Program Memorandum Intermediaries/Carriers

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

Transmittal AB02-108 **Date: JULY 31, 2002**

CHANGE REQUEST 2278

SUBJECT: Clarification of Medicare Contractor Financial Reporting Instructions Outlined in §1900 – §1960.21 of the Medicare Intermediary Manual (MIM) and §4900 – §4960.14 of the Medicare Carriers Manual (MCM). (Issued May 2001)

HBPSS is exempt from making system changes to implement this change request.

Background

This Program Memorandum (PM) clarifies financial reporting instructions related to the Medicare Contractor Financial Reporting Instructions Outlined in §1900 – §1960.21 of the Medicare Intermediary Manual (MIM) and §4900 – §4960.14 of the Medicare Carriers Manual (MCM).

Maintainer Questions

1. How will Line 4c, Collections Deposited at Another Location and Line 10, Cash/Offsets Received for Receivables at Another Location of the Forms CMS-751A/B and CMS-M751A/B be used?

Line 4c and Line 10 will **only** be used to report collections for accounts receivable referred under the Debt Collection Improvement Act (DCIA). Therefore, Line 4c will only reflect collections that central office (CO) has received from the Treasury Offset Program (TOP) or a Debt Collection Center (DCC) for debt referred under DCIA. Furthermore, Line 10 will only be used by CO for debts referred under DCIA. The CO will complete the Collection Reconciliation/Acknowledgement form. The Collection Reconciliation/Acknowledgement form will be forwarded to the applicable Medicare contractor (within 30 days of CMS receipt of the collection or at least 15 days before the end of the quarter per MIM §1960.18 and MCM §4960.11) for allocation between principal and interest amounts. Specific instructions for the application of these collections will be provided in a separate PM.

The manual instruction for Line 4c (issued May 2001) states:

> "Enter the amount collected or offset at another location by a Medicare contractor or central office (CO). **Do not transfer the case to the location where the deposit or offset of the money is made.** Upon notification, enter the amount collected or offset at another location in this line to reduce the outstanding amount of the receivable being reported on Form CMS-751A/B."

However, the explanation for Line 4c, Collections Deposited at Another Location given in the manual **should now** read – Enter the amount collected or offset by CO for DCIA. Do not transfer the case to CO where the deposit or offset of the money is made. Upon receipt of the Collection Reconciliation/Acknowledgement form, enter the amount collected or offset by cross servicing/TOP and received by CO in this line to reduce the outstanding amount of the receivable being reported on Form CMS-751A/B. CO will record the actual deposit of cash/check/offset on Line 10, Cash/Offsets Received for Receivables at Another Location of its' Form CMS-R751.

The manual instruction for Line 10 (issued May 2001) states:

> "This line shall be used in the instances where a Medicare contractor, RO or CO has received cash/check/offset for a receivable that is being reported by another entity, i.e., Medicare contractor or other CMS locations on its H751 or R751, respectively. In this situation, **the case will not be transferred to the location where the deposit or offset of money is made.** The

Medicare contractor will enter the amount received and deposited or offset for receivables being reported at another location in this line."

However, the explanation for Line 10, Cash/Offsets Received for Receivables at Another Location given in the manual **should now** read – This line shall only be used in the instances where CO receives collection from cross servicing/TOP for DCIA debt.

In addition, collections reflected in Line 4c do not need to be broken down by cash, check or offset. That information will be readily available at CO if it is needed.

Treatment of Collections Made by a Medicare Contractor for an Account Receivable at Another Medicare Contractor Location (applies to Non-Medicare Secondary Payer (MSP) accounts receivables and MSP accounts receivables)

Line 4c, Collections Deposited at Another Location and Line 10, Cash/Offsets Received for Receivables at Another Location **will not** be used for collections received by a Medicare contractor where the debt or account receivable is not in the Medicare contractor's ending balance.

If a Medicare contractor collects a debt on behalf of another Medicare contractor, whether the receipt was solicited or unsolicited, then the collection must be forwarded to the Medicare contractor that has the accounts receivable. In these instances, the Medicare contractor receiving the collection would deposit the collection and re-issue that amount to the Medicare contractor that is reporting the accounts receivable. The Medicare contractor reissuing the check should ensure that proper segregation of duties exist over the check re-issuance (e.g., that the preparer is different from the check authorizer).

