CMS Manual System

Pub 100-05 Medicare Secondary Payer

Transmittal 35

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: SEPTEMBER 27, 2005

Change Request 4015

SUBJECT: Updates to the Group Health Plan Identification and Recovery Processes

I. SUMMARY OF CHANGES: Updating current IOM language specific to GHP identification and recoveries to address recent questions and requests. Also, updating GHP sections to reflect any Recovery Management and Accounting System (ReMAS) procedural differences in the current process of identifying GHP mistaken primary payments and recovering debts via the Healthcare General Ledger and Accounting System (HIGLAS) interfaces. Section changes below may include a total deletion of past subjects and instruction with new subjects and instruction using the old section number.

NEW/REVISED MATERIAL
EFFECTIVE DATE: October 27, 2005
IMPLEMENTATION DATE: October 27, 2005

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	Table of Contents
R	7/10/General
R	7/10.1/ IRS/SSA/CMS Data Match (Data Match) GHP Identified Cases
R	7/10.2/Non-Data Match GHP Identified Cases
R	7/10.3/Other Sources of Recovery Actions
N	7/10.3.1./GHP Acknowledges Specific Debt (42 CFR 411.25)
R	7/10.3.2/Exhibit 1 – 42 CFR 411.25 Notice Background Information

N	7/10.3.4/Recovery When a State Medicaid Agency Has Also Requested a Refund from the GHP
N	7/10.3.5/Identification of GHP Mistaken Primary Payments via the Recovery Management and Accounting System (ReMAS)
N	7/10.3.5.1/Progression of ReMAS GHP Lead Identification
N	7/10.3.5.2/Progression of ReMAS History Search
R	7/10.4/Contractor Recovery Case Files (Audit Trails)
R	7/10.5/GHP Letters (Used for ReMas/HIGLASD When the Only Debtor Interfaced to HIGLAS is the Employer)
R	7/10.5.1/Employer GHP Letter
N	7/10.5.1.1/Important Information for Employers
N	**7**/10.5.2/Insurer GHP Letter (Used for ReMAS/HIGLAS Users When the Only Debtor Interfaced to HIGLAS is the Employer)
R	7/10.6/Accountability Worksheet ***(*Not** Applicable to ReMAS/HIGLAS Users)
R	7/10.7/MSP Summary Data Sheet (Not Applicable to ReMAS/HIGLAS Users)
R	7/10.7.1/Field Description on the MSP Summary Data Sheet
R	7/10.8/Payment Record Summary (Used with ReMAS/HIGLAS Users but in a Modified Format)
R	7/10.9/Courtesy Copy of All MSP GHP-Based Recovery Demand Packages to the Employer's Insurer/Third Party Administrator (TPA)
R	7/10.9.1/Insurer/TPA Courtesy Copy Letter
R	7/10.10/ReMAS Error Reports
R	7/20.5/Mistaken GHP Primary Payments
R	7/30/Mistaken Primary Payment Activities and Record Layouts
R	7/30.1/ Contractor Actions Upon Receipt of the Data Match Cycle Tape or Other Notice of Non-Data Match GHP Mistaken Payments (For contractor NOT on ReMAS/HIGLAS for GHP recovery) and Actions to take for those Contractors Using ReMAS/HIGLAS GHP Functions

R	7/30.1.1/COBC Responsibility to Obtain Missing MSP Information
R	7/30.1.1.2/Time Limitations for GHP Recoveries
R	7/30.1.1.2.1/Actual Notice
R	7/30.1.2/Contractor History Search
R	7/30.1.2.1/Aggregate Claims for Recovery
R	7/30.1.3/Documentation of Debt
D	7/30.1.3.2/Recovery Attempt Audit Trails
D	7/30.1.4.1/Summary of Medicare Reimbursement
D	7/30.1.4.2/Claim Facsimiles for Each Claim Mistakenly Paid
R	7/30.2/IRS/SSA/CMS Mistaken Payment Recovery Tracking System (MPaRTS)
D	7/30.2.1/Inpatient, Skilled Nursing Facility, and Religious Non-Medicare Health Care (RNHC)
D	7/30.2.2/Outpatient Mistaken Payment Report Record Layout
D	7/30.2.3/Home Health Agency (HHA) Mistaken Payment Record Layout
R	7/30.3/Communication Receive in Response to Recovery Actions

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-05	Transmittal: 35	Date: September 27, 2005	Change Request 4015

SUBJECT: Updates to the Group Health Plan (GHP) Identification and Recovery Processes

I. GENERAL INFORMATION

A. Background: This change request involves updating terminology to be MMA compliant, clarifying past instructions and updating the GHP identification process to address contractor usage of the Recovery Management and Accounting System (ReMAS) upon transition to the Health Care General Ledger and Accounting System (HIGLAS).

B. Policy

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	
4015.1	Contractors shall ensure compliancy with operationally defined procedures which have been modified to incorporate the use of the Recovery Management and Accounting System (ReMAS).	X	X	X	X					
4015.2	Contractors shall acknowledge/respond to all correspondence (e.g., Mail, fax, email, ECRS notifications, ReMAS notifications, checks, etc.,) within the timeframes documented in the attached manual sections specific to GHP debt identification and recovery initiation.	X	X	X	X					
4015.3	Contractors shall initiate non-data match GHP history searches every 60-90 days.	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	
4015.4	Contractors shall not respond or acknowledge any communications from the employers' insurer/TPA without first having an authorization from the employer which allows the insurer/TPA to act as an agent to the employer.	X	X	X	X					
4015.5	Contractors having converted GHP debts into HIGLAS shall continue to update MPaRTS appropriately.	X	X	X	X					
4015.6	Contractors shall determine potential ECRS transmissions subsequent to receiving a 42 CFR 411.25 Notice without an attached refund.	X	X	X	X					
4015.6.1	Contractors shall confirm the existence of a CWF record specific to the identified 42 CFR 411.25 issue. If no record, contractors shall send an ECRS request.	X	X	X	X					
4015.7	Contractors shall initiate duplicate primary payment provider, physician or other supplier recoveries specific to the receipt of a 42 CFR 411.25 notice only.	X	X	X	X					
4015.8	Contractors shall forward, via ECRS, the 42 CFR 411.25 notice to the COBC when the contractor has received a **notice with a refund** having no indication within the documents to imply or state the COBC had also been notified.	X	X	X	X					
4015.9	Contractors **shall not** forward the 42 CFR 411.25 notice to the COBC when there is an indication upon the notice and/or refund stating COBC has already (simultaneously) been sent a copy of the notice.	X	X	X	X					
4015.10	Contractors shall follow defined procedures specific to voluntary/unsolicited refunds when in receipt of a 42 CFR 411.25 notice accompanied with a check. Pub. 100-6 Chapter 5 Section 411.	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	
4015.11	Contractors shall access ReMAS to identify daily GHP lead workloads.	X	X	X	X					
4015.12	Contractors shall determine complete/valid debtor information as a result of receiving notice of a new GHP case/lead within ReMAS. (Fully Functional ReMAS Users Only)	X	X	X	X					
4015.12.1	Contractors shall submit an ECRS inquiry when the debtor information is incomplete.	X	X	X	X					
4015.12.2	Contractors shall monitor ECRS for a response for COBC specific to the debtor information.	X	X	X	X					
4015.13	Contractors shall delete an incorrect or incomplete debtor name and address from ReMAS if 55 calendar days have passed without any new or updated debtor information having been received. (Specific to fully functional ReMAS/HIGLAS users.)	X	X	X	X					
4015.14	Contractors shall send the GHP demand to the insurer if the employer information is not received or updated fully. (Specific to fully functional ReMAS/HIGLAS users.)	X	X	X	X					
4015.15	Contractors shall create a PC generated cover letter addressed to the employers' insurer/TPA and attach to the courtesy copy of the employer demand package as stated in section 10.9.1.	X	X	X	X					
4015.16	Contractors shall respond with a cc to the insurer/TPA only when in receipt of an employer authorization allowing the insurer/TPA to act as its agent in resolving a debt.	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	
4015.17	Contractors using the full functionality of the ReMAS system shall cease all prior shared system processes used to initiate identification of mistaken primary payments specific to GHP debts.	X	X	X	X					
4015.18	Contractors maintaining electronic case files shall recreate requested case files within 2 business days of a request.	X	X	X	X					
4015.18.1	Contractors shall create hardcopy case files for the storage of all items not housed on ReMAS, HIGLAS or shared systems. For example, copies of incoming correspondence, copies of checks, copies of outgoing correspondence, etc.	X	X	X	X					
4015.19	Fully functional ReMAS users/contractors shall use the HIGLAS system to document all activities or actions to the debt after the successful interface from ReMAS to HIGLAS, for example, any adjustments due to a valid defense, post a check to a debt, write off a debt, etc.	X	X	X	X					

