CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-06 Medicare Financial Management	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 109	**Date: OCTOBER 27, 2006**
	Change Request 5302

SUBJECT: Claims Accounts Receivable - Clarification to CR 3963

I. SUMMARY OF CHANGES: This instruction revises Chapter 4, Section 70.7.3 regarding the inclusion of undemanded outstanding claims accounts receivable in the cost report settlement process. The revision allows fiscal intermediaries discretion for inclusion in the cost report settlement process by considering if collection by withhold from interim payments or through the claims accounts receivable demand process is doubtful.

NEW / REVISED MATERIAL
EFFECTIVE DATE: November 27, 2006
IMPLEMENTATION DATE: November 27, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	4/70/7.3/Intermediary Claims Accounts Receivable (A/R)

III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-06	Transmittal: 109	Date: October 27, 2006	Change Request 5302

SUBJECT: Claims Accounts Receivable - Clarification to CR 3963

I. GENERAL INFORMATION

A. Background: CR3963, Claims Accounts Receivable Update, was issued July 29, 2005 and was effective January 01, 2006. Due to questions and comments received from fiscal intermediaries regarding Business Requirement 3963.7, we revised this paragraph and deleted the requirement that all claims A/R that are outstanding and have not been demanded shall be considered in cost report settlements.

B. Policy: Debt Collection Improvement Act of 1996

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
5302.1	Medicare contractors shall make a determination whether to include claims A/R that are outstanding, but have not yet been demanded in cost report settlements. If collection is determined to be doubtful through the claims A/R recoupment process, these undemanded claims A/R should be included in the cost report settlement.	X								
5302.2	Medicare contractors shall not include claims A/R that have been demanded, in accordance with these instructions, in the cost report settlement process, as these demanded claims A/R are now considered as separate receivables.	X								

II. PROVIDER EDUCATION

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

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
N/A	

B. Design Considerations:

X-Ref Requirement #	Recommendation for Medicare System Requirements
N/A	

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: November 27, 2006 **Implementation Date:** November 27, 2006 **Pre-Implementation Contact(s):** D. Parzynski (Deborah.parzynski@cms.hhs.gov) **Post-Implementation Contact(s):** D. Parzynski (Deborah.parzynski@cms.hhs.gov)	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.**

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70.7.3 - Intermediary Claims Accounts Receivable (A/R)

(Rev.109, Issued: 10-27-06, Effective: 11-27-06, Implementation: 11-27-06)

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 shall 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' shared system shall 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 shall be followed:

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

When recommending write-off (termination of collection action), intermediaries shall follow instructions as outlined in the overpayment section of this manual, which begins at Section 100, or contact their regional office (RO) for guidance.

- 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 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 shall make a concerted effort to validate the claims A/R before selecting this option. A listing of this claims A/R shall 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, shall be recommended and submitted to the RO for termination of collection action and write-off closed.

Intermediaries shall submit, at least quarterly, recommendations for write-off and termination of collection action of outstanding claims A/R meeting the above criteria. Requests shall be submitted to the RO no later than 30 days after the end of each calendar quarter. ROs shall 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 shall 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 Section 130. These instructions, however, do not apply to medical review and fraud overpayments. Claims A/R that are demanded shall age and accrue interest and the aging and interest accrual shall be reported in accordance with chapter 5, section 200.

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, shall be validated and intermediaries shall send an initial demand letter for the outstanding amount claim A/R balance. The demand letter shall have a determination date equal to the date of the demand letter. In accordance with the intermediary's established demand process, the provider shall have 15 days to respond to the demand letter. In addition, the demand letter shall contain the following:

- The letter shall explain the reason for the overpayment, provide the debtor with the opportunity to repay the debt, and explain that interest shall begin to accrue if the debt is not paid in full within 30 days. The letter shall provide the debtor with appeal rights and contain all provisions of a standard initial demand letter. The letter shall also contain language that explains how the overpayment was determined and that the claims A/R have been outstanding as an adjustment, with no recoupment activity in the last 60 days. Intermediaries shall 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 shall 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 shall send the demand letter to the valid address/owner.
- If a current address cannot be located, the intermediary shall send the Debt Collection Improvement Act of 1996 (DCIA) intent to refer letter (IRL), and follow established debt referral procedures.
- If the initial demand letter is not returned undeliverable, the intermediary shall follow established debt collection procedures similar to other accounts receivable overpayments as outlined in chapter 3, sections 20 and 40, with the exception that withhold does not stop for claims A/R for fifteen days from the initial demand letter. The claims A/R debt collection process shall include sending the DCIA IRL if the overpayment is not recouped. The DCIA IRL shall be sent no later than 120 days from the date of the initial demand letter.

- Each demanded claim A/R shall be considered a separate identifiable debt and shall not be aggregated with other demanded claim A/R.
- The contractors' shared system must be able to properly report these claims A/R in accordance with financial reporting requirements outlined in Pub. 100-6, Chapter 5, Sections 200 through 400.

Exception to above procedures for issuing the initial demand letter:

If the intermediary has knowledge that the letter to a debtor shall 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 IRL language. The intermediary shall send the initial demand letter with the DCIA IRL language and follow established debt referral procedures. The date of the initial demand letter shall be the determination date for aging, interest accrual and DCIA referral purposes.

Claims A/R that are outstanding, but have not yet been demanded because they have not met the timeframe for issuing an initial demand letter or do not meet the dollar threshold for being demanded *should* be considered in cost report settlements *if collection by withhold from interim payments or through the claims accounts receivable demand process is doubtful.* Claims A/R that have been demanded, in accordance with these instructions, shall 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, established procedures regarding bankruptcy in Chapter 3, Section 140 shall 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.