



Department of Veterans Affairs

Financial Policy

Volume XII

Debt Management

Chapter 5

Medical Care Debts

Approved:

A handwritten signature in black ink, appearing to read "Ed J. Murray", written over a horizontal line.

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Date

Financial Policies and Procedures
Medical Care Debts

CHAPTER 5

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0501 OVERVIEW

This chapter establishes the Department of Veterans Affairs (VA) financial policies and procedures relating to the collection of debts owed to VA as a result of the receipt of medical care or services from VA that are deposited to the Medical Care Collections Fund (MCCF).

050101 AUTHORITY FOR MEDICAL CARE DEBT COLLECTION. VA is authorized by [38 U.S.C. Chapter 17](#) to recover the reasonable cost of medical care furnished to a Veteran for the treatment of a non-service-connected (NSC) disability or condition when the Veteran or VA is eligible to receive payment for such treatment from a third-party. VA is also authorized to provide emergency and humanitarian medical care to individuals who may not be eligible for such care or whose eligibility has not been confirmed. In addition, VA is authorized to charge some Veterans co-payments for inpatient or outpatient health care, medications, or extended care services.

050102 ACTIONS FOR MEDICAL CARE DEBT COLLECTION. VA recovers medical care costs through assessing fees, referred to as co-payments, to Veterans who receive health care at VA facilities (or non-VA facilities for which VA has paid for treatment rendered) on an inpatient or outpatient basis or for extended care services and medications. VA advises the Veteran of his or her responsibility for copayments for medical services received and follows up on a regular basis to ensure the debt is collected. VA prepares claims to collect medical care costs from third-parties based on VA's reasonable charges for NSC care. A Veteran's co-payment charge may be satisfied or reduced if a payment is received from a Veteran's third-party health insurance.

0502 POLICIES

050201 AUTHORITY FOR MEDICAL CARE DEBT COLLECTION.

A. Reimbursable Medical Health Care. VA will recover the cost of certain health care and services as authorized in existing legislation ([38 U.S.C. 1729](#)).

B. Co-payments. VA collects certain fees, referred to as *co-payments*, from certain Veterans who receive inpatient or outpatient health care, medications, or extended care services. Such debts are subject to interest, late payment charges and referral for collection purposes.

C. Emergency and Humanitarian Medical Care. VA will render medical care or services under emergency or humanitarian conditions to individuals not eligible for such care or services. Such debts are subject to interest, late payment charges, and referral for collection purposes. These debts are not eligible for waiver consideration but may be compromised ([38 U.S.C. 1784](#)).

D. Debt Collection Process. VA will carry out its debt collection process when debts are not being repaid in a timely manner, adhering to the debt collection standards in U.S. Code, VA regulations and [Volume XII, Chapter 1](#). As part of this process, VA will advise debtors of their due process rights relating to various activities associated with debt collection.

050202 ACTIONS FOR MEDICAL CARE DEBT COLLECTION.

A. First Party Co-payments. If a Veteran's medical care appears to qualify for billing under reimbursable insurance and co-payment, the charges for co-payments will be placed on hold for 90 days, pending payment from the third-party payer. If no payment is received within 90 days, the charges will automatically be released and a statement generated to the Veteran. VA will provide sufficient information about first party co-payment debts to Veteran patients reminding them of their responsibilities to pay their share of debts created as a result of medical services rendered as inpatient, outpatient, extended care, or medication. VA will follow up with the debtor until the debt is resolved.

B. Third-party Receivables. VA will prepare claims to collect certain accounts receivable from appropriate third-parties in accordance with [38 U.S.C. 1729](#).

C. Third-party Receivables (Regional Counsel). VA will prepare claims to obtain reimbursement from appropriate third-parties for third-party Tortfeasor, Workers' Compensation and No-Fault insurance claims. The receivables are under the exclusive jurisdiction of VA's Regional Counsels (RC).

D. Multiple Category Claims Processing. If the cost of a Veteran's medical care appears to qualify for reimbursable insurance billing and co-payment, the charges for co-payments will be placed on hold for 90 days, pending payment from the third-party payer. If no payment is received within 90 days, the charges will automatically be released and a statement generated to the Veteran. On all third-party payments, the entire amount of the payment will be applied first to the corresponding co-payment. The Veteran is then billed for the portion of the co-payment not covered by the insurance reimbursement and the portion of the co-payment for any non-covered services.

E. Recording Third-party Receivables. VA will record third-party accounts receivable for claims generated for medical care and any claim settled in full or an amount less than the claim and requiring an accounting adjustment.

0503 AUTHORITY AND REFERENCES

[050301 31 U.S.C. Chapter 37, Subchapter II, Claims of the United States Government](#)

[050302 38 U.S.C. 1503, Determinations with Respect to Annual Income](#)

[050303 38 U.S.C. 1521, Veterans of a Period of War](#)

050304 38 U.S.C. 1710, Eligibility for Hospital, Nursing Home and Domiciliary Care

050305 38 U.S.C. 1710B, Extended Care Services

050306 38 U.S.C. 1722A, Copayments for Medications

050307 38 U.S.C. 1729, Recovery by the United States of the Cost of Certain Care and Services

050308 38 U.S.C. 1784, Humanitarian Care

050309 42 U.S.C. 2651, Federal Medical Care Recovery Act, Recovery by United States

050310 31 C.F.R. Chapter IX, Federal Claims Collection Standards (Department of the Treasury--Department of Justice)

050311 38 C.F.R. Part 1, Section 1.900-1.953, Standards for Collection, Compromise, Suspension or Termination of Collection Effort and Referral of Civil Claims for Money or Property

050312 38 C.F.R. 17.43(b) (1), (2) and (3), Persons Entitled to Hospital or Domiciliary Care

050313 38 C.F.R. 17.102(a), Charges for Care or Services

050314 OMB Circular A-129, Appendix A, Paragraph V, Delinquent Debt Collection

050315 Treasury Financial Manual, Volume 1, Part 6, Chapter 8000, Section 8025.30 Collection Mechanisms

050316 Department of the Treasury Guide: Managing Federal Receivables

050317 Digital Accountability and Transparency Act (DATA Act), Pub. L. 113-101

0504 ROLES AND RESPONSIBILITIES

050401 The Assistant Secretary for Management/Chief Financial Officer (CFO) oversees all financial management activities relating to the Department's programs and operations, as required by the Chief Financial Officers Act of 1990 and 38 U.S.C. 309. Responsibilities include the direction, management and provision of policy guidance, and oversight of VA's financial management personnel, activities, and operations. The CFO establishes financial policy, systems, and operating procedures for all VA financial entities and provides guidance on all aspects of financial management.

050402 Under Secretaries, Assistant Secretaries, Chief Financial Officers, Fiscal Officers, Chief Accountants and other key officials are responsible for ensuring compliance with the policies and procedures set forth in this chapter.