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: None

X-Ref Requirement #	Instructions

B. Design Considerations: None

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: None

D. Contractor Financial Reporting /Workload Impact: None

E. Dependencies: None

F. Testing Considerations:

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: October 27, 2005 **Implementation Date**: October 27, 2005 **Pre-Implementation Contact(s):** Tina Merritt and Bill Zavoina **Post-Implementation Contact(s):** Tina Merritt and Bill Zavoina	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

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

Medicare Secondary Payer (MSP) Manual

Chapter 7 - Contractor MSP Recovery Rules

10 - General

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

If a contractor receives information that a GHP should have been primary payer for services provided to an identified beneficiary, they take the actions described below. *Contractors having ReMAS GHP identification functionality shall functionality shall follow all proce3dures except as modified in §10.3.5 and §10.11 in Change Request 4012.*

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

10.1 – *IRS/SSA/CMS Data Match GHP Identified Cases*

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05 35)

Contractors *that are not using ReMAS for GHP recoveries shall* take the actions described below for services identified within the time period specified in CMS' current *contractors* budget and performance requirements (BPRs). *Contractors having ReMAS GHP identification functionality shall follow procedures except as modified in §10.3.5. and §10.11 in Change Request 4012.*

1. Search claims history for the time period specified in the *current year* BPRs *(usually specified to begin 4 years back from the start of the new fiscal year or contract cutover date)* to determine if the Medicare payments made with respect to any report ID (or group of report IDs) *that* equals or exceeds the recovery tolerance for Data Match cases specified in the *current year* BPRs. *Currently the tolerance level for seeking recovery of an individual debt is $1,000.*
2. Prior to mailing out a demand, contractors *shall* validate the MSP record on the Common Working File (CWF) and include a screen print of the CWF information in the case file;

   NOTE: If a contractor's system will recognize an existing termination date on an MSP record prior to the generation of a demand, that contractor is not required to check CWF prior to the mailing of the demand. If a

contractor's system does not recognize an existing termination date on an MSP record, that contractor shall check CWF prior to mailing.

3. For valid cases, contractors *shall* send the employer demand letter found at the end of this section to the identified employer. *The demand package shall* include claims facsimiles *or claims detail (ie. Payment Record Summary)* for the claims for which Medicare seeks payment and the other identified enclosures to the letter. (Examples are provided with the demand letter.) *Contractors shall* aggregate *(for mailing purposes)* all Data Match letters with respect to report IDs on any Data Match cycle linked to a single employer. *A courtesy copy of the entire employer demand package shall be mailed to the insurer/TPA, if known. (See section 10.9) The courtesy copy shall not be sent first class or certified mail.*

4. The employer or other entity acting on the employer's behalf may respond with a full payment. If the employer or other entity repays Medicare in full (including any applicable interest), contractors *shall* close the case. *Contractors shall send an acknowledgment or response to the full payment by notifying the employer with a copy to the insurer/TPA, if the insurer/TPA had sent in full payment with an employer authorization to act as its agent. (See section 10.9)*

5. If the employer or other entity provides a full payment for certain services and provides a valid documented defense for all other services, contractors *shall* close the case. A valid documented defense consists of evidentiary material demonstrating that the GHP is not obligated to repay Medicare pursuant to the MSP provision. (An assertion of a defense without supporting evidence is **not** a valid documented defense.) *Contractors shall send an acknowledgment or response to the payment and acceptance of the valid documented defenses offered by notifying the employer, only. Without the employer authorization, contractors shall not communicate (not even a cc) with the insurer/TPA until the authorization is received.*

6. If the employer or other entity makes less than a full payment or provides less than a valid documented defense, contractors *shall* adjust the *debt* as appropriate and *continue collection activities. Contractors shall send an acknowledgment or response to the partial payment or invalid defense by notifying the employer only. If the insurer/TPA had sent in an employer authorization to act as its agent, contractors may cc the insurer/TPA with the employer response.*

7. To the extent that an employer or the other entity responds with a valid documented defense to any portion of a recovery claim, contractors *shall* adjust the *debt* accordingly. If the valid documented defense is that the GHP made primary payment to a provider/supplier or beneficiary, contractors *shall* recover from the provider/supplier or beneficiary as explained in *§10.3.2 and §10.3.3. Contractors on HIGLAS shall adjust the portion of the employer debt which had been paid directly to the provider/supplier and create a new AR for the paid claims to the provider. (ReMAS will not allow a claim to be part of more than one case.)*

8. If an employer or other entity requests specific information or asks a specific question about the recovery claim, contractors *shall* provide the information or

answer the questions. *In the event the insurer/TPA or other entity is asking for debt specific information without having submitted an employer authorization, the contractor shall restrict all communication to **only** the employer until such authorization is received. (See Section 10.9)*

Data Match cases are tracked in a special tracking system, the Mistaken Primary Payment Recovery Tracking System (MPaRTS), which is maintained by CMS. *Contractors using the ReMAS/HIGLAS GHP functionality shall cease updating MPaRTS for new GHP Data match initiated debts. Contractors having converted open Data match debts into the HIGLAS system shall continue MPaRTs updates, since the identification and creation of the debt are on their prior debt tracking systems.*

