

MEDICAL CARE DEBTS

- 1. REASON FOR ISSUE:** To revise Department of Veterans Affairs (VA) debt management procedures formerly contained in VA Manual MP-4, part VIII, chapter 19, Medical Care Debts.
- 2. SUMMARY OF CONTENTS/MAJOR CHANGES:** This handbook establishes the procedural guidelines that are specific to the collection of debts resulting from the receipt of medical care or services from VA.
- 3. RESPONSIBLE OFFICE:** Cash and Debt Management Division (047GC1), Office of the Deputy Assistant Secretary for Finance.
- 4. RELATED DIRECTIVE:** VA Directive 4800, Debt Management.
- 5. RESCISSIONS:** VA Manual MP-4, part VIII, chapter 19, dated September 22, 1992.

CERTIFIED BY:

**BY DIRECTION OF THE SECRETARY
OF VETERANS AFFAIRS**

/s/
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MEDICAL CARE DEBTS

1. PURPOSE AND SCOPE. This handbook establishes standardized Department-wide procedures for the collection of debts owed to VA as a result of the receipt of medical care or services from VA.

2. RESPONSIBILITY. The Chief of the Fiscal Activity must ensure that appropriate procedures in accordance with this handbook are followed when collecting medical care debts.

3. GENERAL

a. 38 U.S.C. §1729 (Pub. L. 99-272 and Pub. L. 101-508), authorizes VA to recover the reasonable cost of medical care furnished to a veteran for the treatment of a nonservice-connected (NSC) disability or condition when the veteran or VA is eligible to receive payment for such treatment from a third party. All funds collected by VA from third-party payers for the treatment of insured veterans for NSC disabilities are to be credited to VA's Medical Care Collection Fund (MCCF) 36_5287. Funds collected for tort-feasor claims are to be credited to MCCF 36_5287 as are funds collected for Emergency Humanitarian care whether paid by the patient or an insurer. Funds collected for TRICARE and Ineligible Hospitalization are credited to MCCF 36_0160. Funds collected for CHAMPVA, recoupment from CHAMPVA ineligible, or other CHAMPVA collections should be credited to the MCCF 36_5287.

b. 38 U.S.C. §1710 (Pub. L. 99-272 and Pub. L. 101-508) requires that VA collect certain fees, referred to as copayments (formerly referred to as Means Test copayments), from veterans enrolled in certain priority groups who receive either inpatient, outpatient health care, long-term health care services or medications at its facilities. In addition to the copayment, veterans are also required to pay a \$10 per diem copayment for each day of hospital care starting on the first day of care. All funds collected for the copayments and for the additional per diem charges are to be credited to VA's MCCF 36_5287.

c. Title 38, U.S.C. 1722A (Pub. L. 101-508, Pub. L. 102-568 and Pub. L. 106-117) requires that VA charge veterans, who receive medications on an outpatient basis for the treatment of NSC conditions, a copayment for each 30-day or less supply of medication provided. Veterans receiving medications for treatment of service-connected conditions, veterans rated 50 percent or more service-connected, and veterans whose annual income (as determined under 38 U.S.C. §1503) does not exceed the maximum annual allowed for pension recipients under 38 U.S.C. §1521 are exempt from the copayment requirement for medications. All funds collected for medication copayments are to be credited to VA's MCCF 36_5287.

4. THIRD-PARTY RECEIVABLES UNDER FISCAL ACTIVITY JURISDICTION

a. Bill Generation.

(1) The billing office prepares claims, such as Uniform Bills (UB-92's) or HCFA 1500, to notify appropriate third parties of accounts receivable established for VA-provided reimbursable medical care.

(2) The billing office forwards claims for reimbursable medical care to the Fiscal activity for audit and release to the patient or appropriate third-party payer.

(3) Medical record documentation, i.e., Discharge Summary (Inpatient Care), VA Form 10-1000, should be provided to the third-party payer only upon request. It is not necessary to attach medical record documentation routinely when submitting a claim.

b. Claims Follow-up.

(1) The appropriate staff will follow up on unpaid reimbursable insurance cases as follows:

(a) Telephone follow up should be initiated within 30 days after the initial bill was generated. A bill comment with an appropriate follow-up date should be entered. For the second contact, call on the appropriate follow-up date if there has been no resolution. Enter a bill comment in the third party joint inquiry (TPJI). Call within 21 days if payment was "processed" and not yet received. Enter a bill comment in TPJI. For the third contact, call within 14 days of the second contact and request a supervisor. Enter a bill comment with an appropriate follow-up date. Refer to management if no payment has been received by the next follow-up date.