The re-issued check must be made payable to "Medicare." In addition, the check must be accompanied by a completed Collection Reconciliation/Acknowledgement Form (see MIM §1960.18 and MCM §4960.11), any correspondence received, and a copy of the original check including the postmark date. The CFO for Medicare Operations for the Medicare contractor reporting the accounts receivable should be contacted and informed of the pending check. A listing of CFO contacts has been issued to each Medicare contractor CFO. The deposit and re-issuance of the collection will only affect the CMS-H750A/B of the Medicare contractor that received the collection. The Collection Reconciliation/Acknowledgement Form will allow for tracking of the payment.

Upon receipt of the check and Collection Reconciliation/Acknowledgement Form, the Medicare contractor reporting the receivable will apply its normal cash receipt procedures. However, a signed copy of the Collection Reconciliation/Acknowledgement Form must be returned to the Medicare contractor that sent the collection.

MSP additional information: Medicare contractors should follow the deposit and re-issue process whenever another Medicare contractor has the account receivable or another Medicare contractor is or should be the lead Medicare contractor. If there is no account receivable established but Medicare contractor X is the lead and Medicare contractor Y receives payment, Medicare contractor Y should follow the deposit/re-issue process. If there is no lead established and Medicare contractor Y receives payment, Medicare contractor Y should do an electronic referral via the Electronic Correspondence Referral System (ECRS) and follow the deposit/re-issue process if another Medicare contractor is assigned lead. This rule should be followed even if the non-lead Medicare contractor has an interest and/or has paid some of the claims at issue.

Treatment of Collections Made by a Medicare Contractor for an Account Receivable at a CMS Regional Office Location (applies to Non-MSP accounts receivables and MSP accounts receivables)

If a Medicare contractor collects a debt on behalf of a CMS RO location, whether the receipt was solicited or unsolicited, then the account receivable balance must be transferred to the Medicare contractor that received the collection. In these instances, the Medicare contractor receiving the collection would initiate the process by completing the Collection Reconciliation/Acknowledgement Form and sending it to the CMS RO who is reporting the receivable to notify them of the collection.

The Medicare contractor that received the collection would deposit any cash or checks received into unapplied receipts, which would be reported as a liability until the transfer is complete.

In turn, the CMS RO reporting the receivable will complete the Transfer Request and Notification of Acceptance Form (TRNA) described in §1960.17 of the MIM and §4960.10 of the MCM. (The use of the TRNA is also discussed in question number 68.) Once both parties sign the TRNA, the transfer is considered complete and the collection would then be applied to the account receivable. The CMS RO transferring the receivable would record the account receivable on Line 5c, Transfer Out to other Medicare Contractors. The Medicare contractor receiving the account receivable would record it on Line 5d/5f, Transfers In from other CMS Locations POR/PSOR or Not on POR/PSOR and the applicable collection on either Line 4a, Cash/Check Collections or Line 4b, Offset Collections.

Only in the instance where a collection is made by offset for an account receivable at a CMS RO location can notification of the offset be e-mailed. The e-mail must be retained for audit trail purposes. The e-mail notification must be followed-up with the actual Collection Reconciliation/Acknowledgement Form and the Transfer Request and Notification of Acceptance form with all the appropriate signatures. Furthermore, since offsets may only be identified after being applied, the offset transaction must be moved manually on the Forms CMS-751A/B (i.e., the full amount of the accounts receivable prior to the offset must be shown as a transfer in and the amount of the offset must be captured on Line 4b, Offset Collection.) To assist in accounting for these offset transactions ONLY, Medicare contractors can prepare the Collection Reconciliation/Acknowledgement Form(s) on a monthly basis.

Treatment of Collections Made by A Medicare Contractor for an Account Receivable at CO

Non-MSP: If Medicare contractors receive collections on debt that is at the Debt Collection Center (DCC), and that debt is being reported by CO, the Medicare contractor must notify the CO by submitting the Collection Reconciliation/Acknowledgement form (refer to §1960.18 of the MIM and §4960.11 of the MCM). In addition, the receipt should be deposited into unapplied receipts until the actual account receivable is transferred back to the Medicare contractor.

Once CO receives the Collection Reconciliation/Acknowledgement form, it will perform the necessary steps to update the collection information in the Debt Collection System (DCS) and the Provider Overpayment Reporting (POR) system or the Physician/Supplier Overpayment Reporting (PSOR) system. CO will change the accounts receivable location code in DCS from "H," which means CO is reporting the account receivable to "C," which means the Medicare contractor is reporting the account receivable. CO will also update the POR/PSOR with the appropriate location code of "IDC," which means the fiscal intermediary at debt collection or "CDC," which means the carrier at debt collection (i.e., the debt has been forwarded to debt collection but the debt is still on the books of the fiscal intermediary or carrier). If a balance is remaining after posting the collection, the debt will remain at DCC for cross servicing/TOP.