9. Contractors *shall* update the MPaRTS and keep the information in the system current as specified in the systems documentation. *(See §30.2 for MPaRTS codes and timeframes)*

10.2 – *Non*-Data Match *GHP*-Identified Cases

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05 35)

Contractors shall take the following actions within the time period specified in CMS' current fiscal year BPRs. *Contractors having ReMAS GHP identification functionality shall follow these procedures except as modified in section 10.3.5. and section 10.11 in CR 4012.*

1. Contractors *shall initiate paid* claims history *searches via their standard shared systems every 60-90 calendar days and within* the time *parameter* specified in the BPRs *(usually specified to begin 4 (four) years back from the start of the new fiscal year or contract cutover date)* to determine if *Medicare mistaken primary* payments *have been made which meet or exceed* recovery tolerance *limitations as* specified in the *current year* BPRs. *Currently the tolerance level for seeking recovery for an individual debt is $1,000.*

2. Prior to mailing a demand, contractors *shall* validate the MSP record on the CWF and include a screen print of the CWF information in the case file;

   NOTE: If a contractor's system will recognize an existing termination date on an MSP record prior to the generation of a demand, that contractor is not required to check CWF prior to the mailing of the demand. If a contractor's system does not recognize an existing termination date on an MSP record, that contractor *shall* check CWF prior to mailing.

3. Contractors *not on ReMAS/HIGLAS shall validate* the CWF MSP Auxiliary File *debtor information*. If the CWF MSP Auxiliary File *does not* identify the employer with sufficient specificity (name and complete and accurate address), notify the COB contractor through an ECRS CWF MSP Inquiry transaction to *update or* add the employment information to the MSP Auxiliary File. *For those contractors not on ReMAS for GHP identification, a demand to an employer cannot be issued until complete and accurate debtor information is supplied.*

NOTE: *Contractors on ReMAS for GHP identification shall reference §10.3.5 for demand processes and debtor validity.*

4. Contractors shall send the employer demand letter found at the end of this section to the identified employer. *The demand package shall* include claims facsimiles *or claims detail (i.e., Payment Record Summary)* for the claims for which Medicare seeks payment and the other identified enclosures to the letter. (Examples are provided with the demand letter.) *Contractors shall* aggregate all non-Data Match *GHP* letters with respect to a single employer *into one certified mailing. Contractors shall mail a courtesy copy of the entire employer demand package to the insurer/TPA, if known. (See section 10.9) Contractors shall not send the courtesy copy first class or certified mail. Contractors on ReMAS shall continue to send the cover letter referenced in section 10.9.1 via PC, since this cover letter is not generated through HIGLAS.*

5. The employer or other entity acting on the employer's behalf may respond with a full payment. If the employer or other entity repays Medicare in full (including any applicable interest), contractors *shall* close the case. *Contractors shall send an acknowledgment or response to the full payment by notifying the employer with a copy to the insurer/TPA if the insurer/TPA had sent in full payment with an employer authorization allowing the insurer/TPA to act as its agent. (See §10.9) If there was no employer authorization, contractors shall communicate the payment to the employer, only.*

6. If the employer or other entity provides a full payment for certain services and provides a valid documented defense for all other services, contractors *shall* close the case. A valid documented defense consists of evidentiary material demonstrating that the GHP was not obligated to repay Medicare pursuant to the MSP provision. (An assertion of a defense without supporting evidence is **not** a valid documented defense.) *Contractors shall send an acknowledgment or response for the full payment and acceptance of the valid documented defense offered by notifying the employer, if the insurer/TPA had sent in full payment without having an employer authorization to act as its agent.*

7. If the employer or other entity makes less than a full payment or provides less than a valid documented defense, contractors *shall* adjust the *debt* as appropriate and *continue collection activities. Contractors shall send an acknowledgment or response to the partial payment or invalid defense by notifying the employer with a copy to the insurer/TPA, only if the insurer/TPA had sent in an employer authorization to act as its agent.*

NOTE*: Do not cc the insurer/TPA on any communications to the employer unless it has submitted an authorization from its client (the employer).*

8. To the extent that an employer or the other entity responds with a valid documented defense to any portion of a recovery claim, contractors *shall* adjust the *debt* accordingly. If the valid documented defense is that the GHP made primary payment to a provider/supplier or beneficiary, contractors *shall initiate* recovery from the provider/supplier or beneficiary as explained in *§10.3.2 and*

§10.3.3. Contractors on HIGLAS shall adjust the portion of the employer debt which had been paid directly to the provider/supplier and create a new AR for the paid claims to the provider. (ReMAS will not allow a claim to be part of more than one case.)

9. If an employer requests specific information or asks a specific question about the recovery claim, contractors *shall* provide the information or answer the questions. *In the event the insurer/TPA or other entity is asking for debt-specific information without having submitted an employer authorization, the contractor shall restrict all communication to* ***only*** *the employer until such authorization is received. (See §10.9.)*

10.3 – *Other* Sources of Recovery Actions

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

10.3.1. - GHP Acknowledges Specific Debt (42 CFR 411.25)

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

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

1) *Confirm whether a CWF record of the MSP situation has been established. If a record has been established, do not send an ECRS transaction to the COBC, as the COBC will already have the MSP information. This will eliminate duplication. If a record has not yet been established, send an ECRS transaction to COBC. After COBC updates the MSP record resultant from the GHP's submission, all appropriate contractors will receive an alert from CWF when the MSP record is posted to CWF. (For more detailed information regarding the automatic notice process, refer to Pub.100-5 MSP, Chapter 6, §30, Subsection 4 on Automatic Notice of Change to MSP Auxiliary File).*

2) *Contractors shall initiate the recovery process by issuing a demand to the provider/supplier for duplicate primary payments. The contractor shall follow the instructions listed in §10.3.2 of CR 4012.*

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

1) *Look for any indication that the GHP has advised COBC of its primary payment responsibility. (e.g., there may be a cc at the bottom of the requesting showing COBC was copied, etc.)*
2) *If there is no indication that the GHP has advised COBC of its primary payment responsibility, forward the 42 CFR 411.25 notice information to COBC via ECRS. If there is an indication that the GHP has advised COBC of its primary payment responsibility, do not send an ECRS request.*
3) *Process the refund check as described in Pub. 100-06 Chapter 5, §410.4.*

10.3.2 – Exhibit 1 –42 CFR 411.25 Notice Background Information

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

A GHP may learn that Medicare has made a mistaken primary payment for health care services of a Medicare beneficiary where the GHP should have made the primary payment. In this situation, the GHP is obligated under 42 CFR 411.25 to provide notice and payment to the contractor that made the primary payment. When a GHP or any other primary payer provides a 42 CFR 411.25 notice, the notice shall contain the following information:

- *A description of the specific situation giving rise to the Medicare mistaken primary payment (including the type of insurance coverage); and*
- *If appropriate, the time period during which the insurer/other entity is primary to Medicare.*

If a GHP is self-insured and self-administered, the employer must provide the notice to CMS. In all other circumstances, the insurer, underwriter, or third party administrator must give the notice.

