening period. If a cost report reopening during this period results in an underpayment, the contractor shall apply the underpayment to recover the debt or any other outstanding debts for the debtor, before releasing any funds.

9. Does the debtor have any open appeal(s)? If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall await the final determination on the appeal(s), and apply any funds due from a favorable decision to any outstanding debts first, before releasing any funds.
10. Does the debtor have an active fraud case? If so, the contractor shall not recommend the debt for WOC. Instead, the contractor shall forward the debt to the appropriate Unified Program Integrity Contractor (UPIC) or CMS Centers for Program Integrity that has the open fraud case.

If the contractors have considered all of the above criteria above and are recommending the debts for WOC, the contractors shall submit a request to the CMS RO for approval. The contractor shall submit these debts as instructed in Chapter 4, § 70.16. The contractor shall include the Contractor Validation Statement below with each close-out request submission:

Contractor Validation:
We recommend these debts for termination of collection action, close out and write-off-closed. We considered all criteria in section 70.17.2 in making this recommendation and determined that these criteria for referral have all been met.
Total debts recommend for Write-Off-Closed:
Number of Debts: _____ Principal Balance: ____________ Interest Balance: ____________

Signature of Medicare Contractor CFO: ________________________
Date: _______________

The debts recommended for WOC that do not meet the above criteria shall remain open until the criteria for WOC has been met. The contractors shall report these debts on the appropriate line of the CMS Forms 751 or the Treasury Report on Receivables (TROR) to indicate Treasury has RTA the debts but the WOC process has not been completed. (See CMS Pub 100-06, chapter 4, section 70.15.4) For all debts that meet the criteria above, the contractor utilizing HIGLAS shall change the status to the appropriate Request for Write-Off status code. The contractors shall submit a report of the debts recommended for WOC to the CMS using established procedures for recommending debts for WOC.

Once CMS approves the debts for WOC, the contractors shall complete the WOC process including changing the status to the appropriate Write-Off/Approved/Closed status code, making the appropriate adjustments in HIGLAS or internal system, and making all appropriate adjustments on CMS Form 751 or the TROR.