To allow the Medicare contractors to properly apply the collection in their internal systems, CO will then transfer the receivable back to the Medicare contractor using the TRNA (refer to §1960.17 of the MIM and §4960.10 of the MCM). Upon CO receiving the signed TRNA from the Medicare contractor, CO will cease to report the receivable on its Form CMS-R751A/B. Once the TRNA has been signed and the receivable has been transferred, the Medicare contractor will record the transfer in of the receivable on Line 5d, Transfers In from other CMS Locations, POR/PSOR, or Line 5f, Transfers In from other CMS Locations, Not POR/PSOR. The receipt would then be applied to the account receivable and the collection would be recorded on Line 4a, Cash/Check Collections or Line 4b, Offset Collection on the appropriate Form CMS-H751A/B.

MSP: If Medicare contractor X has an account receivable other than a debt which has been referred to the Department of Health and Human Services (DHHS) Program Support Center (PSC) under the DCIA and the CO/RO receives payment, the Medicare contractor should use Line 4c, Collections Deposited at Another Location and footnote in the comments section of the Form CMS-M751A/B that the CO/RO received the payment. An example of this type of receipt would be coordination of benefits contractor misrouted checks.

2. When should interest be assessed on Medicare Secondary Payer (MSP) debt and when should offset begin?

For Group Health Plan (GHP) based demand letters to employers, insurers, third party administrators, group health plans, or other plan sponsors, interest is due and payable if the demand letter has not been repaid in full within 60 days from the date of the demand letter. Interest is not charged on GHP based demand letters to beneficiaries.

For GHP based demand letters to providers/physicians/other suppliers and for liability/no-fault/workers' compensation based demand letters to any party, CMS is aware that some Medicare contractors use demand letters which require the payment of interest if the demand is not repaid in full within 30 days of the date of the demand letter; and some Medicare contractors use a 60 day standard. Interest is due and payable if the debt is not repaid in full within the time frame stated in the demand letter, and where interest is due and payable, it accrues from the date of the demand letter. Additionally, where interest is due and payable, it is due and payable for each new 30 day period as of the first day of that period. Consequently, if a demand letter states that the debt must be repaid within 30 days, on day 31 interest is due for two 30-day periods. If a demand letter states that the debt must be repaid within 60 days, on day 61 interest is due and payable for three 30-day periods.

It is CMS' intent, that in the future, all MSP debt will use the 60 day standard. Medicare contractors are not **required** to make system changes to accommodate the future direction regarding the MSP interest standard of 60 days (versus 30 days). However, in the event a Medicare contractor is already making system changes related to interest, CMS will give approval to reflect the interest standard of 60 days for all MSP debt. Additionally, in the event Medicare contractors decide to make the interest standard change within their systems, they must also ensure that demand letters are also changed to reflect the 60 days standard. CMS is aware that some Medicare contractors and/or systems maintainers have made the change from the 30 day standard to the 60 day standard. However, the date when automatic recoupment (internal offset) takes place for an MSP recovery from a provider, physician or other supplier has not been changed. CMS wants to make it clear that Medicare contractors or system maintainers should not change the time frame for internal offset for MSP provider, physician or other supplier MSP recoveries until CMS issues specific instructions to make this change. CMS may continue to use the existing time frame for internal offset as long as the provider, physician or other supplier has notice of when such action will take place. Until formal policy is drafted, do not make changes to the internal offset parameters.

MSP standards and instructions should be followed on all MSP initiated debt regardless of who the current MSP debtor is. For example, in the course of demanding repayment from the employer or insurer a response may be received stating that the provider, physician or other supplier was paid. A demand must then be made to the provider, physician or other supplier; and all MSP standards and provisions must be followed specific to this demand.

3. What amount should be re-established when a cash/check/offset collection is made on MSP Currently Not Collectible (CNC) debt?

The treatment of MSP CNC debt when a collection is received should follow the instructions given in the Form CMS-750/751 manual instructions under MIM §1953.4 and MCM §4953.4. The instructions require that the **whole** debt be reactivated on the Form CMS-M751A/B regardless of the amount collected. (The re-establishment of MSP CNC debts due to a collection via cash/check/offset will follow the same instructions for Non-MSP CNC debts). Specifically, the instructions state that the total amount of MSP CNC debt is re-established as active debt because cash/checks/offsets have been collected on MSP CNC debts during the fiscal year. CMS recognizes that the debt remaining after the collection has been applied will automatically qualify for MSP CNC reclassification.