Effective January 8, 2001, CMS transferred the GHP's reporting requirement(s) to the COBC (see Pub100-5 Chapter 4).

The GHP should transmit data to the COBC regarding beneficiaries for whom the GHP should have paid primary via an electronic file in the format and record layout that are used to convey quarterly Voluntary Data Sharing Agreement (VDSA) information. If there is no existing VDSA agreement between the GHP and CMS, this information will be reported in another acceptable format for both CMS and the GHP. The GHP should send claims payment data to each contractor with an attached payment made payable to Medicare along with an explanation of benefits (EOB) associated with each identified claim that Medicare mistakenly paid primary.

Furthermore, under §1862(b)(2) (B)(ii) of the Social Security Act, as amended in §301 of the Medicare Modernization Act (MMA), specifies that "A primary plan…shall reimburse the appropriate Trust Fund…if it is demonstrated that such primary plan has or had the responsibility to make payment…." Therefore, when a GHP identifies a mistaken primary Medicare payment for which the GHP has or had primary payment responsibility (a demonstration of primary payment responsibility), and the GHP had not previously made such a primary payment, the GHP must repay ***Medicare*** *directly. The GHP should* ***not*** *pay another entity (e.g., a provider or supplier) after its primary payment responsibility is demonstrated. The GHP should not claim a credit against Medicare's mistaken primary payment for any payments it previously made to any entity other than Medicare.*

When calculating repayment amounts where a GHP has not made a full primary payment prior to demonstration of its primary payment responsibility, the GHP is required by law to repay Medicare the lesser of (1) the amount that Medicare paid and (2) the full primary payment obligation. The following example illustrates an obligation to repay using the above rule if the following occurred:

Example*:*

- *Medicare paid $8,000*
- *Primary payer's full primary payment obligation is $10,000*
- *Primary payer previously paid $2500 to an entity other than Medicare.*

The amount due to Medicare is the lesser of (1) $8,000 and (2) $10,000, which in this case would be $8,000. The lesser of these two payment amounts is the only amount, which conforms to the statutory requirement. The primary payer may not reduce its repayment obligation to Medicare by the amount it previously paid to another entity.

When a GHP calculates a repayment amount, the GHP should send the 411.25 notice of mistaken Medicare payment electronically to the COBC. The GHP should also forward all associated claims, refunds, EOBs and other identifiable claims payment information to the Medicare contractor that made the mistaken payment.

If the GHP had made primary payment to a provider/supplier or other entity, prior to realizing that Medicare made a primary payment as well or mistakenly makes primary payment to an entity other than the Medicare contractor, the contractor shall recover the lesser of the GHP's full primary payment and the amount that Medicare mistakenly paid as primary payer from the provider, supplier or beneficiary as appropriate. The recovery shall be made without regard to any MSP or overpayment tolerances.

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

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

Situations may arise in which both Medicare and a State Medicaid Agency have conditionally or mistakenly paid for services and the amount payable by a GHP is insufficient to reimburse both programs. Under the law, Medicare has the right to

recover its benefits from a GHP before any other entity does, including a State Medicaid Agency. Medicare has the right to recover its benefits from any entity, including a State Medicaid agency that was paid by a GHP.

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

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

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

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

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

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

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

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

NOTE: *Contractors having access to ReMAS **and** the Healthcare Integrated General Ledger and Accounting System (HIGLAS) shall follow these additional instructions when identifying and recovering GHP mistaken primary payments. Contractors will not be able to use ReMAS to identify GHP primary payments without also having implemented HIGLAS.*

ReMAS will identify newly accreted beneficiary MSP records daily. ReMAS is dependent on the information in CWF to determine the debtor or the debtor relationship. Contractors shall no longer receive Data match cycle tapes nor will they need to update MPaRTS on cases created initially through ReMAS history search.

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

10.3.5.1 – Progression of ReMAS GHP Lead Identification

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

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

The user can convert these statuses to either "DEV" to develop the lead or "DEL" to delete the lead. ReMAS will hold leads for a "waiting period" of 60 days before initiating a history search. This "wait period" is to ensure the validity of the record. Any CWF updates made by the COBC as a result of their responding to the ECRS referral or obtaining new information after the lead was created in ReMAS will be overlayed in the

ReMAS lead case. Contractors shall track all ECRS referrals specific to inaccurate or incomplete debtor (employer) information. Upon the lead reaching 55 days from the date of accretion, the contractor shall delete all employer information in the ReMAS case while the case is still in a "DEV" status, if it still remains incomplete or inaccurate, thereby enabling ReMAS to assign the insurer as the debtor prior to the case moving into a "RES" status. In the event the insurer information is not accurate or complete but there is accurate and complete employer information, delete the insurer information in the ReMAS case.

10.3.5.2 – Progression of ReMAS GHP History Search

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

- *Those cases having been in ReMAS for 60 days will have their status moved systematically to "DIN" – Development initiated, unless:*

  - the lead coverage dates end before the GHP recovery date (begin date of history search request). This situation will prompt the case to be moved to a "PRR" – Prior to ReMAS recovery; no request is sent to DESY.

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

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

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

HIGLAS will receive two files, one containing the debtor and debtor relationship information (ANSI 271) and one containing claims detail (ANSI 810). Depending on the actual debtor information interfaced to HIGLAS, there will be instances when HIGLAS will generate 1 of 3 letters; 1) an employer GHP letter, 2) an insurer/TPA GHP letter or 3) a letter having the employer and the insurer/TPA as addressees. In this instance, the employer is the primary debtor. The contractor will receive a second demand letter package addressed to the insurer/TPA through the HIGLAS letter generation function. Contractors shall continue to follow section 10.9 when sending the cover letter to the

insurer/TPA of the employer, when addressing authorizations and when addressing defenses raised by the insurer/TPA.

Upon successful interface with HIGLAS, the HIGLAS system will create the receivable and generate a demand package to be sent to the designated contractor's print locations. All activities or actions taken on the case/debt after the ReMAS interface to HIGLAS shall be addressed in HIGLAS. For example: if the debtor submits a valid documented defense, the adjustment shall be completed in HIGLAS by the contractor.

10.4 – Contractor Recovery Case Files (Audit Trails)

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

Each *hardcopy* case file must be organized as follows:

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

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

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

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

10.5.1. – Employer GHP Letter (Used for ReMAS/HIGLAS Users When the Only Debtor Interfaced to HIGLAS is the Employer)

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

Dear Employer:
We are writing to advise you that your organization either has sole liability or shares liability for a debt to the Medicare program. The following explains how this happened and what you must do to resolve this matter.