(b) If the claim was submitted to a Medicare Remittance Advice (MRA) contractor and no response has been received within 30 days after submission, then stations should follow up appropriately with the MRA contractor.

(2) In all cases, the telephone follow-up should be documented to include, at a minimum, the name, position, title and telephone number of the person contacted, the date of contact, and a brief summary of the conversation.

(3) Whenever notification is received from a third-party payer that a claim has been paid, VA records are to be examined to determine if payment was received. If there is no evidence of payment, the third-party payer will be requested to either send a copy of the canceled check, or issue a "stop payment" request and reissue payment. When a third-party payer provides a copy of the canceled check, prompt action must be taken to insure the appropriate payment was applied to the correct receivable.

(4) Claim is Returned Without Payment. A claim may be returned for a number of reasons, i.e.:

(a) Claim form was not completed properly.

(b) Additional information is required to process the claim.

(5) Monies Were Paid to Subscriber. Contact the third-party payer for reimbursement. The veteran will not be contacted for payment. If the veteran pays with funds from the insurance check, a comment will be made by using the "Bill Comment Log" stating check number, date of check, etc. This will ensure a true credit trail. If the insurance company refuses to pay, contact Regional Counsel (RC) for guidance.

Note: It is important that these issues are addressed promptly and the claim resubmitted for payment, if appropriate. The third-party payer may be contacted for clarification when necessary.

(6) Claim Payment is Denied. When a third-party payer claims that payments for VA medical care are not covered under the insurance policy or disclaims liability for other reasons, the Explanation of Benefits (EOB) should be reviewed by appropriate staff, which may be the Utilization Review Nurse, the MCCF Coordinator, or designated MCCF staff. If it is determined that the claim denial is unjustified, the MCCF staff is to contact the third-party payer by telephone to request reconsideration. Following reconsideration, if the third-party payer agrees the claim denial was in error, the claim will be resubmitted to the third-party payer. If the third-party payer maintains that the claim denial was justified, the reviewing staff may appeal the decision. When it is determined that part or all of the claim is not valid, the claim will be cancelled by the billing staff.

(7) No Response Received. If there is no response from the third-party payer within 30 days after the second follow-up (third notice), telephone contact should be made to the carrier to determine the reason for non-response. If the case has been referred to a contractor for collection, the MCCF coordinator should contact the RC for guidance, in accordance with subparagraph 4d, prior to referring the case to the RC. Referrals to the RC should include information about the patient's health insurance policy, copies of any written or electronic correspondence, copies of all denials received from the third-party payer, summaries of telephone conversations with the third-party payer, and a summary of all actions taken by the MCCF staff to collect from the insurance company, to include any actions taken by a collection agency.

c. Payment.

(1) Payment in Full. Payment in full closes the case.

(2) Partial Payment. Payment by a third-party payer of an amount which is claimed by such payer to be the full amount payable under the terms of the applicable insurance policy or other agreement will normally be accepted as payment in full, thereby closing the case. The balance (unpaid amount) is to be contractually adjusted down before the payment has been applied. However, if there is a question as to the validity of the reason given by the third-party payer for reduction of the reimbursed portion of the claim, or if there is a considerable difference between the amount collected and the amount established as the accounts receivable, the MCCF staff should take the following action(s):

(a) Review the EOB to determine if the payment is paid in accordance with the veteran's health benefit coverage.

(b) If necessary, request the advice of the MCCF Coordinator and Utilization Review staff. The accounts receivable (AR) staff should contact the third-party payer by telephone or in writing if it is determined that there is potential error in the claim payment. When the third-party payer agrees that the original claim was not paid correctly, the claim should immediately be resubmitted for additional payment. If the third-party payer maintains that the claim was paid correctly and the MCCF Coordinator agrees, the balance of the claim is to be contractually adjusted down. However, if the MCCF Coordinator is still uncertain as to

whether the claim was properly adjudicated, advice is to be requested from the RC.

d. Referrals to the Regional Counsel (RC). Individual third-party receivables are referred to the RC for review and advice as to how to handle collection procedures in problem cases. If appropriate, the RC will forward such receivables to the Office of General Counsel (021) to review for possible litigation. Documentation must be submitted with all referrals to the RC.

(1) After reasonable recovery efforts have been made by the MCCF staff, third-party claims are referred to the RC for appropriate action under the conditions listed below:

(a) Litigation Issues. Refer bill if payment is denied because of VA-related litigation.

(b) Veteran Not Responsible for Cost of Care. Refer bill if payment is denied because veteran is not required to pay VA for the care.

(c) Refusal to Pay Government Hospital. Refer bill if payment is denied because insurer is not required to pay a government hospital/facility.