4. What is the purpose of Line 5b, Transfers In from other Medicare contractors, of the Form CMS-M751A/B?

This line will be used when transitions occur and if the transfer of an account receivable between Medicare contractors is necessary for some other reason. The transfer of MSP accounts receivable between Medicare contractors is generally limited to situations where one Medicare contractor's workload is transitioning to another Medicare contractor.

CMS has been informed that the SMART system is not designed to transfer-in accounts receivable from another Medicare contractor. Therefore, Medicare contractors will continue to account for these transfer situations in the same manner as they have in the past – even if it was being performed manually.

5. For the 2174 Report (Beneficiary Overpayment Report), would a debt being transferred in by another entity be the same classification as discovered?

In the current process, transferring of a debt removes it from the books of one contractor to another. Therefore, the transferring contractor will not include the dollars or numbers in their 2174 reporting. The transferring of a debt does not preclude the receiving contractor from using the discovered column. The 2174 Report does not indicate a separate column for transfers between Medicare contractors. The case is considered discovered by the original contractor and must be counted only once regardless of the number of separate instances of overpayments found on them. (See MCM §13360.)

Although the debt has been discovered only once, MCM §13360.2 instructs on line 4 for "Discovered During Reporting Quarter -- The contractor must report the number of claims and the dollar amounts for which a determination was made during the reporting quarter…" regardless of where the claims are located. The instructions further indicate that potential overpayments under investigation as well as returned or checks not negotiated should be counted in this column. These cases should not be counted in the pending column since this column is used only for cases pending at the end of the quarter which have already been validated, booked and/or partially recouped. Placing cases transferred between Medicare contractors in the pending column would not reconcile to the number and dollar amounts entered on line items 24 - 28 of the 2174 Report.

6. For debts recorded as Department of Justice (DOJ) and cross servicing, which PSOR code would be appropriate?

For cross servicing, a new location was established for debts being reported by the Medicare contractor for the Form CMS-751A/B - that location code is "CDC" – carrier at debt collection – and the cross servicing PSOR status code of "X" –cross servicing – would be used to indicate that the debt was referred for cross servicing. For debts being reported by CO for the Form CMS-751A/B, the PSOR location code would be DCC and the status code is "X". For debts referred to DOJ, if the location code does not change, but remains "CAR" – for at carrier location, the suggested code would be "L" In litigation. If at the debt is at DOJ, then it is assumed that the debt is in litigation and exempt from cross servicing.

7. How would debts transferred to a Medicare contractor be recorded in the PSOR?

Transferred debts should already be recorded in the PSOR. The debts should have been recorded in the PSOR by the previous Medicare contractor. To facilitate the changing to the new carrier number, the receiving contractor should contact CO. The change to the new contractor number will be done by the systems analyst in CO. The Medicare contractor should generate a PSOR adhoc report to verify that the debts have been changed in the PSOR to the new Medicare contractor location.

8. Should Lines 4(a) through (e) on Forms CMS-C751A/B and MC751A/B agree to Line 6b, Transfers In from CNC on Forms CMS-751A/B and CMS-M751A/B?

No, they should not. The manual instructions for MIM §1933.4 and MIM §1953.4 for Non-MSP CNC and MCM §4933.4 and MCM §4953.4 for MSP CNC (issued May 2001) state:

"Lines 4(a) through (e), Reclassified CNC Debt. Reclassified MSP and Non-MSP CNC debt reported on these lines must agree with the total amount reported on Line 6b, Transfers In from CNC on Forms CMS-751A/B and CMS-M751A/B."

However, only amounts reported on Lines 4(a) through (c) must agree with the total amount reported on Line 6b of the Forms CMS-751A/B and CMS-M751A/B.

9. How should MSP CNC be aged?

Delinquency is determined based on the due date for repayment. In the event a debt is owed within 60 days from the date of a demand letter, the debt will be classified delinquent on the 61st day from the date of the demand letter. In the event a debt is owed within 30 days from the date of the demand letter, the debts will be classified as delinquent on the 31st day from the date of the demand letter. Specific to MSP, delinquent is defined as a debt not being paid in full unless other arrangements have been made, no response from the debtor regarding the debt, and/or no valid documented defense to the debt.

MSP debt is eligible for CNC classification when the debt is 180 days delinquent. Since delinquency is based off of the repayment timeframe, 180 days delinquent will also equate to 240 days from the date of the demand, if the timeframe for repayment is 60 days (i.e., 180 days + 60 days = 240 days). One hundred and eighty days delinquent will equate to 210 days from the date of the demand, if the timeframe for repayment was 30 days (i.e., 180 days + 30 days = 210 days).

