CMS Medicare Manual System
Pub. 100-6 Financial Management

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2436

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
4		**70.7.3**	
		70.7.4	
		70.15.2	

Red italicized font identifies new material.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2003
IMPLEMENTATION DATE: July 1, 2003

Medicare contractors only: these instructions should be implemented within your current operating budget. CMS will allow Systems Maintainers to make system changes to comply with these instructions.

Section 70.7.3 Intermediary Claims Accounts Receivable (A/R) – Provides instructions to intermediaries to identify, recommend for termination of collection action and write-off closed, or demand and pursue collection of intermediary claims A/R, including referral to cross servicing.

Section 70.7.4 Physician/Supplier Overpayment Reporting (PSOR) System Summary Entry Debts - Addresses the delinquent overpayments, with a principal balance greater than or equal to $25, listed in the PSOR summary entries and provides instructions to carriers for identifying this debt for termination of collection action and write-off closed or referral to cross servicing.

Section 70.15.2 Financial Reporting for Intermediary Claims Accounts Receivable (A/R) – Provides instructions for financial reporting for intermediary claims A/R addressed in §70.7.3.

These instructions are being manualized to conform to the new Internet only manual process. Contractors will continue to follow debt referral instructions for overpayments.

70.7.3 - Intermediary Claims Accounts Receivable (A/R)
(Rev. 13, 02-03-03)

Intermediary claims A/R arises from adjustments in the intermediary's claim processing systems (this type of adjustment may also be referred to as a carryover adjustment). The adjustments may be the result of duplicative processing of a claim, payment of a claim at the wrong Diagnostic Related Group (DRG) rate, a request from a provider, or for any reason an intermediary adjusts a claim payment. These adjustments are usually recovered through recoupment and the recovered amounts are included in the remittance advices to the providers. If the overpayment has not been recouped, the balance remains outstanding and is reported on the intermediary's financial records.

The CMS has determined that these types of debt are eligible for referral for cross servicing/Treasury Offset Program (TOP). The following outlines procedures for referral/collection/termination of collection action and write-off closed of these debts. Intermediaries will use these procedures to:

- *Address the current inventory of intermediary claims A/R.*
- *Demand and refer delinquent intermediary claims A/R as part of their on-going debt collection procedures.*

To identify and address the current inventory of outstanding intermediary claims A/R and to identify, on an ongoing basis, claims A/R to be demanded or recommended for termination of collection action and write-off closed, intermediaries must be able to separately identify the following:

- *Claims A/R, of any amount, regardless of age, that cannot be validated.*
- *Claims A/R, for an individual provider, totaling less than $25 for the aggregated principal balance, where no adjustment/recoupment has occurred in the past 60 days.*
- *Claims A/R for an individual provider, greater than 10 years old, regardless of amount.*
- *Claims A/R, for an individual provider, with an aggregate principal balance greater than or equal to $25, which is less than 10 years old, and no adjustment/recoupment has occurred in the past 60 days.*

After these separations are made, the following procedures will be followed:

For Recommendation of Write-Off (Termination of Collection Action):

When recommending write-off (termination of collection action), intermediaries will follow instructions as outlined in the overpayment section of this manual, which begins at §100.

- *Claims A/R for an individual provider, totaling less than $25 for the aggregated principal balance, where no recoupment has occurred in the past 60 days, should be recommended for termination of collection action and write-off closed. A listing should be forwarded to the regional office (RO) which contains the following information:*

    - *Provider number;*
    - *Provider name;*
    - *Amount of claims A/R being requested for termination of collection action and write-off closed;*
    - *Date of claims A/R;*
    - *Date of last activity; and*
    - *Reason for requesting/recommending termination of collection action and write-off closed.*

- *Claims A/R, of any amount, regardless of age that cannot be validated, should be recommended for termination of collection action and write-off closed. This could include claims A/R received as a result of a Medicare contractor transition where no remittance advices are available, and other claims A/R where no remittance advice is available to support the balances. The intermediary must make a concerted effort to validate the claims A/R before selecting this option. A listing of this claims A/R must be forwarded to the RO for approval. The list should contain the same information as above, with the reason for termination of collection action and write-off recommendation that provides reasonable evidence to substantiate that the claim is no longer available.*

- *Claims A/R for an individual provider greater than 10 years old, regardless of amount, will be recommended and submitted to the RO for termination of collection action and write-off closed.*

Intermediaries will submit, at least quarterly, recommendations for write-off and termination of collection action of outstanding claims A/R meeting the above criteria. Requests will be submitted to the RO no later than 30 days after the end of each calendar quarter. ROs will have 30 days after receipt of the request to respond, except for cases exceeding the RO's delegated authority. For those cases exceeding the RO authority, the RO will forward the case to CO with the RO's recommendation, within 30 days of receipt of the contractor's request.

For issuing an initial demand letter:

This instruction supercedes any other instructions for issuing demand letters for claims A/R, including those found in FMM §130. These instructions, however, do not apply to medical review and fraud overpayments.