(d) Veteran Paid Directly. Refer bill if payment is sent to the veteran instead of VA.

(e) MCCF Coordinator Referral With RC Consent. The MCCF Coordinator must contact the RC for approval to forward other significant issues for review. PLEASE NOTE: This referral code is a restricted menu option that is only available to the MCCF Coordinator at a VA medical center (VAMC). Also a mandatory comment box must be added to this option that contains the date, time and name of the person that the MCCF Coordinator spoke with at RC.

(2) Reasons Not To Refer to Regional Counsel. Third-party claims shall not be referred to the RC for the following reasons unless the station MCCF coordinator has consulted with the RC and the RC has agreed to accept the referral.

(a) Medical Necessity/Emergency Denials. The insurance company determines that the medical treatment was not a medical necessity within the policy guidelines or a legitimate emergency as required by most Health Maintenance Organizations (HMO).

(b) Pre-authorization/Pre-admission Certification Denials. The care was not pre-authorized or pre-certified, as required by the insurance company, and no payment or a reduced payment was made in accordance with the insurance policy.

(c) Insurance Deductibles. The claim was approved or partially approved, but the payment was applied to the deductible.

(d) Maximum Benefits Used. The insurance company has a dollar or visit ceiling and the maximum was met or exceeded the limits of the policy. This includes "lifetime ceilings." An example is a limited number of outpatient visits for mental health allowed each calendar year.

(e) Reasonable and Customary Rates. The insurance company has paid based upon usual and customary rates in the community for the care provided.

(f) Length of Stay. The insurance company pays based upon an appropriate determination of length of stay and the veteran has an extended stay beyond the terms of the insurance policy.

(g) Level of Care, Acute vs. Non-Acute Coverage and Nursing Home Coverage vs. Skilled Nursing Home Coverage. The carrier's payment (or lack thereof) is based upon an appropriate determination that the level of care exceeded that which was medically necessary.

5. THIRD-PARTY RECEIVABLES UNDER REGIONAL COUNSEL JURISDICTION

a. Claims Generation.

(1) The billing office prepares claims to recover payments from appropriate third parties for accounts receivable established for tort-feasor claims, workers' compensation and no-fault insurance. The claims are addressed to the RC.

(2) The billing office forwards claims for tort-feasor cases, workers' compensation, and no-fault insurance to the Fiscal activity for audit and for forwarding to the office of the RC. The claims state that payments are to be sent to the RC.

b. **Claims Follow-up.** The RC will follow up on unpaid accounts receivable under their jurisdiction.

c. Payments.

(1) The RC must forward all payments to the nearest agent cashier on the same day that they are received in order to ensure that all payments are deposited in accordance with Treasury requirements. The cashier prepares a receipt for the RC, who subsequently sends the receipt to the VAMC where the charges originated. The RC's transmittal will clearly state that the amount received is in full or partial settlement and will list the related charges. VAMCs may also receive payment. When payment is received at a medical center, the RC will be contacted and funds will be deposited without being sent to RC.

(2) Payment in full closes the case.

d. **Decreases.** Unpaid third-party accounts receivable will be decreased if they meet one or more of the following criteria:

(1) The remaining balance will be decreased to zero when payment is accepted for less than the amount of the original claim as a compromise; or

(2) The entire receivable will be decreased to zero when no response or payment is received and the RC advises that the claim amount is uncollectible after the claim has been referred to them as instructed in paragraph 4.

6. FIRST PARTY COPAYMENTS (INPATIENT, OUTPATIENT, MEDICATION AND PER DIEM COPAYMENTS). It is important that veterans are provided

information regarding their responsibilities for copayments and that they are given the opportunity to satisfy these obligations prior to leaving the medical facility. This will reduce the need to process billing statements for copayments.

a. **Claims Generation.** First Party copayments are automatically generated by the integrated billing system. If there is health insurance, these charges are placed on hold for up to 90 days to allow the insurance carrier claims to be generated and payment(s) received. If payment is not received within the 90 days, the copayment will be automatically released. Statements are sent each month until the debt is resolved or other action, as detailed below, is needed.

b. **Claims Follow-up.**

(1) The MCCF staff follows up on unpaid First Party copayment debts at 30-day intervals. Statements that include assessed interest and other late payment charges are sent every 30 days, unless there has been no activity for 60 days. Interest and administrative charges will continue to accrue each month.