Section B of the Form CMS-MC751A/B is categorized as "Aging of CNC Receivables (from determination date)". The date of determination is the demand date. Before re-classification as CNC, the debt must be delinquent (Section B. M751A/B Delinquent Receivables). The Form CMS-MC751A/B on the Contractor Administrative and Financial Management (CAFM) system will be changed to replace the word "determination" with the word "demand."

10. Should accounts receivables that have been transferred to another carrier be backdated? Should Medicare contractors maintain the original date of determination on the debt in order to accrue the appropriate interest rate and aging category?

Yes, accounts receivable should be backdated to the original date of determination. However, it has been brought to CMS' attention that due to system limitations, some Medicare contractor systems cannot backdate an accounts receivable that is transferred to them by another Medicare contractor in order to accrue interest at the appropriate time and rate in addition to tracking the true age of the debt. In part, this function was done manually. If this system change was not included in the scope of the system changes necessary to implement the revised financial reporting instructions, Medicare contractors should continue to perform this function as they have in the past. If it was done manually, then it will have to continue to be done manually.

11. How do accounts receivables impact Form 1099 reporting?

Medicare contractors should continue to do Form 1099 reporting based on current instructions. CMS is still reviewing the requirements for issuing Form 1099-Cs for both MSP and Non-MSP debts that are written off.

12. Should Line 3(e), Other Status and Line 4(e), Other Status for Section B: Delinquent Receivables on the Form CMS-751A/B have any breakouts?

CMS has decided that a breakout of these two lines is not required at this time.

13. Should under tolerance accounts receivable be included in delinquent debt and reflected in the aging categories? For Non-MSP, would under tolerance be considered delinquent? How can it be considered delinquent if the debt is not demanded and should they accrue interest?

CMS does not believe under tolerance accounts receivables should be included in delinquent debt or reflected in the aging categories. Furthermore, interest should not accrue on these debts because they have not been demanded.

14. Extended Repayment Plans – At the point that a provider gets behind on payments, what category would they fall in, in Section B – Status of Delinquent Receivables? Is the provider delinquent when two consecutive payments are missed or any two payments are missed during the life of the repayment plan?

An extended repayment plan becomes delinquent the day after the payment due date if no payment is received. Therefore, as soon as one payment is missed the amount of the payment is considered delinquent. The amount of the missed payment would be reported in Section B under (A) 1-30 days when the first payment is missed. However, when two consecutive payments are missed the debt is considered in default and the total amount of the debt should be reported in the appropriate delinquency aging category based on the date of original determination of the debt.

15. When should an Extended Repayment Schedule (ERS) be considered delinquent?

An extended repayment plan or schedule becomes delinquent the day after the payment due date if no payment is received. See answer to # 14.

16. What changes need to be made to the Form CMS-750A/B under the Assets Section – MSP?

The MSP Assets Section of the Form CMS-750A/B Statement of Financial Position report will be reformatted as shown:

Medicare Secondary Payer (MSP)
- Group Health Plans
  - Data Match _____
  - Non Data Match _____
  - MSP Provider/Physician/Supplier/Beneficiary _____
- Liability (including WC, Auto, No-Fault)
  - MSP Beneficiary _____
  - Other MSP _____

Total MSP _____

The term ”liability” is used generically to include liability, no-fault and workers compensation (WC). Please note that the categories indented under “Group Health Plans (GHP)” and “Liability” are sub-categories under those headings. For example, “Other MSP” is limited to liability, no-fault, or WC debt where the debtor is an individual or entity other than the beneficiary. The Total MSP line should equal Line 7, Ending Balance on the Form CMS-M751 report.

<u>Questions Applicable to the Form CMS-750A/B</u>

17. Should the Periodic Interim Payment (PIP) Providers Cost Reports Settlement liability line on the Form CMS-750A include rate reviews on PIP Providers? Should this line also include an underpayment not issued that resulted from the Medicare contractor performing a rate review and approving a lump sum adjustment?

Rate reviews performed on PIP providers should be included on the Form CMS-750A on the Liability/Provider/PIP Provider Cost Reports Settlement line. In addition, if a lump sum adjustment has been issued, but the underpayment has not been issued, Medicare contractors should also record this on the PIP Providers Cost Reports Settlement line.

18. Why are rate reviews and cost report settlements broken out on the Form CMS-750A under Liabilities/Provider for non-PIP providers?

Separately reporting rate reviews and cost report settlements for non-PIP providers is necessary because this information is needed for the actuarial calculation on benefits payable performed at CO.

19. Where do Medicare contractors' "Other" amounts go, for example claims that have been suspended for fraud and abuse? Right now, these claims are included in penalty withholding amounts. System changes may be needed to separately report these amounts; otherwise, Medicare contractors will need to manually review every penalty withholding to pull out the amounts.