050403 The Chief of the Finance Activity is solely responsible and accountable for all requirements outlined in this chapter, regardless of the organizational alignment of the unique functions or activities and therefore will ensure that appropriate procedures are followed when collecting medical care debts.

050404 The Debt Management Center (DMC), located in St Paul, MN, is responsible for offsetting Veterans' compensation and pension benefits in instances of unpaid first party co-payment debts.

050405 The Consolidated Patient Accounts Centers (CPAC) were authorized by the Veterans' Mental Health and Other Improvements Act (Public Law 110-387). The centers re-engineer and integrate all business processes of the VA revenue cycle, standardize and coordinate all VA activities related to the revenue cycle for all health care services furnished to Veterans for NSC medical conditions, apply commercial industry standards for measures of access, timeliness and performance metrics with respect to VA revenue enhancement, and apply other requirements with respect to such revenue cycle improvement as deemed necessary. The CPAC consolidated traditional Veterans Health Administration (VHA) business office functions into seven regional centers with the goal of transforming VHA billing and collections activities and more closely aligning VHA with industry best practices. Each CPAC includes a fiscal officer who retains fiscal authority over the facility.

050406 Regional Counsels (RC) and designated staff attorneys are authorized, in any matter within the jurisdiction of the VA General Counsel, delegated or otherwise assigned, to conduct investigations, examine witnesses, take affidavits, administer oaths and affirmations, and certify copies of public or private documents. The RC is authorized, under the guidance of the General Counsel, to provide legal services, advice, and assistance to VA installations within the region assigned. In any area of regulatory, assigned or delegated responsibility, the RC may delegate to staff members or other VA attorneys authority to perform, to the extent specified, any legal function under the professional direction of the RC. The RC may modify, suspend, or rescind any authority delegated hereunder.

050407 The Office of Finance, OFP is responsible for developing, coordinating, reviewing, evaluating, and issuing VA financial policies, including those that impact financial systems and procedures for compliance with all financial laws and regulations.

0505 PROCEDURES

050501 AUTHORITY FOR MEDICAL CARE DEBT COLLECTION.

A. Reimbursable Medical Health Care. VA will recover certain health care and services costs as authorized in 38 U.S.C. 1729.

1. Subject to the provisions of appropriations acts, amounts in the MCCF will be available, without fiscal year limitation, to the Secretary for furnishing medical care and services for the same purposes and subject to the same limitations (other than with respect to the period of availability for obligation) as apply to amounts appropriated from the general fund of the Department of the Treasury (Treasury) for that fiscal year for medical care.

2. VA will implement the provisions of 38 U.S.C. Chapter 17, to include assessing fees for the cost of medical care and services rendered to Veterans, collecting co-payments for medications, receiving reimbursement for humanitarian or emergency care treatment and depositing the funds in the MCCF 36 5287.

a. VA is authorized to recover the reasonable cost of medical care furnished to a Veteran for the treatment of an NSC disability or condition when the Veteran or VA is eligible to receive payment for such treatment from a third-party (38 U.S.C. 1729).

(1) Funds collected from the following are credited to MCCF 36 528704:

- Third-party payers for the treatment of insured Veterans for NSC care;
- Non-Federal Workers' Compensation programs;
- No-Fault Auto Insurance; and
- Third-Party Tortfeasor claims;.

(2) Funds collected from Third-Party payer for prescription claims are credited to MCCF 36 528711 (see Appendix B).

(3) Funds collected for the following are credited to Medical Services 360160:

- DoD sharing arrangements;
- TRICARE;
- Ineligible hospitalization;
- Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); and
- CHAMPVA third-party.

(4) Funds collected under the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.) by the CHAMPVA office in Denver, Colorado are credited to MCCF 36 528704.

b. VA is authorized to collect co-payments from certain Veterans who receive inpatient or outpatient health care provided to Veterans by VA (38 U.S.C. 1710(a) (3), (f)). In addition to the co-payment, Veterans are also required to pay a \$10 per diem co-payment for each day of inpatient hospital care, starting on the first day of care. Funds

collected for the co-payments and for the additional per diem charges are credited to MCCF 36 528703.

c. VA is authorized to collect co-payments from certain Veterans who receive extended care services (38 U.S.C. 1710B). Funds collected for the co-payments are credited to MCCF 36 528709.

d. VA is authorized to charge certain Veterans who receive medications on an outpatient basis for treatment of NSC conditions a co-payment for each 30-day or less supply of medication provided (38 U.S.C. 1722A). Veterans are exempt from the co-payment requirement for medications if they are:

- Receiving medications for treatment of service-connected conditions;
- Rated 50 percent or more service-connected;
- Former Prisoners of War;
- Treated under certain other special authorities;
- If their annual income (as determined under 38 U.S.C. 1503) does not exceed the maximum annual rate of pension that would be payable to the Veteran if he/she were eligible for pension under 38 U.S.C. 1521;
- Medications provided as part of a VA approved research project authorized by 38 U.S.C. 7303; or
- A Veteran who VA determines to be catastrophically disabled, as defined in 38 CFR 17.36(e).

e. Funds collected for medication co-payments are credited to MCCF 36 528701.

f. Funds collected for emergency humanitarian care, whether paid by the patient or their insurance are credited to MCCF 36 528703.

B. Emergency and Humanitarian Medical Care.

1. VA is authorized in accordance with 38 C.F.R. 17.43(b) (1), (3) to provide 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 C.F.R. 17.102(b). If a person provides their health insurance information, VA may bill the health insurance and balance bill the individual for the amount not paid by the individual's health insurance. If a person does not have health insurance information, a form letter will be sent to the person treated requesting payment for medical care or services provided to that person.

2. VA is authorized in accordance with 38 C.F.R. 17.43(b)(2) to provide medical care or services to a person – thought to have been discharged or retired from the Armed Forces – in an emergency. The person will be billed for medical care or services if it is subsequently determined that he or she was not eligible for treatment by VA. Billing for such care or services is authorized in 38 C.F.R. 17.102(a). If a person provides their health insurance information, VA may bill the health insurance and balance bill the

individual for the amount not paid by the individual's health insurance. If a person does not have health insurance information, a form letter will be sent to the person treated requesting payment for medical care or services provided to that person.

3. Interest and other late-payment charges are to be assessed on these debts as prescribed in Volume XII Chapter 1A, *Interest, Administrative Costs and Penalty Charges*.

4. Compromise offers received on emergency or humanitarian medical debts will be processed in accordance with Volume XII Chapter 1C, *Compromise of Debts*. Referrals to the Treasury Offset Program (TOP) are governed by the procedures in Chapter 1E, *Treasury Offset Program and Treasury Cross-Servicing*. The procedures for suspension or write-off of collection action are contained in Chapters 1H, *Suspension of Collection Action* and 1I, *Termination of Collection Action and Debt Close Out*, respectively. Referrals for enforced collection are governed by the procedures in Chapter 1G, *Referrals for Enforced Collection (Litigation)*.