- *Claims A/R for an individual provider with an aggregate principal balance greater than or equal to $25 and less than 10 years old, and where no recoupment has occurred in the past 60 days, must be validated and intermediaries will send an initial demand letter for the outstanding amount claim A/R balance. The demand letter will have a determination date equal to the date of the demand letter. In accordance with the intermediary's normal demand process, the provider will have 15 days to respond to the demand letter. In addition, the demand letter will contain the following:*

    - *The letter must explain the reason for the overpayment, provide the debtor with the opportunity to repay the debt, and explain that interest will begin to accrue if the debt is not paid in full within 30 days. The letter will provide the debtor with appeal rights and contain all provisions of a standard initial demand letter. The letter must also contain language that explains how the overpayment was determined and that the claims A/R has been outstanding as an adjustment, with no recoupment activity in the last 60 days. Intermediaries will include the date(s) of the remittance advice and original amount(s) of the claims A/R.*

    - *If the initial demand letter is returned as undeliverable, the intermediary will attempt to locate a valid address. If a valid address is found, or it is determined that there was a change of ownership, the intermediary must send the demand letter to the valid address/owner.*

    - *If a current address cannot be located, send the Debt Collection Improvement Act (DCIA) intent letter, and follow regular debt referral procedures.*

    - *If the initial demand letter is not returned undeliverable, the intermediary will follow normal debt collection procedures, including sending the DCIA intent to refer letter if the overpayment is not recouped. The DCIA intent to refer letter must be sent no later than 120 days from the date of the initial demand letter.*

- *Recoupment will cease once the initial demand letter is issued. If the provider does not respond to the initial demand letter within 15 days, recoupment will commence in accordance with your normal procedures.*

- *Each demanded claim A/R will be considered a separate identifiable debt and will not be aggregated with other demanded claim A/R.*

Exception to above procedures for issuing the initial demand letter:

If the intermediary has knowledge that the letter to a debtor will be returned undeliverable, based on prior attempts to contact the debtor, and where the intermediary cannot obtain a current address, the initial demand letter may be expanded to include the DCIA intent to refer language. The intermediary will send the initial demand letter with

the DCIA intent to refer language and follow normal debt referral procedures. The date of the initial demand letter will be the determination date for aging, interest accrual and DCIA referral purposes.

Claims A/R that are outstanding, but have not yet been demanded due to the fact that they have not met the timeframe for issuing an initial demand letter will be considered in cost report settlements. Intermediaries will review and include all outstanding undemanded claims A/R in the settlement process. Claims A/R that have been demanded, in accordance with these instructions, will not be included in the cost report settlement process, as these are now considered as separate receivables.

If the intermediary determines that the provider has filed bankruptcy, normal procedures regarding bankruptcy will be followed, including administrative freezes on recoupment, exemption to DCIA, and issuance of letters regarding the overpayment. This instruction does not change any of the procedures to be followed for bankrupt providers.

70.7.4 - Physician/Supplier Overpayment reporting (PSOR) System Summary Entry Debts (Carriers Only)(Rev. 13, 02-03-03)

This instruction addresses the delinquent overpayments, with a principal balance greater than or equal to $25, which is listed in the PSOR in summary entries 0888888888 and 099999999.

If a debt does not meet the criteria set forth by the Code of Federal Regulations, 42 CFR 405.376 for termination of collection action and write-off closed, the debt should be processed for referral to the Debt Collection Center (DCC) for cross servicing/TOP. The "intent to refer" letter must be sent when the debt is no more than 90 days delinquent (120 days from determination date).

Carriers will not update the PSOR status code for summary entry debts to reflect that the "intent to refer" letter was sent, since all debts included in the summary entry will not have the "intent to refer" letter sent. Carriers will be responsible for identifying and tracking these debts for timely referral. Carriers will follow normal debt collection and referral procedures, including financial reporting on these debts.

Once an overpayment included on a summary entry is collected, the summary entry should be downwardly adjusted to reflect the correct outstanding balance.

70.15.2 - Financial Reporting for Intermediary Claims A/R

(Rev.13, 02-03-03)

Intermediaries must be able to identify and separate the claims A/R that have been demanded from those claims A/R that have not been demanded. The date of the initial demand letter will become the new determination date for aging purposes and the

financial reporting of the receivable in Line 2a. New Receivables on the H751, Status of Accounts Receivable, report. The date of the initial demand letter must be the determination date for interest accrual, delinquency determination and referral to DCC. The demanded claims A/R adjustment must be reported as delinquent in Section B, Delinquent Receivables, if payment is not received within 30 days after the date of the initial demand letter. The accrual of interest will begin on the 31st day, and will be charged from the date of the initial demand letter. Claims A/R that have been demanded, in accordance with this instruction, will be recorded on CMS Form H750 on the line "Claims Accounts Receivable."

Claims A/R that have not been demanded will be included on the H750 under "Other." The outstanding balance of the undemanded claims A/R will be included in the "Adjustment" line on CMS Form H751. The claims A/R that have not been demanded will be reported as "current" for aging purposes.