These amounts should be recorded on the Form CMS-750A/B on the Liabilities/Suspended Payment/Claims line.

Questions Applicable to the Form CMS-751A/B

20. Currently, Medicare contractors record accruals for claims pending in the system that are adjustment claims or cancelled claims that will result in a receivable. These are estimates. Should these accruals be recorded on the Line 2b, Accrued Receivables of the Form CMS-751A/B?

No, the only accrual recorded on Line 2b, Accrued Receivables of the Form CMS-751A/B will be the PIP accrual. The only estimated account receivable recorded on Line 2b is PIP.

However, once these claims are fully processed, the claims account receivable should be reported on Line 2a, New Receivables and any collections would be reported on Line 4b, Offset Collections.

21. Should the title of the lines on the Form CMS-751A/B be the same as the ones on the Form CMS-750A/B where it reads PIP accrual?

No, the lines on the Form CMS-750A/B are provided to identify the components related to the total accounts receivable balance. The lines on the Form CMS-751A/B are provided to reflect the activity for the reporting period.

Currently, Medicare contractors are instructed to record only the PIP accrual on Line 2b, Accrued Receivables of the Form CMS-751A/B. This amount should equal the amount of the PIP accrual recorded on the Accounts Receivable/Non-MSP Overpayments/Provider/PIP Accrual line of the Form CMS-750A/B.

22. Should voluntary Non-MSP receipts be recorded on the PSOR?

Voluntary Non-MSP receipts are not required to be reported in the PSOR. However, if you are currently reporting them in the PSOR, CO has decided that Medicare contractors may continue to do so. There was some discussion regarding this issue at the CFO conferences in that some Medicare contractor systems automatically generates a report of overpayments to be entered into the PSOR system where voluntary receipts are included and are not separately identified in the report. Not requiring their input to the PSOR would mean a change to their current procedures – which may require a system change to Medicare contractor internal systems. Therefore, CMS is not requiring systems changes to separately identify these amounts in the report.

Questions Applicable to the Form CMS-M751A/B

23. Would MSP under tolerance be recognized as a new account receivable since Non-MSP under tolerance is recognized and aggregated although a demand letter is not sent? For MSP provider/supplier debt, is there an under tolerance threshold for recognizing an accounts receivable? Is it the same as Non-MSP?

In accordance with CMS's policy for recognizing an accounts receivable (See MIM §1960.21 and MCM §4960.14), Medicare contractors will recognize and report an account receivable, in most cases, as of the date a demand letter is issued. There is no recognition of an MSP receivable until a demand letter is issued. The only under tolerance threshold for MSP debt applies to datamatch and routine non-datamatch GHP based on recoveries where the debtor is a third party payer. For these recoveries there is a $1000 front-end tolerance, with no requirement for aggregation (recovery is not

pursued and no demand letter is issued). This **would not** be reported as a receivable on Line 2a, New Receivables of the Form CMS-M751A/B. Because MSP under tolerance dollars are not demanded, there is no receivable to establish, report or write off as bad debts. There is no front-end tolerance if a GHP based recovery is the result of a 42 CFR 411.25 notice or is a duplicate primary payment recovery.

MSP provider/supplier (including physicians) demands do not have a tolerance. Most MSP provider/supplier debt is demanded because of a response coming in from the original debtor indicating that they have already paid the provider/supplier for the service in question.

24. Who has the responsibility for approving MSP waivers? How should waivers be reported on the Forms CMS-M751A/B?

Medicare contractors are responsible for making waiver determinations under §1870 of the Social Security Act. This includes: 1) the determination regarding whether or not the provider, physician, or supplier was " without fault" if there is a fee-for-service provider/physician/supplier overpayment; and 2) making the determination regarding whether or not a beneficiary is " without fault" and recovery would either defeat the purposes of the program (financial hardship criteria) or be against equity and good conscience, if a beneficiary requests a waiver of recover for a fee-for-service overpayment. The §1862(b) waiver is a discretionary MSP specific waiver, which is rarely used and is not within contractor authority. Medicare contractors will be told when a §1862(b) waiver has been granted. Once a waiver is approved, it should be removed from the accounts receivable ending balance and "zeroed out" on the Medicare contractors' internal system. Financial reporting instructions for the period before October 1, 2001, require §1870 and §1862(b) waivers to be reported on Line 5b, Waivers of the Form CMS-M751A/B. The revised financial reporting instructions that were effective October 1, 2001, require these waivers to be reported on Line 5h, Waivers of the Form CMS-M751A/B.