C. Debt Collection Activities. VA will adhere to VA's debt collection standards when collecting medical care debts from Veterans who received health care and services from VA medical facilities. It is important that VA advises the debtors of their due process rights.

Refer to Volume XII Chapter 1, *VA Debt Collection Standards* for more information on the standards to be followed by VA in its debt collection process. Refer also to the subchapters under Chapter 1 for delegation of authority responsibilities assigned to various VA officials for other various actions relating to debt collection; including waiver, suspension, compromise, termination of collection action, voluntary and involuntary offsets, and referrals of debts to Treasury or the Department of Justice (DOJ).

050502 ACTIONS FOR MEDICAL CARE DEBT COLLECTION.

A. First-Party Receivables. VA will provide information to Veterans regarding their responsibilities for first party co-payments (inpatient, outpatient, extended care services, medication, and per diem). Veterans who do not have health insurance should have the opportunity to satisfy these obligations at the Agent Cashier's office prior to leaving the medical facility.

1. Claims Generation. First party co-payments will automatically be 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. Once a claim is generated, if payment is not received within 90 days, the co-payment will automatically be released by the system and appear on the Veteran's next monthly billing statement.

a. Information is automatically generated from the Veterans Health Information Systems and Technology Architecture (VistA) accounts receivable system for each VHA medical facility and forwarded to the Austin Information Technology Center (AITC)

where monthly statements are produced for first-party co-payment debts through the Consolidated Co-payment Processing Center (CCPC).

b. The Veteran will receive three statements which include new charges, unpaid balances, assessed interest and other late-payment charges. The statements are sent every 30 days unless there has been no activity for an additional 60 days. Interest and administrative charges will continue to accrue each month in the VistA accounts receivable system.

c. The statements will no longer be generated once a patient has gone through three statement cycles with no activity.

2. Referrals to the DMC and TOP. The VistA system does not allow automatic co-payment referral to the DMC or TOP for Veterans with a service-connected rating of 50 percent or greater or for those in receipt of a VA pension. A manual review must be completed and if determined to be appropriate, charges will be verified and then referred to the DMC.

VA will monitor the co-payment debt collection activity using the following methods.

a. DMC. Accounts referred to the DMC are those that have a balance of \$25 or more (accounts can consist of single or multiple charges), 30 days or more have passed since the third patient statement was mailed and bills are in an active status (not in a repayment plan), suspended pending an administrative decision, or referred to Regional Counsel.

These debts are then matched against the DMC pension system to identify those Veterans in receipt of VA benefits. Only accounts of those Veterans with an active award and a net check amount of greater than \$25 are loaded into the DMC's computer system and set up for offset.

All other accounts are returned to the medical center for other collection actions and eventual referral to TOP.

Any accounts not eligible for DMC offset are considered "DMC rejects" and are automatically stored in a file at the AITC. The "DMC Reject" file is used to create potential offset notification letters that the AITC sends to the Veteran informing them of impending referral to TOP.

The AITC holds the file of returned accounts for 60 days before passing them to TOP. This "hold" ensures these debtors have the required amount of time to resolve their debt before referral to TOP.

b. AITC compiles referral information from all medical centers into an offset file and forwards to DMC. The DMC merges the VHA debt data with the VBA debt data and the Veterans Canteen Service (VCS) debt data and sends a master VA file to Treasury.

TOP Referrals include:

- First Party Medical Debts, including both ChampVA and TRICARE copayments;
- Ex-employee Debts;
- Current Employee Debts (unless in a repayment plan); and
- Vendor debts.

These bills have an account balance of \$25 or more, including principal, interest, administrative cost, the debt is at least 120 days delinquent (150 days old) and the status of the bill is active.

Debts not referred to TOP include:

- Debts where the Veteran has included VA debts in their bankruptcy petition;
- Debt is in litigation – referred to DOJ;
- Debts where the debtor's date of death is recorded in VistA;
- Debt is on repayment plan in VistA;
- Debt is in a suspended status; and
- Third-party (Insurance) debts are not eligible for referral to TOP

As debts become eligible, they are referred during the next monthly TOP transmission.

If a debt resides at Treasury for payment offset, the Account Receivable (AR) software will transmit increases and decreases to the debt balance. Increases may include new delinquent debts as well as additional interest and administrative charges.

Offset payments are recorded in the Financial Management System (FMS) by the DMC staff using Transfer Disbursing Authority (TDA). An electronic copy of the offset list is placed on a secure SharePoint server. VA and CPAC staff who have authorization can retrieve the TOP listing as it is posted.

3. Referrals to the RC/DOJ. First-party co-payment receivables will be referred for enforced collection (litigation) as prescribed in Volume XII Chapter 1G, *Referrals for Enforced Collection (Litigation)*.

4. Write-Off. The fiscal officer, including the CPAC Fiscal Officer or their designees, may either write-off or refer for write-off, any delinquent first-party co-payment debt that meets the criteria set forth in Volume XII Chapter 1I, *Termination of Collection Action and Debt Close Out*. Write-off of any co-payment debt may be accomplished by delegation to the revenue program, even if they do not directly report to the finance activity; however, the responsibility and accountability remains with the finance activity, including CPAC finance activity.

5. Waiver. The fiscal officer, including the CPAC Fiscal Officer or their designees, may waive delinquent first-party co-payment debt that meets the criteria set forth in Volume XII Chapter 1B, *Waiver of Debts*.

6. Interest and Administrative Costs. Interest and other late-payment charges are assessed on delinquent first-party co-payment debts as prescribed in Volume XII Chapter 1A, *Interest, Administrative Costs and Penalty Charges*.

B. Third-Party Receivables Under the Jurisdiction of the Fiscal Activity. VA will prepare claims under the jurisdiction of VA's finance activities, including CPAC finance activities, to obtain reimbursement from appropriate third-parties.¹

1. Bill Generation. The billing office will prepare claims on standard medical claim billing forms to notify appropriate third-parties of accounts receivables established for VA-provided reimbursable medical care. Medical record documentation will not be provided to the third-party payer unless requested (e.g., discharge summary from VistA Computerized Patient Record System (CPRS)). It is not necessary to attach medical record documentation when submitting a claim.

a. The billing unit may be local and consolidated within the finance activity or separate and distinct from the finance activity or it may be a part of CPAC.

b. The bill will be sent to the third-party payer once it has been generated and audited by the finance activity.

c. The chief of the finance activity, including CPAC finance activity, is responsible for the billing accuracy regardless of the billing unit status.

2. Claims Follow Up. The appropriate staff will follow up on unpaid third-party insurance cases according to the guidelines in Appendix A. VHA may use contractors to assist with follow-up and collection from third-party payers. VHA has some national blanket purchase agreements available and many facilities/Veterans Integrated Service Networks (VISNs) also contract on their own.

a. If the claim was submitted to the Medicare Fiscal Intermediary and no response was received within 30 days after submission, then CPACs are required to follow up.

b. All third-party claims follow-up conducted via telephone or online inquiry will be documented in the VistA Third-party Joint Inquiry (TPJI), as follows:

(1) If follow-up is conducted via telephone, documentation should include the name of the payer, title and telephone number of the person contacted, the date of contact, the claim reference number provided by the payer, and a brief summary of the conversation.