(2) On a monthly basis, unpaid First Party copayment debts will be referred to the Department of the Treasury for the Treasury Offset Program (TOP). The total amount of the debt owed by the individual must be \$25 or more and have three statements sent and be at least 180 days delinquent. Accounts in referral status to DOJ will not be referred to TOP.

c. **Referrals to the Regional Counsels/Department of Justice (DOJ).** First Party copayment receivables will be referred for enforced collection as detailed in VA Handbook 4800.12, Referrals for Enforced Collection (Litigation).

d. **Write-Off.** The Fiscal activity is to write off, or refer for write-off, delinquent First Party copayment debts that meet the criteria as set forth in VA Handbook 4800.6, Termination of Collection Action and Close-Out of Debts.

e. **Interest and Administrative Costs.** Interest and other late payment charges are assessed on delinquent First Party copayment debts as detailed in VA Handbook 4800.9, Interest, Administrative Costs, and Penalty Charges.

7. CLAIMS PROCESSING UNDER TWO OR MORE CATEGORIES

a. **Copayments and Reimbursable Insurance.**

(1) In cases where the cost of a veteran's medical care may appear to qualify for billing under reimbursable insurance and copayment, the charges for copayments will be placed on hold for 90 days pending payment from the third-party payer. If no payment is received within 90 days, then the charges will automatically be released and a statement generated to the veteran.

(2) On all insurance policies, the entire amount of the claim payment will be applied first to the copayment. However, to ensure that appropriate accounting of remittance is made, the EOB should be examined carefully. The veteran is then billed for the portion of the copayment not covered by the insurance reimbursement and the portion of the copayment for any non-covered services.

b. **Workers' Compensation/Tort-Feasor and Copayment.** The Claims activity will prepare a claim to the third-party payer for all the medical care

provided (including the copayment) for Workers' Compensation/Tort-Feasor claims, and will bill the veteran for the copayment at the same time. The claim to the third-party payer will include the following statement: "Gross amount includes the Copayment." If the veteran pays the copayment and all or a portion of the copayment is recovered from the third-party payer, a refund to the veteran is to be made promptly.

8. RECORDING THIRD-PARTY ACCOUNTS RECEIVABLE

a. The Fiscal activity will record a firm receivable for claims rendered for third-party medical care, including workers' compensation, no-fault, tort feasor and reimbursable insurance cases, and medical riders on patient's automobile or homeowners policy. Payments less than the claim amount accepted as full settlement of the claim are to be adjusted in accordance with instructions contained in MP-4, part V, paragraph 2D.03, General Fund Receipts.

b. The Fiscal activity will ensure that duplicative payments are not received for the same episodes of care through the coordination of benefits (COB) review. COB is a common provision in most health benefit plans and the benefit determination rules established by the National Association of Insurance Commissioners (NAIC) are utilized by the majority of health benefit plans. A COB situation occurs when a veteran has other insurance coverage that is primary such as another health care plan, Medicare, motor vehicle insurance for medical expenses, or workers' compensation. Generally, a veteran's primary health insurance plan will not provide primary coverage if recovery is available from another source resource. In this instance, the veteran's primary plan is a secondary payer and payment, if any, is based on the payment made, or should have been made, by the other insurance. There are two types of COB provisions used by secondary claim payers when paying COB claims. The first type is a non-duplication COB provision, where the secondary claim payer pays the difference between their normal allowed amount and the primary carrier's payment. The second type is where the secondary claim payer pays the difference between the total amount of the claim and the primary claim payer's payment when reimbursement also has been received from a third-party health plan. The coordination of benefit requirements in many plans, as well as State law, may create an obligation to refund. In all such cases, the RC, who has jurisdiction of tort feasor and workers' compensation claims, should be consulted for determination of these issues.

9. BILLING FOR INELIGIBLE/EMERGENCY MEDICAL CARE OR TREATMENT

a. 38 CFR 17.43(b)(1), (2), and (3) authorize medical care or services to the general public and employees and their families in an emergency or on a humanitarian basis. Billing for such care is authorized in 38 CFR 17.62(b). VA FL 4-481(or other similar form letter) will be attached to the bill sent to the person treated.

b. 38 CFR 17.43(b)(2) authorizes medical care or services to a person in an emergency situation pending verification of eligibility for treatment as a veteran. The person will be billed for medical care or services if it is subsequently determined that he/she was not eligible for treatment by VA. Billing for such care or services is authorized in 38 CFR 17.102(a). VA FL 4-480 (or other similar form letter) will be attached to the bill sent to the person treated.

c. Interest and other late payment charges are to be assessed on these debts as detailed in VA Handbook 4800.9.

d. Compromise offers received on the above debts will be handled in accordance with VA Handbook 4800.4, Compromise of Debts. The procedures for write-off or suspension of collection action on these billings are located in VA Handbook 4800.6. Referrals for enforced collection are governed by the instructions provided in VA Handbook 4800.12, Referrals for Enforced Collection (Litigation).