25. Should Medicare contractors capture a count based on the number of demand letters sent or the number of claims? Some Medicare contractors base it on the number of claims, some on the number of debts.

The count on the Form CMS-M751A/B should be reported in the same manner as the count for the ending line balance, whether it is calculated based on claims or number of demands. Depending on how each type of MSP debt is tracked, the basis for the count may be inconsistent among Medicare contractors.

26. Are duplicate GHP debts reported as MSP or Non-MSP debts?

Beneficiary duplicate primary payment GHP debts are reported as MSP debts and do not accrue interest. Provider/supplier (including physician) duplicate primary payment GHP debts are also reported as MSP debts and **do** accrue interest.

27. How do you handle subrogated cases?

If you have a liability insurance case, it should not be referred to as a subrogation case because to do so would indicate that Medicare has lesser rights than its priority right of recovery. Refer to CMS manuals for directions specific to liability, workers compensation and no fault recoveries.

28. What amount is established as an account receivable when a Medicare contractor has sent out a notice of the amount of conditional payments made to date, and the attorney sends in a check for the full amount of the conditional payments? Will a refund be issued for procurement costs?

The Medicare contractor should contact the attorney and request the settlement information (i.e., including attorney fees and procurement costs) and deposit the check in unapplied receipts. In the event no information is received from the attorney within a reasonable time frame (e.g., 45 days after request), treat the receipt as a voluntary refund – establish and record an account receivable for the full amount of the check on Line 2a, New Receivables of the Form CMS-M751A/B and

simultaneously record a collection on Line 4a, Cash/Check Collections of the Form CMS-M751A/B. If the attorney furnishes sufficient documentation regarding procurement costs, the Medicare contractor must issue any appropriate refund. Note that refunds do not affect Forms CMS-M751A/B (refer to question 39). This answer assumes that the Medicare contractor receiving the payment is the appropriate lead Medicare contractor.

29. Would Data Match accounts receivable not yet verified be included as accounts receivable on the Form CMS-M751A/B?

No. The debt must be verified before the issuance of the demand letter/creation of the account receivable. Again, a MSP receivable is not established until a demand letter is sent.

30. Are Federal debtors excluded from write-off closed?

Yes. Where the current debtor is a Federal entity, the debt does not qualify for write-off closed.

31. Reactivation of debt and subsequent reporting. Address the following questions:

Scenario 1: The debtor sends in all requested dollars, which closes out the account receivable and then later requests and is granted a waiver. How would you report this on the Form CMS-M751A/B?

Answer to scenario 1: Refunds would not affect the Forms CMS-M751A/B. Refunds are liabilities. A check would be cut for the appropriate amount and the transaction would be recorded as a payable in the liability section of the Form CMS-750A/B.

Scenario 2: The debtor sends in all requested dollars to avoid paying interest and at the same time sends in a waiver request. How would you report this on the Form CMS-M751A/B? How long can the contractor hold the check before applying it because Medicare contractors have 120 days from the time the waiver is requested? Once the waiver request is reviewed some type of waiver is granted whether full or partial. How would you report this on the CMS-M751A/B?

Answer to scenario 2: Deposit the check, show it on the Form CMS-750A/B as unapplied receipts, and make the waiver determination. Upon reaching the waiver determination, remove the check from unapplied receipts. If the waiver is:

1) Approved for full waiver – reflect the waive amount in Line 5h, Waivers on the Form CMS-M751A/B and refund the payment amount to the beneficiary;

2) Partially approved – reflect that portion approved for waiver in Line 5h, Waivers on the Form CMS-M751A/B and apply the collection to the remaining account receivable balance using Line 4a, Cash/Check Collections of the Form CMS-M751A/B. Excess monies should be refunded to the beneficiary.

3) Disapproved – apply the collection to the outstanding account receivable.

32. Listed is a reference guide to assist Medicare contractors in evaluating responses to a MSP demand. **All valid defenses must be appropriately documented in order to be accepted by the Medicare contractor.** This list is for general reference purposes and does not replace existing instructions.

- Valid Defenses – GHP- from an insurer or employer:

    1) Not a covered service under the plan under any conditions.
    2) Covered service but benefits for services are exhausted.
    3) Beneficiary not a covered individual (as member, spouse, other dependant) under the plan.
    4) Beneficiary is covered under the plan but not on the basis of current employment status.
    5) Made full primary payment.
    6) Timely filing. Medicare contractors should refer to the requirements stated in the demand letter issued to the debtor. A timely filing defense is no longer possible in some instances due to the provisions of the Balanced Budget Act of 1997.