(2) If follow-up was conducted via an online query, documentation should include the URL or Web-site name and payer name, the date of the query, claim reference number provided by the payer, and a brief summary of the information provided.

¹ Refer to Appendix C for additional VHA guidance.

c. If letters are sent via mail or faxed for follow-up (not the preferred method), a file copy will be retained. The date the letter was sent, along with mailing address or fax number, will be noted in the comments.

d. Written documentation within TPJI will be the only approved record of follow-up activity.

e. Whenever notification is received from a third-party payer that no payment will be made due to deductible or co-insurance, this information will be included with the follow-up comments and the account will be closed. The comment should clearly state that there is zero pay due to deductible and/or co-insurance and will include the reference number provided by the payer and proper Health Insurance Portability and Accountability Act (HIPAA) standard adjustment code.

Whenever notification is received from a third-party payer that a partial payment will be made at a future date, this information should be included with the follow-up comments and the account can be decreased to the amount of the expected partial payment (using a decrease adjustment transaction) in the VistA AR system. The comment should clearly state that this is due to expected partial payment and will include the reference number provided by the payer and expected payment date for the remaining payment. For example, a third-party payer indicates they will pay \$400 of a \$1000 receivable; however, the agreed upon amount will be paid at a determinable time in the future. In these instances the receivable can be decreased by the \$600 that will not be paid. The bill will remain open/active for the \$400 until payment is received. Do not post the actual collection until it is received.

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:

(1) If the payment was made via an electronic payment, ask the payer for the date of the Electronic Funds Transfer (EFT), trace number and the amount of the EFT. Review the Daily Activity Report to locate the EFT in VistA. If unable to locate it in VistA, review the Explanation of Benefits and Payments, Healthcare Resolution Application (EPHRA) to locate the EFT. If EFT is in EPHRA, but not in VistA, contact Enterprise Product Support (EPS) to request the EFT be re-transmitted. If the EFT is not in VistA or EPHRA, complete the "ePayments Problem Reporting Form" and forward the form to the ePayments' Veterans Integrated Service Networks/Point of Contact (VISN/POC). VISN/POCs will forward the research request through the appropriate channels at the PNC Bank.

(2) If payment was made via check, ask the third-party payer to either send a copy of the canceled check image or provide the check number and the date of the check. When a third-party payer provides a copy of the canceled check image or check number

and date of check, prompt action will be taken to ensure that the appropriate payment was applied to the correct receivable.

f. Contact the third-party payer for reimbursement for monies paid to a subscriber. The Veteran may also need to be contacted. If the Veteran provides the insurance check or pays with funds from the insurance check, a comment will be made in TPJI stating the check number, date of the check, etc. This will ensure a true audit trail. Written documentation within TPJI will be the only approved record of follow-up activity. If the insurance company refuses to pay, facilities are to contact the RC in writing for guidance. It is important to address these issues promptly and re-submit the claim for payment, if appropriate.

g. When a third-party payer denies the claim, the Explanation of Benefits (EOB) or other information provided by the payer should be reviewed by appropriate staff, which may include accounts management, the Revenue Utilization Review (RUR) Nurse, supervisors of appropriate revenue functional areas, or other designated staff. If the denial correctly identifies a billing error involving patient registration or demographic data, including specifics of the Veteran's insurance coverage (verification), the accounts management staff will communicate in writing to the staff responsible for the accuracy of the patient database to make the appropriate corrections. If it is determined that the claim denial is unjustified, the revenue staff should contact the third-party payer to request reconsideration. Following reconsideration, if the third-party payer agrees the claim was denied in error, a request for the claim to be reprocessed will be made. If the payer will not automatically re-process the claim, the claim will need to be re-submitted to the third-party payer. If the third-party payer maintains that the claim denial was justified, the revenue staff may appeal the decision. When it is determined that part of, or the entire claim, is not valid, billers will use the VistA CLON Copy/Cancel option for re-submission of the claim or the VistA CANC Cancel Bill option as appropriate. If an appeal is in progress, research is being performed or a claim is being resubmitted, this information will be documented in TPJI to demonstrate that VA is working on the claim.

h. If there is no response from the third-party payer within the timeframes in the Table in Appendix A, additional follow-up as required will be completed. Written documentation within the TPJI menu will be the only approved record of follow-up activity.

i. Once all required follow-up has been completed and all administrative remedies exhausted (such as appeals), the accounts management supervisor should contact RC for guidance (see paragraph 050502B4 below) prior to referring the case to RC. Referrals to 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 follow-up activities with the third-party payer, and a summary of all actions taken by the revenue staff to collect from the insurance company to include any actions taken by a collection agency.

j. In all cases involving the write-off of any debt, the fiscal officer, including the CPAC fiscal officer or their designees, is solely responsible and accountable to ensure that all write-off activity conforms to the applicable regulations and directives. Write-off of third-party accounts receivable may only be approved in advance by the OGC.

3. Payment.

a. Payment in full will close the case.

b. Partial payment by a third-party payer 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 decreased. 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 revenue staff should take the following action(s):

(1) Review the EOB to determine if payment was paid in accordance with the Veteran's health benefit coverage and/or the third-party payer agreement, if one is in place.

(2) If it is determined a potential error in the claim payment exists, the accounts management staff will contact the third-party payer. When the third-party payer agrees that the original claim was not paid correctly, request the payer re-process the claim. If the payer cannot re-process it, the claim should be re-submitted immediately for additional payment. If the third-party payer maintains that the claim was paid correctly, request the advice of the revenue supervisory staff. If the supervisor agrees, the balance of the claim is to be contractually adjusted. Claims processed under the Coordination of Benefits (COB) rules will be evaluated based on the health insurance plan. However, if the revenue supervisor is still uncertain as to whether the claim was properly adjudicated, he/she should request advice from the RC.

The contractual adjustment will be completed within 5 business days after the payment has been applied. A comment should be entered into the claim explaining the reason for the contractual adjustment.

If the correct third-party receivable cannot be identified, the payment is to be returned or posted to the suspense fund to be resolved within 30 days. Payments may not be posted directly to the collection funds.

4. Referrals to the RC. Individual third-party receivables are referred to the RC for review and advice as to how to handle collection procedures in cases where there are potential legal action activities (see paragraph 050502B2i above).

a. After all required follow-up efforts have been made by the revenue staff, third-party claims will be referred to the RC for appropriate action under the following conditions:

- (1) Litigation Issues. Refer bill if payment is denied because of VA-related litigation.
- (2) Veteran Not Responsible for Cost of Care. Refer bill if payment is denied by the third-party payer because Veteran is not required to pay VA for the care provided by VA.
- (3) Refusal to Pay Government Hospital. Refer bill if payment is denied because third-party payer states they are not required to pay a Government hospital/facility.
- (4) Veteran Paid Directly. Refer bill if payment is sent to the Veteran instead of VA and contacts have been made with the insurance company and Veteran without any action.
- (5) Revenue Supervisor Referral with RC Consent. The revenue supervisor will contact the RC for approval to forward other significant issues for review other than those noted above in paragraphs 050502B4b(1)-(4).

