

MEDICAL CARE DEBTS

- 1. REASON FOR ISSUE:** To revise and republish in its entirety VA Handbook 4800.14, Medical Care Debts, which was originally published on December 8, 2003.
- 2. SUMMARY OF CONTENTS/MAJOR CHANGES:** This handbook establishes guidelines for the collection of debts resulting from the receipt of VA medical care or services. Major changes include clarification of appropriate accounts for deposit of collections in paragraph 3, revision of follow-up procedures on third-party debts in paragraph 4, and several other revisions. Revised material is not within brackets.
- 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 Handbook 4800.14, Medical Care Debts, December 8, 2003.

CERTIFIED BY:

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

/S/
Robert T. Howard
Assistant Secretary for Information
and Technology

/S/
Robert J. Henke
Assistant Secretary for Management

MEDICAL CARE DEBTS

CONTENTS

PARAGRAPH	PAGE
1. PURPOSE AND SCOPE	5
2. RESPONSIBILITY	5
3. GENERAL	5
4. THIRD-PARTY RECEIVABLES UNDER FISCAL ACTIVITY JURISDICTION	6
5. THIRD-PARTY RECEIVABLES UNDER REGIONAL COUNSEL JURISDICTION	10
6. FIRST-PARTY COPAYMENTS	10
7. CLAIMS PROCESSING UNDER TWO OR MORE CATEGORIES	11
8. RECORDING THIRD-PARTY ACCOUNTS RECEIVABLE	12
9. BILLING FOR INELIGIBLE/EMERGENCY MEDICAL CARE OR TREATMENT	13

MEDICAL CARE DEBTS

1. PURPOSE AND SCOPE. This handbook establishes standardized Departmentwide 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 is solely responsible and accountable for all requirements outlined in this handbook, regardless of the organizational alignment of the unique functions or activities, and therefore 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 tortfeasor 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 Medical Services 36_0160. Funds collected for CHAMPVA, recoupment from CHAMPVA ineligible, or other CHAMPVA collections should be credited to Medical Services 36_0160 for the fiscal year in which they were collected. However, any CHAMPVA collections recovered under the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.) must be credited to 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 certain veterans who receive inpatient or outpatient health care 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 inpatient 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. 38 U.S.C. 1710B (Pub. L. 106-117) requires that VA collect certain fees referred to as *copayments* from certain veterans who receive extended care services. All funds collected for the copayments and for the additional per diem charges are to be credited to VA's MCCF 36_5287.

d. 38 U.S.C. 1722A (Pub. L. 101-508, Pub. L. 102-568 and Pub. L. 106-117) requires that VA charge certain 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 are exempt from the copayment 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; or treated under certain other special authorities; or 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. 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 Universal Billing (UB 92s) and Centers for Medicare and Medicaid Services (CMS) 1500, to notify appropriate third parties of accounts receivable (AR) established for VA-provided reimbursable medical care. The billing unit may be local and consolidated within the Fiscal activity or separate and distinct from the Fiscal activity, or it may be a regional function. Regardless, the Fiscal activity is responsible for the billing accuracy.

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

(3) Medical record documentation, such as the 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) For bills \$250 and over, the first telephone or online query follow-up should be initiated within 45 days after the initial bill was generated. If necessary, a second follow-up should be initiated within 21 days following the first follow-up. If necessary, a third follow-up should be initiated within 14 days following the second follow-up. When a telephone or online query follow-up is made, a bill comment with an appropriate follow-up date should be entered. Enter the comments in the third-party joint inquiry (TPJI) menu in VistA. If no payment is received within 7 days of the third follow-up, refer the bill to the VA medical center (VAMC) senior management official responsible for collection of the bill. This official will determine the next appropriate action, including possible referral to the Regional Counsel (RC) of jurisdiction, in accordance with paragraph 4d.

(b) For bills ranging from \$10 to \$249.99, the first telephone or online query follow-up should be initiated within 60 days after the initial bill was generated. If necessary, a second follow-up should be initiated within 30 days following the first follow-up. If necessary, a third follow-up should be initiated within 14 days following the second follow-up. When a telephone or online query follow-up is made, a bill comment with an appropriate follow-up date should be entered. Enter the comments in the TPJI menu in VistA. If no payment is received within

7 days of the third follow-up, refer the bill to the VAMC senior management official responsible for collection of the bill. This official will determine the next appropriate action, including possible referral to the RC of jurisdiction, in accordance with paragraph 4d.

(c) For bills under \$10, no telephone or online query follow-up is required. However, if workload permits, one phone call or online query should be made 60 days after the initial bill was generated.

(d) If the claim was submitted to a Medicare contractor and no response has been received within 30 days after submission, then stations are required to follow up with the Medicare contractor by telephone or online inquiry.