How This Happened

This repayment claim arises because Medicare mistakenly made primary payments for services furnished to the Medicare beneficiaries identified below that should have been the primary payment responsibility of a group health plan that you sponsor or to which you contribute. The Medicare Secondary Payer (MSP) provisions of the Social Security Act require group health plans to make primary payment for services provided to Medicare beneficiaries if those individuals are also covered by the group health plan and certain conditions delineated in the Medicare law (42 U.S.C. 1395y(b)) and regulations (42 CFR 411.20ff) are satisfied. Medicare did not know that these conditions were satisfied at the time that Medicare made primary payment for certain services. The information now available to Medicare indicates that these conditions were satisfied when the services were provided.

The Medicare law obligates us to recover primary payments that Medicare mistakenly made when a group health plan is the proper primary payer. We may recover from any entity responsible for making primary payment, including employers that sponsor or contribute to group health plans, other plan sponsors, and insurers.[1] We are sending this letter to you because

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[1] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(iii), in order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that*

sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan.

you are an entity responsible for payment under the Medicare law and are subject to an excise tax under the Internal Revenue Service if any group health plan to which you contribute fails to comply with the MSP requirements. We want to afford you every opportunity to resolve this matter. We also encourage you to contact other entities, such as the plan itself or the plan's insurer (if any), that are also entities responsible for payment, for assistance in resolving this matter. An enclosure entitled, "**Important Information for Employers**" explains further how your obligations arise and what happens if you do not satisfy your obligations.

The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized below. Detailed information about each beneficiary and the services for which Medicare mistakenly paid primary are provided in an enclosure to this letter.

Name:
Health Insurance Claim Number:
Total Repayment Requested:

How to Resolve This Matter:

Within 60 days of the date of this letter, you or someone acting on your behalf; e.g., your insurer or plan administrator, must provide one of the following responses.

1. Repayment of the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan (as a primary payer). Please provide the report identification number, which is found in the upper right corner of the enclosed summary sheet, with the repayment. If the amount repaid for any item or service is less than the amount that Medicare paid, provide an explanation of how the amount repaid was determined. If primary benefits already have been paid to the beneficiary or provider of the services shown in the enclosures, please provide a copy of the explanation of benefits and proof of payment;

2. If the group health plan is not obligated to make primary payment under any circumstances for services provided to an identified beneficiary under the Medicare Secondary Payer provisions, provide an explanation as to why not and a copy of any applicable plan provision. Include the name, address and tax identification number on the plan and, if applicable, other plan sponsors, insurers and third party administrators.

    - If the specific basis upon which the group health plan is not obligated to make primary payment for services provided to an identified beneficiary under the Medicare Secondary Payer provisions is that the plan's claims filing

requirements have not been met[2], submit a written statement indicating that all existing records of the plan have been searched and indicate whether a claim for the identified services was found under any plan (primary or supplemental) covering the individual. Identify the plan's claims filing requirements and provide a copy of the applicable plan provisions.

- If the claim is denied by the group health plan because the claim was not timely filed, consider this letter, pursuant to Medicare's subrogation rights, to constitute an appeal of the denial by the identified individual. Similarly, if the identified individual may seek waiver of this plan requirement, consider this letter to be a request for waiver. The plan must apply the same criteria to this appeal and request for waiver as it would had the appeal or waiver request been made by the identified individual. Please notify Medicare of the plan's decision regarding the appeal and waiver request and provide copies of any plan provisions upon which it bases its decisions.

Dates of coverage under the group health plan are shown on the enclosed summary sheet. If you believe the dates listed are inaccurate, please provide the correct dates of coverage along with your repayment or explanation of why Medicare is primary. Please include the Medicare report identification number from the summary sheet on all correspondence. This enables Medicare to reconcile its records.

Your failure to respond within sixty (60) days of the date of this letter will be taken as evidence of noncompliance with your responsibility, which may result in the initiation of additional recovery procedures.

If you fail to pay this debt to Medicare or take other action as described above within sixty (60) days of the date of this letter, Medicare will assess interest beginning with the date of this letter (42 CFR 411.24(m), 42 U.S.C. 1395y(b)(2)(B)(I)). Any payments made in satisfaction of this debt will be applied first to the amount of interest due, then to the principal.

Medicare may also determine that the group health plan is a nonconforming group health plan. The basis upon which CMS will make a determination of nonconformance is explained at 42 CFR 411.110, et seq.

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2 Pursuant to 42 U.S.C. 1395y(b)(2)(B)(vi). An entity responsible for payment under a group health plan may not assert a timely filing defense if it receives the Medicare recovery demand letter within the longer of the plans timely filing or 3 years.

If a group health plan is determined to be nonconforming, the Internal Revenue Service will impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations which contribute to the health plan (Section 5000 of the Internal

Revenue Code). Moreover, 31 U.S.C. 3720(a) provides that agencies of the United States Government may refer debts to the Internal Revenue Service for collection by offset against tax refunds owed to individuals or entities by the Government. In addition, the Debt Collection Improvement Act of 1996 requires Federal Agencies to recover debts by offset against any monies otherwise payable to the debtor by the United States.

For further reference to the Medicare program's rights of recovery and potential penalties for noncompliance, please see 42 U.S.C. 1395y(b) and regulations found at 42 CFR 411.20-37, 411.100-206.

If you have any questions concerning this matter, please write or call _____ at _____.

Sincerely,

MSP Supervisor

Enclosures:
MSP Summary Data Sheet;
Payment Record Summary
Important Information for Employers

10.5.1.*1* - Important Information for Employers

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

Important Information for Employers

Employers often ask us to explain why an employer, especially one that purchases insurance from an insurance company, has or shares liability for this debt and to explain

the potential consequences if the employer fails to resolve this matter. We provide these explanations in this enclosure.

Congress has created a statutory framework in the Medicare statute and the Internal Revenue Code that imposes responsibility on an employer for its plan's actions in certain circumstances. The Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)) state that Medicare may seek to recover a mistaken primary payment from "any entity which is required or responsible" to pay for medical services under a primary plan. The statute specifically identifies employers that sponsor or contribute to group health plans as such an entity. This means that Medicare may hold an employer responsible if the employer sponsors the group health plan, is a "self insurer" for the group health plan, contributes to the purchase of an underwritten health insurance product, or otherwise contributes to the group health plan.

The MSP provisions generally require group health plans to make payments primary to Medicare for:

1. Individuals entitled to Medicare on the basis of age or disability if the individual has coverage under the group health plan on the basis of the individual's own or a family member's current employment status; and

2. Individuals who are or could be entitled to Medicare on the basis of end stage renal disease for a thirty-month coordination period if the individual is covered under a group health plan on any basis.

A group health plan is defined in the Internal Revenue Code at 26 U.S.C. §5000(b) as a "plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, or others associated or formerly associated with the employer in a business relationship, or their families." Taken together, the MSP provisions and the Internal Revenue Code definition of group health plan establish that employers have, or at least share, responsibility for the group health plan's compliance with the MSP rules.

Employer accountability is also reflected by Internal Revenue Code provisions allowing the employer to claim health plan expenditures as a deductible business expense (26 U.S.C. §162), and subjecting the employer to an excise tax if a plan to which it contributes does not conform to the MSP provisions (26 U.S.C. §5000(a) and (b)). Employers create, direct, authorize and control their health plans. Where an employer establishes a plan to provide health benefits indirectly through insurance, the employer determines the nature of the coverage and has the right to enforce its insurance contract to assure compliance with applicable laws.