NOTE: The VistA referral code is a restricted menu option that is available only to the revenue supervisor. A mandatory comment will be entered into this option and it will contain the date, time and name of the person the revenue supervisor spoke with at the RC.

- b. Individual third-party receivable cases should not be closed in the VistA accounts receivable package. If appropriate, the RC will forward such receivables to OGC to review for possible litigation. Documentation will be submitted with all referrals to the RC.
- c. Reasons Not to Refer to RC. Third-party claims will not be referred to the RC for the following reasons unless the revenue supervisor has consulted with the RC and the RC has agreed to accept the referral:
 - (1) 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.
 - (2) 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.
 - (3) Insurance Deductibles. The claim was approved or partially approved, but the payment was applied to the deductible.
 - (4) 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 limit on the number of outpatient visits for mental health allowed each calendar year.

(5) Reasonable and Customary Rates. The insurance company has paid on the basis that their rates are the same as what is paid to other providers in the community and demonstrated that to VA's satisfaction.

(6) Length of Stay. The insurance company pays on the basis of an appropriate determination of length of stay and the Veteran's stay extends beyond the terms of the insurance policy.

(7) 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 the level that was medically necessary.

C. Third-Party Receivables Under the Jurisdiction of the Regional Counsel. VA collects certain accounts receivable from appropriate third-parties under the jurisdiction of the RCs.

1. Claims Generation. The billing office will prepare claims, addressed to the appropriate RC, to recover payments from third-parties for accounts receivable established for Tortfeasor, Workers' Compensation (non-Office of Workers' Compensation and Pension) and No-Fault Auto Insurance claims. The claims will be audited and forwarded to the RC for appropriate action.

2. Claims Follow Up. RCs will follow up on un-paid accounts receivable under their jurisdiction.

3. Payments. RCs will forward all payments, on the same day received, for immediate deposit to the Agent Cashier at the CPAC where the charges originated. The transmittal notice to the Agent Cashier will clearly state that the amount received is full or partial settlement and will list the related charges.

a. If a payment is received at a CPAC or facility, the CPAC or facility will contact the RC and funds will be deposited without being sent to the RC.

b. All accounts paid in full will result in a closed case.

4. Decreases. Unpaid third-party accounts receivable will be decreased to zero if they meet one or both of the following criteria:

a. Payment is accepted for less than the amount of the original claim as a compromise; or

b. Claim has been referred to the RC for review and advice as to how to handle collection procedures, no response or payment is received, and the RC advises that the claim amount is uncollectible.

D. Multiple Category Claims Processing.

1. Co-payments and Reimbursable Insurance. If a Veteran's medical care appears to qualify for reimbursable insurance and co-payment, the charges for co-payments will be placed on hold for 90 days, pending payment from the third-party payer. If no payment is received within 90 days, the charges will automatically be released and a statement will be generated to the Veteran.

a. For insurance company payments, the amount of the payment for the specific episode of care on a particular date of service will be applied to the first-party bill for the same episode of care and date of service.

b. The EOB should be examined carefully to ensure appropriate accounting of remittance.

c. The Veteran is then billed for the portion of the co-payment not covered by the insurance reimbursement and the portion of the co-payment for any services not covered by third-party insurance.

2. Non-Federal Workers' Compensation, Tortfeasor and No-Fault Auto and Co-payment. The claims activity will prepare a claim to the third-party payer for all the medical care provided for non-Federal Workers' Compensation, Tortfeasor and No-Fault Auto claims and will bill the Veteran for the co-payment at the same time. The claim form for non-Federal Workers' Compensation, third-party Tortfeasor and No-Fault Auto claims will include the following statement: "Gross amount includes the co-payment." If the Veteran pays the co-payment and all or a portion of the co-payment is recovered from the third-party payer, a refund to the Veteran is to be made promptly.

E. Recording Third-Party Receivables when there are multiple third-party payers.

1. When a bill is generated, an accounts receivable is recorded for the claim rendered for third-party medical care, including Workers' Compensation, No-Fault Auto, Tortfeasor, reimbursable insurance cases and medical riders on a patient's homeowners' policy.

2. Payments received for less than the claim amount, accepted as full settlement of the claim, are to be contractually adjusted and closed.

3. The revenue staff will ensure that duplicate payments are not received for the same episodes of care through a Coordination of Benefits (COB) review of accounts receivable. COB is a common provision in most health benefit plans and the majority of health benefit plans use the benefit determination rules established by the National Association of Insurance Commissioners. A COB duplicate payment may occur 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. In this instance, the Veteran's primary plan is a secondary payer and payment, if any, is based on the payment that was 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:

- A non-duplication COB provision, in which the secondary claim payer pays the difference between the normal allowed amount and the primary carrier's payment; and
- A COB provision 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 COB requirements in many plans, as well as in state law, may create an obligation to refund.

In all such cases, the RC, who has jurisdiction of Tortfeasor, non-Federal Workers' Compensation and No-Fault Auto claims, should be consulted for determination of these issues. The fiscal officer is responsible for ensuring that VA has not received two payments for the same episode of care or medications and the COB review.

0506 DEFINITIONS

050601 Close-out. Occurs when an agency, after determining that additional future collection efforts on a debt would be futile, reports the amount of a terminated debt to the Internal Revenue Service (IRS) as potential income to the debtor on Form 1099-C, Cancellation of Debt. For debts that are not reportable to IRS, close-out never actually occurs.

050602 Compromise. An offer and acceptance of a partial payment in settlement and full satisfaction of the offeror's indebtedness, as it exists at the time the offer is made. It is a final settlement, binding on the parties to the compromise, unless procured by fraud, misrepresentation of a material fact, or mutual mistake of fact.

050603 Co-payment. A fixed fee charged to a Veteran who receives health care (inpatient, outpatient, extended care) and/or medications provided by VA or obtained by contract.

050604 Consolidated Patient Accounts Center (CPAC). A [Congressionally-mandated program](#) that consolidated traditional VHA business office functions into [seven regional centers](#). This initiative is transforming VHA billing and collections activities by deploying industry-proven methods, processes, business tools and increased accountability at all levels of the organization.

050605 Debts. Claims for money made by or owed to the Government, arising out of activities of VA. Third-party receivables (health insurance, Tortfeasor, non-Federal Workers Compensation, and No-Fault Auto claims) are not considered debts.

050606 Delinquent. In the case of most administrative debts (e.g., overpayments), delinquency occurs when payment is not made in full or when an acceptable repayment plan is not established by the due date specified in the initial billing notice (usually 30

calendar days from the date the Notice of Indebtedness is mailed). For first-party medical care debts, delinquency occurs 30 calendar days after a charge first appears on a Patient Statement. In the case of a debt being paid in installments, delinquency occurs when payment is not made by the end of the “grace period” as established in the repayment agreement.