(2) In all cases, 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. If follow-up was conducted via an online query, this should also be documented. Written documentation within the defined follow-up system (Bill Comment Log) will be the only approved record of follow-up activity.

(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 ensure that the appropriate payment was applied to the correct receivable.

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

- (a) Claim form was not completed properly.
- (b) Additional information is required to process the claim.

(5) Monies Paid to Subscriber. Contact the third-party payer for reimbursement. The veteran may also need to be contacted. 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 audit trail. Written documentation within the Bill Comment Log 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.

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

(6) Claim Payment 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 or contract staff. If the denial correctly identifies a billing error involving patient registration or demographic data,

including specifics of the veteran's insurance coverage (verification), then AR staff are to 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 MCCF staff is to contact the third-party payer by telephone to request reconsideration of this denial. Following reconsideration, if the third-party payer agrees the claim denial was in error, the claim may need to be resubmitted to the third-party payer. If the third-party payer maintains that the claim denial was justified, the VAMC 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 nonresponse. Written documentation within the defined follow-up system (Bill Comment Log) will be the only approved record of follow-up activity. If the case has been referred to a contractor for collection, the MCCF Coordinator should contact the RC for guidance, in accordance with paragraph 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.

(8) In all cases involving the write-off of any debt, the Fiscal activity is solely responsible and accountable to ensure that all write-off activity conforms to the applicable regulations and directives.

c. Payment.

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

(2) Partial Payment. Payment by a third-party payer of an amount 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 AR, the MCCF staff or contract 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 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 be resubmitted immediately 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, he/she should request advice from the RC.

d. **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 problem cases. These cases should not be closed in the VistA AR package. 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 all required recovery efforts have been made by the MCCF staff, third-party claims are referred to the RC for appropriate action under the following conditions:

(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) Veteran Fails to Respond to Insurance Carrier Request for Information. Refer bill if veteran fails to respond to insurance carrier requests for information, such as claim form to be completed.

(f) 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 available only to the MCCF Coordinator at a VAMC. Also, a mandatory comment box must be added to this option, and it must contain the date, time, and name of the person the MCCF Coordinator spoke with at RC.

(2) Reasons Not to Refer to RC. Third-party claims will 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.

(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 limit on the number of outpatient visits for mental health allowed each calendar year.

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

(f) Length of Stay. The insurance company pays on the basis of an appropriate determination of length of stay, and the veteran has a stay that extends 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 the level that was medically necessary.

5. THIRD-PARTY RECEIVABLES UNDER RC JURISDICTION

a. Claims Generation.

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

(2) The billing office forwards claims for tortfeasor 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 AR under their jurisdiction.

c. Payments.

(1) The RC must forward all payments, on the same day they are received, for immediate deposit to the Agent Cashier at the station 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 AR 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 4d.

6. FIRST-PARTY COPAYMENTS (INPATIENT, EXTENDED CARE SERVICES, OUTPATIENT, MEDICATION, AND PER DIEM COPAYMENTS). It is important to provide information to veterans regarding their responsibilities for copayments and give them the opportunity to satisfy these obligations at the Agent Cashier's office 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. Once a claim is generated, 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. If patients have no additional activity on their account, they receive only three statements. The statements do not continue to print once a patient has gone through three statement cycles with no activity.

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) Unpaid first-party copayment debts will be referred monthly to the Department of the Treasury for the Treasury Offset Program (TOP). Facility revenue staffs have an obligation to ensure that no copayment referral is made for veterans with a service-connected rating of 50 percent or greater or for those in receipt of VA pension. The total amount of the debt owed by the individual must be \$25 or more. The debt will be referred to TOP after three statements have been sent, the debt has been rejected by the Debt Management Center as not having an available compensation and pension debt to offset, and the debt is at least 180 days delinquent. Accounts in referral status to the Department of Justice (DOJ) will not be referred to TOP.

c. **Referrals to the RC/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. Write-off of any copayment debt may be accomplished by delegation to the revenue program, but the responsibility and accountability remains with the Fiscal activity.

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) If the cost of a veteran's medical care appears 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 corresponding copayment. However, to ensure appropriate accounting of remittance, 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/Tortfeasor 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/tortfeasor 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/revenue activity will record a firm receivable for claims rendered for third-party medical care, including workers' compensation, no-fault, tortfeasor, and reimbursable insurance cases, and medical riders on a 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, chapter 2, section D, paragraph 2D.03, General Fund Receipts.

b. The Fiscal/revenue 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 majority of health benefit plans use the benefit determination rules established by the National Association of Insurance Commissioners. A COB duplicative payment 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. 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. The first is 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. In the second, 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 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 17.102. 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, 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 or if the veteran refuses to complete and sign the appropriate VHA registration and enrollment forms. 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).