Regulations under the Federal Claims Collection Act establish that all entities responsible for paying a debt to the Federal Government are jointly and severally liable for payment of the debt. As previously explained, the employer is one of potentially several entities

responsible for making primary payment under the MSP provisions. If the United States must take legal action to recover this debt, the Government may take action against any or all entities responsible for payment, including the insurer, the plan and the employer (See 42 U.S.C. §1395y(b)(2)(B)(iii); and 42 CFR 401.623.) If the Government is unable to recover the total debt from one of the entities responsible for payment, it may then pursue recovery from another.

If an employer does not repay Medicare or arrange for Medicare to be paid in full, any tax refunds that may be due the employer under the Internal Revenue Code may be applied toward satisfaction of the MSP debt (31 U.S.C. 3720(a)). In addition, the MSP provisions state that a plan that does not repay Medicare may be held to be a "nonconforming" plan (See 42 U.S.C. §1395y(b)(3)(B) and 42 CFR 411.100 et seq.) The Internal Revenue Code at §5000 imposes a 25 percent excise tax on all employers, except government entities; on all health plan expenditures of employers and employee organizations that contribute to a nonconforming group health plan. A plan may be found to be nonconforming both in the year that it failed to repay Medicare and in the year in which it was originally obligated to have made primary payment. In addition, the Debt Collection Improvement Act of 1996 (Chapter 10 of P.L. 104-134) requires Federal Agencies to collect debts by offset from any monies otherwise payable to the debtor by the United States.

*10.5.2 - Insurer **GHP** Letter **(Used for ReMAS/HIGLAS Users When the Only Debtor Interfaced to HIGLAS is the Employer)***

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

Dear Sir or Madam:

It has come to our attention that Medicare has made payment for services, under the Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)(2)), when payment may be or is the responsibility of a group health plan for which you are/were the insurer, underwriter, sponsor, or claims processor. The Medicare beneficiaries are identified and the amounts of Medicare's recovery claim are summarized below. Detailed information about each beneficiary and the services for which Medicare mistakenly paid primary are provided in an enclosure to this letter.

Name:
Health Insurance Claim Number:
Total Repayment Requested:

How This Happened

The MSP provisions of the Social Security Act require group health plans to make primary payment for services provided to Medicare beneficiaries if those individuals are also covered by the group health plan and certain conditions delineated in the Medicare law (42 U.S.C. 1395(y)(b)) and regulations (42 CFR411.20ff) are satisfied. Medicare did

not know that these conditions were satisfied at the time that Medicare made primary payment for certain services. The information now available to Medicare indicates that these conditions were satisfied when the services were provided.

The Medicare law obligates us to recover primary payments that Medicare mistakenly made when a group health plan is the proper primary payer. We may recover from any entity responsible for making primary payment, including employers that sponsor or contribute to group health plans, other plan sponsors, and insurers.[1]

How To Resolve This Matter

Within sixty (60) days of the date of this letter, you must provide one of the following responses:

1. *Repayment of the amount identified as a mistaken primary payment or, if less, the total amount payable under the group health plan (as a primary payer). Provide the report identification number, which is found in the upper right corner of the enclosed summary data sheet, with the repayment. If the amount repaid for any item or service is less than the amount that Medicare paid, provide an explanation of how the amount repaid was determined;*

2. *If primary benefits already have been paid to the beneficiary or provider of the services shown in the enclosures, provide a copy of the explanation of benefits and proof of payment;*

3. *If the group health plan is not obligated to make primary payment under any circumstances for service provided to an identified beneficiary under the Medicare Secondary Payer provisions, provide an explanation as to why not and a copy of any applicable plan provision. Include the name, address and tax identification number on the plan.*

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[1] *Pursuant to 42 U.S.C. 1395y(b)(2)(B)(iii), in order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan.*

- *If the specific basis upon which the group health plan is not obligated to make primary payment for services provided to an identified beneficiary under the MSP provision is that the plan's claims filing requirements have not been met,*[2] *submit a written statement indicating that all existing records of the plan have been searched and indicate whether a claim for the identified services was found under any plan*

(primary or supplemental) covering the individual. Identify the plan's claims filing requirements and provide a copy of the applicable plan provision;

- *If the claim is denied by the group health plan because the claim was not timely filed, consider this letter, pursuant to Medicare's subrogation rights, to constitute an appeal of the denial by the identified individual. Similarly, if the identified individual may seek waiver of this plan requirement, consider this letter to be a request for waiver. The plan must apply the same criteria to this appeal and request for waiver as it would had the appeal or waiver request been made by the identified individual. Please notify Medicare of the plan's decision regarding the appeal and waiver request and provide copies of any plan provisions upon which it bases its decisions.*

Dates of coverage under the group health plan are shown on the enclosed summary data sheet. If you believe the dates listed are inaccurate, please provide the correct dates of coverage along with your repayment or explanation of why Medicare is primary. Include the report identification number from the summary sheet on all correspondence. This enables Medicare to reconcile its records. Your failure to respond within sixty (60) days of the date of this letter will be taken as evidence of noncompliance with your responsibility, which may result in the initiation of additional recovery procedures. If you fail to pay this debt to Medicare or take other action as described above within 60 days of the date of this letter, Medicare will assess interest beginning with the date of this letter (42 CFR 411.24(m), 42 U.S.C. 1395y(b)(2)(B)(I)). Any payments made in satisfaction of this debt will be applied first to the amount of interest due, then to the principal.

Medicare may also determine that the group health plan is a nonconforming group health plan. The basis upon which CMS will make a determination of nonconformance is explained at 42 CFR 411.110, et seq. If a group health plan is determined to be nonconforming, the Internal Revenue Service will impose a 25 percent excise tax on all health plan expenditures of employers and employee organizations which contribute to the health plan (§5000 of Internal Revenue Code).

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2 Pursuant to 42 U.S.C. 1395y(b)(2)(B)(vi). An entity responsible for payment under a group health plan may not assert a timely filing defense if it receives the Medicare recovery demand letter within the longer of the plans timely filing or 3 years.

Moreover, 31 U.S.C. 3720(a) provides that agencies of the United States Government may refer debts to the Internal Revenue Service for collection by offset against tax refunds owed to individuals or entities by the Government. In addition, the Debt Collection Improvement Act of 1996 requires Federal agencies to recover debts by offset against any monies otherwise payable to the debtor by the United States.

If you have any questions concerning this matter, please write or call _____ *at* _____.