050607 Due Process. Due process in the administration of VA benefits informs the beneficiary of a proposed adverse action that could reduce or terminate benefits (VA’s debt collection process); and provides the beneficiary with the opportunity to provide additional evidence to contest the action and/or hold a hearing before VA decision-makers. ([M21-1 MR, Part 1, Section 2](#))

050608 First-Party Co-payment Debt. A debt owed by an individual resulting from the provision of medical care or services under the authority of [38 U.S.C. Chapter 17](#). These debts include prescription co-payments, inpatient and outpatient co-payments, per diem charges for hospital care or nursing home care and debts resulting from the provision of care on a humanitarian basis or to individuals who are not eligible for VA medical benefits.

050609 Medicare Fiscal Intermediary. An entity that processes Medicare remittances received from VA.

050610 Offset. The collection of a debt, in part or in full, from moneys a debtor is currently receiving or may receive in the future from the Government.

050611 Suspension. Temporary stoppage of collection actions on a debt owed to VA until some future predetermined time(s) when collection action will be resumed.

050612 Termination of Collection Action. Refers to a decision made to cease active collection action on a debt, in accordance with criteria set out in the Federal Claims Collection Standards, because such action is not economically worthwhile or is otherwise inappropriate. The Federal Claims Collection Standards do not apply to third-party receivables (health insurance, Tortfeasor, non-Federal Workers Compensation, and No-Fault Auto claims).

050613 Third-Party Claims. Claims against a third-party (i.e., insurance company, workers’ compensation carrier, employer or other responsible person) for reimbursement to VA for the cost of treating a Veteran for a condition when that party is obligated to provide or pay the expenses of such treatment.

050614 Tortfeasor. A person who commits a civil wrong (breach of a legal duty) which results in damage to another person.

050615 Treasury Offset Program (TOP). Program required by the Debt Collection Improvement Act of 1996 to recover all referred agency debts delinquent more than 120 days, by offset of tax refunds and other Federal payments, including salary offsets,

Federal retirement offsets or vendor offsets. Third-party receivables (health insurance, Tortfeasor, non-Federal Workers Compensation and No-Fault Auto claims) will not be referred to TOP.

050616 Veterans Health Information Systems and Technology Architecture (VistA). The automated environment supporting day-to-day operations at local VA health care facilities. It is built on a client-server architecture, which ties together workstations and personal computers with graphical user interfaces at VHA facilities, as well as software developed by local VHA medical facility staff. VistA includes the links that allow commercial off-the-shelf software and products to be used with existing and future technologies.

050617 Veterans Integrated Service Networks (VISN). The networks of medical centers, Veterans centers and outpatient clinics offering primary and specialized care, managing nursing homes, readjustment counseling, Veterans centers and domiciliaries. These networks are grouped into 21 geographic regions.

050618 Waiver. A decision that conditions exist, under the applicable statutes ([38 U.S.C. 5302](#) and [5 U.S.C. 5584](#)) and implementing regulations (38 CFR 1.955-1.969, 17.105) that prohibit recovery by VA of certain debts as defined in the statutes and regulations, including interest and other late payment charges assessed on such debts. The statutory reference above does not apply to third-party receivables (health insurance, Tortfeasor, non-Federal Workers' Compensation, and No-Fault Auto claims).

050619 Write-Off. Occurs when the agency determines that the debt has no value for accounting purposes. All debt will be reserved for in the allowance account and all write-offs will be made through the allowance account. Under no circumstances are debts to be written off directly to expense.

0507 RESCISSIONS

This chapter rescinds VA Financial Policy Vol. XII Chapter 5, dated November 2012.

0508 QUESTIONS

Questions concerning these financial policies and procedures should be directed as follows:

VHA
All Others

VHA Accounting Policy (10A3A) (Outlook)
OFP Accounting Policy (Outlook)

0509 REVISIONS

Section	Revision	Office	Reason for Update	Effective Date
0503 Authority and References	Updated to include addition of 050317 Digital Accountability and Transparency Act (DATA Act) with Link	OFP (047G)	To comply with new Law	July 2016
050617 Treasury Offset Program (TOP)	Updated to reflect mandatory change of 180 days to 120 days	OFP (047G)	To comply with new Law	July 2016
0509 in Table of Contents and Revisions	Updated to include addition of Revisions within Table of Contents and REVISIONS section of policy.	OFP (047G)	To highlight chapter changes	July 2016

APPENDIX A: UNPAID REIMBURSABLE THIRD-PARTY INSURANCE CASE – REIMBURSEMENTS DEPOSITED TO MCCF

The following table provides guidelines for follow-up on unpaid reimbursable third-party insurance cases where reimbursements are deposited to the Medical Care Collection Fund (36 5287), to include both medical and pharmacy. All references to days for follow-up are calendar days. If a follow-up timeline falls on a weekend or Federal holiday, the follow-up would move to the next business day. In addition, if a partial payment has been received, the residual balance is used to determine the dollar category for additional follow-ups. All action taken will be clearly documented in VistA Third-Party Joint Inquiry (TPJI) menu.

DOLLAR VALUE	FIRST FOLLOW-UP	ADDITIONAL FOLLOW-UPS
<\$51	No Follow-up unless resources permit.	No follow-up unless resources permit.
≥\$51 to <\$250	1 st Follow-up within 90 days after the initial bill was generated. The follow-up may consist of a bill re-submission based on no initial response from payer within 90 days from day of bill submit. If a response has been received from the payer then a follow-up phone call/ web site review should be done. Comments will be added to CPAC workflow tool/TPJI with an appropriate tickle time for subsequent follow-up if required	One additional follow-up based on results of the previous follow-up which will be documented in the VistA Third-party Joint Inquiry (TPJI) menu. When a follow-up query is made, a comment with the follow-up date should be entered into the TPJI menu.
≥\$250 to <\$1,500	1 st Follow-up within 60 days after the initial bill was generated.	One additional follow-up based on results of the previous follow-up which will be documented in the VistA TPJI menu. When a follow-up query is made, a comment with the follow-up date should be entered into the TPJI menu.

≥\$1,500	1 st Follow-up within 45 days after the initial bill was generated.	Additional follow-up based on results of the previous follow-up which will be documented in the VistA TPJI menu. There will be at least two additional follow-ups after the first follow-up if payment is not received. When a follow-up query is made, a comment with the follow-up date should be entered into the TPJI menu.
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APPENDIX B: FUNDS FOR DEPOSITS AND REFUNDS AND ASSOCIATED ADMINISTRATIVE FUNDS

The following table depicts the funds used for deposits and refunds for Medical Care Collections and the associated administrative funds.

RECEIVABLE TYPE	FUND COLLECTIONS DEPOSITED	FUND REFUNDS RECORDED
Administrative Charges Paid on Receivables	36_3220	20X1807
Extended Care Co-payments (Long Term Care)	36X528709	36X528709
First-party Medication Co-payments	36X528701	36X528701
First-party Medical Care Co-payments	36X528703	36X528703
Funds Deposited to Suspense	36F3875	36F3875
Interest Paid on Receivables	36_1435	20X1807
Marshall Fee and Court Cost	36X0869	36X0869
Third-Party Reimbursable Insurance (includes non-Federal Workers' Compensation, Tortfeasor and No-Fault Automobile Insurance claims)	36X528704	36X528704
Third-Party Payer for Prescription Claims	36X528711	36X528711
Treasury Offset Program (TOP) Fee	None	36X0160X4

APPENDIX C: WRITE-OFFS, DECREASES, AND TERMINATION OF THIRD-PARTY ACCOUNTS RECEIVABLE (AR) BALANCES IN MEDICAL CARE COLLECTIONS FUND (MCCF) ACCOUNTS

This VHA Appendix defines the procedures involving decreases in and termination of third-party accounts receivable (AR) balances in Medical Care Collections Fund (MCCF) accounts at all CPACs/facilities. It outlines specific responsibilities of VHA management in ensuring that all VHA financial transactions conform to generally accepted government accounting principles. The procedures in this Appendix apply to all VHA entities. Further operational instructions for AR management can be found on the Chief Business Office (CBO) website: <http://vaww1.va.gov/CBO/accrec/guides.ASP>.

VHA staff is responsible for supporting the VHA CFO, who is obligated under the CFO Act of 1990 to ensure that appropriate procedures are followed for the termination of collection activity and close-out of medical care debts.

VHA management must create an environment of appropriate internal controls in accordance with the Office of Management and Budget (OMB) Circular A-123, which defines internal control as an integral component of organizational management.

VHA ROLES AND RESPONSIBILITIES

A. VHA MANAGEMENT RESPONSIBILITIES

1. CFO.
 - a. All financial practices;
 - b. Developing and reporting of VHA financial management standards;
 - c. Development of training materials for VHA finance staff;
 - d. Collaborating with the CBO in designing and implementing national monitoring and auditing procedures, appropriate internal control mechanisms, and performance measures; and
 - e. Collaborating with the CBO and Chief Compliance and Business Integrity Office (CBIO) in developing AR Performance Measures.
2. CBO:

- a. Ensuring that activities associated with the generation and management of Revenue Cycle activities at the CPACs comply with the standards and requirements articulated in the related financial policy;
- b. Developing and distributing appropriate training for CPAC/MCCF staff involved in billing and AR duties;
- c. Developing and distributing appropriate revenue program standards;
- d. Developing and distributing guidance in conformance with VA and VHA financial policy;
- e. Assisting the CFO in designing and implementing national monitoring and auditing procedures, appropriate internal control mechanisms, and performance measures; and
- f. Developing AR Performance Measures (along with the CBIO and CFO).

3. CBIO

- a. Training staff in business integrity and collaborating with the CBO and CFO in the maintenance of appropriate financial auditing practices;
- b. Monitoring and reporting the AR Performance Measures; and
- c. Developing AR Performance Measures (along with the CBO and CFO).

4. Veterans Integrated Service Network (VISN) Director:

Ensuring that facilities have appropriate internal controls in place and are in compliance with all financial transaction standards and guidance, regardless of the organizational design, location, or organizational element responsible for conducting AR activities.

5. VISN Financial Quality Assurance Manager (FQAM):

Performing the necessary audit activities associated with this Handbook and reporting the results of the monitoring to both the local and VISN CBI committees, the CFO, and the CBO.

6. CPAC Director:

- a. Establishing applicable internal controls; and

b. Ensuring that financial staff members are aware of all applicable regulations and standards and for performing these actions irrespective of organizational alignment and/or operational responsibility assignment of AR activities.

7. CPAC Accounts Management Manager:

a. Collaborating with CPAC leadership, internal controls, quality assurance and Fiscal staff to ensure all AR staff performing financial transactions comply with applicable regulations, policies, and directives; and

b. Accomplishing internal monitoring activities as a routine component of business operations.

8. Facility and CPAC Fiscal Officers:

a. Ensuring that all staff responsible for accomplishing financial transactions is adequately trained;

b. Ensuring transactions comply with established internal controls;

c. Ensuring financial activities conform to all established requirements; and

d. Ensuring CPAC and facilities comply with the Service Level Agreement.

B. GENERAL MEDICAL CARE THIRD-PARTY AR BUSINESS RULES THAT APPLY ONLY TO THIRD-PARTY RECEIVABLES:

1. If payment is not received by follow-up date as prescribed in Appendix A, accounts management staff must make management aware of the delinquent AR. **NOTE:** *Staff is reminded that all follow-up activities must be documented within the appropriate Veterans Integrated Systems Technology Architecture (VistA) option.*

2. General Counsel and Regional Counsel are the only VA entities allowed to determine if an AR is uncollectible. Until General Counsel or Regional Counsel make that determination, the AR must reflect the actual value of the services rendered remaining uncollected.

3. If staff desires to utilize the services of an outside collection agency for collection of third-party AR the following guidelines must be followed:

a. The receivable is not to be sent to an outside source for collection before the end of the follow-up period described in appendix A.

b. When an outside source for collection determines that no further collection is

possible (e.g. the care was not pre-authorized or pre-certified as required by the insurance company; medical treatment was not a medical necessity within the policy guidelines; it was paid based upon usual and customary rates in the community for the care provided; etc.), the CPAC needs to follow the recommendation, and the balance of the claim is to be contractually adjusted down.

- c. If a receivable has been referred to an outside agency for collection and the CPAC Accounts Management Manager disagrees with the contractor's recommendation, the Accounts Management Manager needs to contact Regional Counsel for guidance, in accordance with paragraph 050502, B.4.a.
- d. Staff must not decrease the balance of third-party AR prior to, or subsequent to, referring the receivable to an outside source for collection.
4. Third-party AR reduced to a \$0 balance in error must be re-established in AR with a comment in Third-Party Joint Inquiry (TPJI) as to the reason for the re-establishment with necessary follow-up action or referral to Regional Counsel, as appropriate.
5. Generally, increasing the principal balance of AR beyond the original amount for which the AR was established is not permitted. A review of the explanation of benefits (EOB) needs to be conducted to determine if an amount received in excess of the billed charges is:
 - a. The usual and customary payment from the third-party payer in the same geographic area in which the medical care or services were provided and the third-party payer chooses not to pay the less billed charges; or
 - b. The result of a third-party payer re-bundling the coding for the originally submitted claim in accordance with their reimbursement and utilization review policies, thereby resulting in a higher payment to VA.
6. Employees responsible for collecting revenues will not maintain or be in a position to adjust related accounts receivable records.
7. The Fiscal Year-End Financial Reports and Statements Certification² require certification that all ARs are correct as of September 30. To support this certification each facility must have documentation to support every receivable that is established and subsequent adjustments, deposits, and write-offs.