Sincerely,

MSP Supervisor

Enclosures:
MSP Summary Data Sheet
Payment Record Summary
Requested Reimbursement Summary Report
Summary of Medicare Reimbursement Key

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

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

Data Match Report (if applicable): _____

Data Match Report Date (if applicable): _____

Beneficiary Name: _____

Beneficiary HICN: _____

Third Party Payer: _____

First Demand Sent: _____

Second Demand Sent: _____

Recovery Status: _____

Recovery Status Date: _____

Total Potential Mistaken Payment Identified: $_____

Additions: _____$_____

Total Recovered: _____$_____

Difference Between Identified Amount and Amount Recovered (1) $_____

Briefly Explain Above Entry:

If the identified third party payer paid primary, list the entities from whom you were required to recoup duplication payment and amount recovered on an attachment.

10.7 – MSP Summary Data Sheet *(Not Applicable to ReMAS/HIGLAS Users)*

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

MSP SUMMARY DATA SHEET | | REPORT ID:
TYPE OF MSP SITUATION: WORKING AGED
DATE OF ACTUAL NOTICE:
BENEFICIARY NAME:
HEALTH INSURANCE CLAIM NUMBER (HICN):
DATE OF BIRTH:
THIRD PARTY PAYER NAME:
THIRD PARTY PAYER ADDRESS:

COVERAGE BEGIN DATE: | COVERAGE END DATE:
GROUP IDENTIFICATION:
PATIENT POLICY IDENTIFICATION:
SUBSCRIBER NAME:
EMPLOYEE ID NUMBER:
EMPLOYER NAME:
EMPLOYER ADDRESS:
REPAYMENT AMOUNT REQUESTED | *SEE ATTACHED DOCUMENTATION |
ACCRUED INTEREST/RATE/DATE
TOTAL REPAYMENT AMOUNT | REQUESTED INCLUDING INTEREST |
MAKE YOUR CHECK OUT TO: THE MEDICARE PROGRAM MEDICARE SECONDARY PAYER UNIT AT TAX EIN: PLEASE INSURE THAT THE REPORT ID AND HICN LISTED ON THE SUMMARY SHEET IS REFERENCED ON YOUR CHECK.
X | CHECK BOX IF CASE WAS IDENTIFIED THROUGH THE IRS/SSA/CMS DATAMATCH

10.7.1 - Field Descriptions on the MSP Summary Data Sheet

(Rev)

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

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

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

- Name of the subscriber; and
- Effective dates of coverage under the plan.

For some recoveries, contractors will not list a date because all the information to constitute actual notice is not available. However, contractors should still attempt recoveries and attempt to obtain this information through the recovery process. If sufficient information is not available to establish actual notice, indicate “Actual Notice Not Established” in this field.

Beneficiary Name - Self Explanatory;

Health Insurance Claim Number - Self Explanatory;

Date of Birth - Self Explanatory;

Third Party Payer Name - The name of the entity that is identified as the primary insurer for the beneficiary. (For example, Blue Cross and Blue Shield of Maryland, United Healthcare, etc);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

PAYMENT RECORD SUMMARY

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

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

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

All contractors currently initiate Data Match and Non-Data Match GHP-based recoveries of mistaken payments to the employer (considered the debtor if it received the original demand) if the employer is known. In order to facilitate employer efforts in responding to demand packages, contractors shall send a copy of these demand packages to the employer's insurer/TPA, if the insurer/TPA is known. For purposes of this section, the term "demand package" also includes the "intent to refer" package. Refer to the

definition of "debtor" and "current debtor" in section 60. The courtesy copy sent to the employer's Insurer/TPA does **not** change the employer's status as the "debtor." The insurer/TPA is **not** considered a debtor because the insurer/TPA was not the addressee on the original demand letter.] *Contractors on ReMAS/HIGLAS shall also comply with the sending of the courtesy copy of the demand package(s) to the employer's insurer/TPA. HIGLAS will print the demand letter with both addressees at the top. The employer is still considered the "debtor." The insurer/TPA addressee will be used as the courtesy copy. Contractors shall attach the PC-generated cover letter (section 10.9.1) to the courtesy copy of the entire demand package to the insurer/TPA.*

Contractors shall:

1) Send a copy of all GHP-based recovery demand packages issued *(*initial recovery demand and subsequent "intent to refer" letter and all enclosures) to the employer's insurer/TPA at the same time they issue the original or subsequent demand package to the employer. 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) Use a cover letter (see 10.9.1*)* 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. *Contractors on ReMAS/HIGLAS shall use the cover letter.*

3) Maintain *or ensure recreation of* copies of all letters and demand packages sent to employers and insurers/TPAs within the case file. *For those contractors on ReMAS and HIGLAS, both systems have a recreate function.*

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

    - If the insurer/TPA is acting as an agent of the employer, the contractor shall address correspondence to the employer with a copy to the insurer/TPA. The insurer/TPA cover letter (see §10.9.1*)* sets forth the

documentation required when an insurer/TPA wishes *to* act as an agent to resolve a debt on behalf of its client, an employer debtor.

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

Contractors shall *follow* 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.

Contractors shall use extra care when evaluating defenses submitted by the insurer/TPA when the debtor is the employer. A defense raised by the insurer/TPA might be valid if the insurer/TPA were being pursued with respect to the debt, but invalid as a defense for the employer. For example, the insurer might respond that it did not provide coverage during the period in question; or the TPA might respond that its contract was not in effect during the period in question. While proper documentation could establish these as defenses for the insurer and/or TPA, **they are not defenses for the employer**. The employer could have provided coverage through another insurer or had a different TPA contract in effect. Where the offered defense is an issue involving the specific coverage or payment limits of the policy, this should not be an issue. For example, a defense of exhaustion of the payment limits of the policy applies equally to the employer and the Insurer /TPA. Contractors *shall* continue to evaluate alleged defenses and accompanying documentation as addressed in §60.10.1.5.

10.9.1 – Insurer/TPA Courtesy Copy Letter

(To be used by contractors not on ReMAS/HIGLAS for GHP)

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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)

10.10 – *ReMAS Error Reports*

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

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

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

20.5 - Mistaken GHP Primary Payments

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

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

The GHP, employer or other entity may request that the Medicare contractor provide written agreement that it is the primary payer for certain specified services or all claims between specified dates. The Medicare contractor shall advise the GHP, employer or other entity that it will process claims in accordance with Medicare coverage rules and consistent with Medicare's payment and claim submittal requirements. The Medicare contractor shall further advise the GHP, employer or other entity that Medicare does not waive its timely filing requirements for initial claims and does not re-open previously adjudicated claims beyond one year from the date of initial determination in these situations.