C. EXAMPLES OF APPROPRIATE AND INAPPROPRIATE THIRD-PARTY AR ADJUSTMENTS

² For further information, refer to [Volume VII Chapter 2 Consolidated Financial Statements, dated June 2012](#).

1. Appropriate reasons for decrease adjustments to third-party AR:
 - a. Partial payment received, and the payment received is the full amount expected from the insurance carrier. AR status will be Collected or Closed.
 - b. Usual and customary payment received. AR Status will be Collected or Closed.
 - c. Payment was applied to Veteran's deductible (any remaining AR billed to the insurance company will be closed). AR Status will be Collected or Closed.
 - d. Treatment does not meet medical necessity (this claim should be re-submitted to Revenue Utilization Review (RUR) prior to any decrease to file appeal and if there is no appeal it will be closed).
 - e. Insurance was not in effect for the time billed. AR Status will be Canceled.
 - f. Services are not covered under policy. AR Status will be Canceled.
 - g. Procedure is not a covered service. AR Status will be Canceled.
 - h. Procedure is not authorized (this claim should be re-submitted to RUR prior to any decrease to file appeal and if there is no appeal it will be closed).
 - i. Medicare Part A deductible was previously paid to another provider. Status will be Collected or Closed.
2. Examples of appropriate decrease adjustments are provided below:
 - a. A claim is issued to the insurance company for \$100. An EOB is received from the insurance company listing a payment of \$80 for this claim. After a review of the insurance coverage which determined that the company pays at 80 percent of allowed charged, the \$80 payment will be posted to the bill and \$20 will be contractually adjusted with a collected/closed status. Comments entered into VISTA's Third-party Joint Inquiry (TPJI) will provide clear and unambiguous meaning of actions taken. Suggested Comment: Paid at 80 percent of allowable charges.
 - b. A claim is issued for \$100. EOB received with information that insurance will only pay 80 percent of the allowable charge. According to the insurance company, allowable charge was \$50. Payment received was \$40, which is 80 percent of \$50, the allowable charge. The amount of \$40 will be posted to the bill and \$60 will be contractually adjusted with a collected/closed status. Comments entered into VISTA's Third-party Joint Inquiry (TPJI) will provide clear and unambiguous meaning of actions taken. Suggested Comment: Paid at 80 percent of allowable charge of \$50.

- c. A claim is issued for \$150. EOB received stating that the insurance was not in effect for the treatment period. AR needs to be decreased with a status of canceled. Comments need to be entered into TPJI and the Insurance and the Billing Office needs to be notified to followup and determine if the patient changed or canceled coverage. Comments entered into VistA's TPJI will provide clear and unambiguous meaning of actions taken. Suggested Comment: Insurance not in effect.

NOTE: All decreases must have a comment as to the reason for the decrease. CPAC should also refer to the Accounts Receivable Third-Party Guidebook for additional guidance.

3. An example of an inappropriate decrease adjustment for third-party AR is:

A claim is generated to the insurance carrier for outpatient care in the amount of \$150. Follow-up notices were sent with no response from the insurance carrier. TPJI does not indicate any other type of follow-up, such as phone calls or e-mails. Six months after the claim was generated and no payment was received from the insurance carrier, the claim was written off by the Fiscal Officer as "inability to collect." The Fiscal Officer does not have authority to write-off any third-party claim. General Counsel and Regional Counsel are the only entities that have write-off authority. Any bill that was written off, or decreased to zero due to the inability to collect, or was not cost effective to collect, needs to be re-established and continued follow-up needs to be maintained.

4. Examples of inappropriate increase adjustments for third-party AR are provided below:

- a. The patient is covered by a Medigap policy and receives inpatient treatment. A claim is generated in the amount of \$68,000 and issued to Fiscal Intermediary. A Medicare-equivalent Remittance Advice (MRA) is received from Fiscal Intermediary indicating the patient's responsibility is \$952. The claim and MRA are forwarded to the Medigap carrier. A receivable is established in VistA for \$952. Payment is received from the carrier in the amount of \$31,000 (an overpayment). The AR staff increases the principal balance of the receivable from \$952 to \$31,000 in order to retain the overpayment. No authority existed to increase the principal balance of the receivable. The AR staff should have applied the \$952 to the insurance bill, applied \$30,088 to suspense (36X3875), and initiated an action to refund the overpayment of \$30,088.
- b. A claim is issued to an insurance carrier for \$1,240. A third-party receivable is established in VistA (528704). The Fair Claims Practices regulations require the insurance carrier to pay interest on the reimbursable amount if the carrier doesn't adjudicate the claim within 45 days. The insurance carrier pays \$1,364. The AR staff increases the principal balance of the receivable from \$1,240 to \$1,364 to accommodate the interest payment. Interest payments need to be deposited to the General Fund Receipt account (36 1435). It is inappropriate to increase the

principal balance of the debt to accommodate the interest payment.

- c. A claim is issued to an insurance carrier for \$120 for Mr. Smith. VA receives payment in the amount of \$300. Upon receiving the payment, the AR staff contacts the insurance carrier for an explanation of their payment of the claim. The insurance carrier representative states “Yes, we overpaid VA on that claim by \$180; however, we don’t need a refund, because we have offset your claim for treating another patient.” The AR staff increases the principal balance of Mr. Smith’s claim by \$180, thereby retaining the overpayment, and decreases the balance of the other patient’s claim by \$180, bringing the balance to zero. VA facilities may not adjust third-party claims in order to accommodate insurance carrier offset preferences. The correct action is to refund the overpayment of \$180 for the first claim.

5. Examples of appropriate increase adjustments for third-party AR are provided below:

- a. A claim is issued to an insurance carrier for \$75. VA receives a payment in the amount of \$100. It is determined that the billed amount for the Current Procedural Terminology (CPT) codes billed was less than the insurance company’s usual and customary payment for this specific geographic area, and their payment methodology does not allow for the payment of the lesser charges billed. The AR staff must increase the balance of the third-party claim up to the amount of the carrier’s payment and apply the payment to the claim. The AR staff must document the contact with the carrier representative in TPJI and add a comment as to the payment methodology of the carrier.

NOTE: Payment methodology information needs to be forwarded to insurance staff so they can add carrier or plan comments to the insurance file for this carrier or plan.

- b. A claim is issued to an insurance carrier for \$250. VA receives a payment in the amount of \$400. It is determined that the insurance company re-bundled the coding of the originally submitted claim in accordance with their reimbursement and utilization review policies and made payment reflective of their policies. The AR staff must increase the balance of the third-party claim up to the amount of the carrier’s payment and apply the payment to the claim. The AR staff must document the contact with the carrier representative in TPJI and add a comment as to the payment methodology of the carrier.

NOTE: Payment methodology information needs to be forwarded to insurance staff so they can add carrier or plan comments to the insurance file for this carrier or plan.