30 – Mistaken *Primary* Payment Activities and Record Layouts

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

30.1 - Contractor Actions Upon Receipt of the *Data Match Cycle Tape* or Other Notice of *Non-Data Match GHP* Mistaken Payments *(For contractor NOT on ReMAS/HIGLAS for GHP recovery) and Actions to take for those Contractors Using ReMAS/HIGLAS GHP Functions*

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

The following table indicates the actions contractors must complete *upon receipt/notice of each* IRS/SSA/CMS *Data Match Cycle tape,* other notices *of Non-Data Match GHP* mistaken payments, *and notices of ReMAS GHP Lead identification*:

Contractor Action	**IRS/SSA/CMS Data Match**	**Non-Data Match**	***ReMAS/HIGLAS Users***
Down load within 10 calendar days the Data Match Cycle tape sent from CMS.	*X*		
Refer to COBC to Develop for Missing *Debtor or Record* Information	*X*	X	*X*
Research claims history and identify mistaken *primary* payments. *For ReMAS GHP users this is done automatically.*	X	X	
Update the MPaRTS tracking system *prior to sending a Data Match demand*.	X		
Send the initial demand letter to the employer *with a courtesy copy to the insurer/TPA.*	X	X	*X*
Send the Intent to Refer to Treasury letter for all debt not yet resolved and delinquent.	*X*	*X*	*X*
Refer all eligible delinquent debt to Treasury via the use of the DCS. Referral must take place by the time the debt is 180 days delinquent.	*X*	*X*	*X*
Track and report all activity taken on all debts.	*X*	*X*	*X*

All demands specific to the receipt of a Data Match Cycle tape must be issued within 60 calendar days from the download of the cycle tape.

Non-Data Match mistaken primary payment claims identification shall take place every 60-90 calendar days.

30.1.1 - COBC Responsibility to Obtain Missing MSP Information

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

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

Medicare contractors send MSP recovery demand letters in MSP situations involving *GHPs* to the employer that sponsors or contributes to the *GHP* that provides coverage to the identified beneficiaries. There are *three* types of such recovery situations: The IRS/SSA/CMS Data Match situations where the requisite employer identification is always provided to the contractors by CMS; Non-Data Match situations that are identified in other ways which do not always identify the employer*; and ReMAS identified newly accreted GHP records.* Contractors refer Non-Data Match *and ReMAS identified GHP lead* situations where the employer is not identified *or information regarding the employer is incomplete* to the COBC via ECRS for development of missing information. The COBC will update the MSP Auxiliary File with complete employer information once it is obtained. *The updated MSP Auxiliary file data will be overlayed in the ReMAS case file during the 60 day "wait period" (see §10.3.5).*

30.1.1.2 - Time Limitation for *GHP* Recover*ies*

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

30.1.1.2.1 - Actual Notice

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

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

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

NOTE: Contractor recoveries shall be pursued according to the priorities and tolerances sited above in §10.1.

30.1.2 - Contractor History Search

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

Upon receipt of information indicating that a third party payer is primary to Medicare (*non-data match GHP)*, the *contractor that has not implemented ReMAS/HIGLAS* shall search its *paid claims* history *file every 60-90 days* according to the *search parameters* and tolerances sited above in §10.1 *and §10.2 and their annual BPRs* to identify *Medicare* claims mistakenly *paid as* primary. If the effective dates of coverage under the plan are known, *the standard systems will* limit the review of the beneficiary's claims payment history to this period.

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

30.1.2.1 - Aggregate Claims for Recovery

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

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

30.1.3 - Documentation of Debt

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

- Demand letter to the employer using language provided by CMS as shown in §10.5 below;
- MSP Summary Data Sheet;

- *Accountability Worksheet (Data Match only)* and
- Claim Facsimiles *or claim detail* for each claim mistakenly paid *primary. The facsimiles or claim detail must contain the name of the provider, type or description of services, date of services, place of service, charged amount and Medicare paid amount. The demand package must summarize and total the amount due Medicare. The total must equal the claim facsimiles or claim detail.*

Contractors shall send all IRS/SSA/CMS Data Match demands *and Non-Data match GHP demands by* certified mail with return receipt requested. *The courtesy copy sent to the insurer/TPA shall not be sent first class or certified mail.*

30.2 - IRS/SSA/CMS Mistaken Payment Recovery Tracking System (MPaRTS)

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

The IRS/SSA/CMS Data match recovery progress is monitored via a contractor tracking system called Mistaken Payment Recovery Tracking System (MPaRTS) maintained at the CMS Data Center *(not used for ReMAS GHP Users).* The following data elements are contained on each report of the tracking system:

- Contractor ID Number;
- Report ID Number;
- Date Data Transmitted to Contractor;
- Beneficiary HICN;
- Beneficiary Last Name;
- MSP Type;
- Patient Relationship;
- Insurer Name;
- Employer Name;
- Insurance Group Name;
- Total Mistaken Payments - Intermediary (Part A);
- Total Mistaken Payments - Intermediary (Part B);
- Total Mistaken payments - Carrier (Part B);
- Total Summary Payments - Carrier (Part B - In office); and
- Total to Be Recovered.

The status codes, definitions, and required fields to be completed by contractors to update the status of each MPaRTS case are in the following table:

STATUS CODE	DEFINITION
00	Open case: Case still under investigation, no Demand sent yet.
DR	Deferred Recovery: applies to any report with MSP termination date prior to 1/1/87
BR	Backlog Recovery Project Cases which are now tracked in MPaRTS
CB	Amounts identified were previously recovered. No demand was sent
CD	Case Closed: Duplicate Report. Recovery will be made under another Report ID. No demand was sent.
CN	Case Closed: No Recovery (After demand was sent.)
CP	Case Closed: Partial Recovery (After Demand was sent.) **NOTE:** Total recovery amount must be less than demand amount.
CT	Case Closed: Total Recovery (after demand was sent). **NOTE:** Total recovery amount must equal demand amount.
DS	Demand Letter *sent. Status must be entered prior to mailing of the demand*.
IL	"Intent to refer" letter is sent.
NR	No Recovery Required: Contractor records show no mistaken payments made. (No demand sent).
PR	Partial Recovery (after demand was sent). Case Still Open: Additional recovery is expected, and multiple entries are allowed

STATUS CODE	DEFINITION
PS	Debt is referred to the PSC *for Treasury collection.*
RR	Referred to Regional Office *(use of this code should be rare)*
RC	Referred to Central Office *(use of this code should be rare)*
SF	Settlement/Fully closed (CR899)
SP	Settlement/Partially collected (CR 899)
WN	WriteOff/No Recovery (CR899)
WP	WriteOff/Partial recovery (CR 899)
XX	Litigation Referral

Contractors shall update MPaRTS within 10 days of completing recovery action or receiving partial payment. Update the MPaRTS system prior to issuing any demand letters.

A critical data element on each data match mistaken payment report is the report identification number. This is the key variable in the MPaRTS. Contractors can update and aggregate recovery actions by debtor by using report identification numbers.

30.3 - Communications Received in Response to Recovery Actions

(Rev. 35, Issued: 09-27-05; Effective/Implementation Dates: 10-27-05)

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

If a GHP or employer that is primary to Medicare refuses to reimburse Medicare for conditional primary benefits, it must explain its reason. If the explanation is that plan benefits are not payable because, for example, the services are not covered under any circumstances, or benefits are exhausted, or the beneficiary is not entitled to benefits, the *contractor shall* accept the explanation in the absence of evidence to the contrary. If some other reason is given, the contractor shall inform the employer that it is obligated to refund such payments to Medicare under the Medicare law. *(See §60 for plausible defenses and appropriate responses to such defenses.)*

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