- Valid Defenses – Other – from an insurer or beneficiary/attorney (this is for liability/no-fault/workers' compensation cases):

    1) Services not related to the settlement, judgment, or award.
    2) Benefits exhausted (no-fault).
    3) Claim not filed within applicable time limits.
    4) Made full primary payment (payment has already been made to the provider, physician or other supplier).
    5) Not a covered service under the plan under any conditions (workers' compensation).

Questions Applicable to the Forms CMS-751A/B & CMS-M751A/B

33. What should Medicare contractors do when they receive a collection of money before the establishment of a receivable?

The amount of the check must be recorded as "unapplied receipts" under the liability section on the Form CMS-750A/B until the Medicare contractor can research the check. Once the research has been completed and it has been determined that a receivable exists, the receipt must be applied by the date the research was completed. This date will normally be later than the check receipt date and the check deposit date. Unapplied receipts should be researched within a reasonable timeframe (e.g., within 45 days of the receipt of the check). If after research is performed it is determined that an accounts receivable does not exist and based on research performed the Medicare contractor does not have sufficient information to determine that a refund is due to the provider, then the Medicare contractor should establish an account receivable for the amount of the check and apply the receipt.

34. What are the definitions of a current and non-current receivable?

A current receivable is a receivable that is due within 12 months of its creation; therefore, all delinquent receivables (31 or 61 days old) are current receivables because they are due immediately. A non-current receivable is a receivable that is due in 12 months or more. An example of a non-current receivable is a debt that has been approved for an extended repayment plan (i.e., only those scheduled payments that are not due within 12 months and are not delinquent).

35. What does the count represent on Line 5a – the number of account receivables or debts being adjusted or the number of transaction adjustments? Should this number be broken down between internal and external adjustments?

The count for Line 5a represents the number of all **principal** adjustments being made from Line 5a to Line 5g. No, the number should not be broken down between internal and external adjustments since it is the total of all adjustments made to Line 5 as a whole.

36. Would an interest only adjustment be counted in the principal number field for Line 5a, Adjusted Amounts of the Forms CMS-751A/B and CMS-M751A/B?

Adjustments related to interest only should not be included in the number count. The number count associated with this line is for principal adjustments only. However, an adjustment related to principal and interest on the same debt is one (1) count.

37. What should happen if a **carrier** receives a check that should have gone to a fiscal intermediary (FI)? Would the Collection Reconciliation/Acknowledgment Form be used and the check deposited or would the actual check be forwarded to the FI in order to get it to the correct trust fund?

In the case of misdirected checks, a **carrier** should deposit the check received and reissue a check to the FI.

NOTE: Carriers who are leads in MSP recovery cases should issue a demand including all claims associated with that recovery (both Part A and Part B). They should also be requesting

that the repayment be made to them for both the Part A and the Part B dollars. Upon receipt of the dollars demanded, carriers should deposit checks and reflect collections on Line 4a, Cash/Check Collections of the Form CMS-M751B. The carrier must be able to breakout Part A dollars in a footnote on the Form CMS-M751B. The CO will shift funds to the appropriate trust fund.

38. What should Medicare contractors do if a collection is received for debts transferred to the Social Security Administration (SSA) if these debts are no longer reflected in the ending balance? How would the collection be reported and applied to the receivable?

If Medicare contractors receive collections on debt that was previously transferred to SSA, an account receivable should be re-established via Line 5a, Adjusted Amounts and the collection applied and recorded on Line 4a, Cash/Check Collections on the Forms CMS-751A/B and CMS-M751A/B. With the revised reporting instructions, the transfer to SSA line has been removed; however, **referrals** can still be made to SSA for collection assistance. The account receivable will stay on the Medicare contractor's books instead of being transferred so the reporting responsibility remains with the Medicare contractor.

39. How do refunds affect the Form CMS-751A/B and CMS-M751A/B?

Receivables should not be adjusted if a refund is subsequently issued. Refunds would not affect Forms CMS-751A/B and CMS-M751A/B. Refunds are liabilities. In the case of a refund, Medicare contractors should cut a check for the appropriate amount, and record the transaction as a payable in the liability section of the Form CMS-750A/B.

40. Under Section B of the Forms CMS-751A/B and CMS-M751A/B, should Line 2, Total Delinquent equal the total of Line 3, Total Delinquent 1-180 days and Line 4, Total Delinquent 181 days & over?

Yes, the total of Lines 3 and 4 under Section B of Forms CMS-751A/B and CMS-M751A/B should equal Line 2 of Section B for the respective forms.

41. What is the current policy for the retention of written demand letters in case files?

Currently there is a Department of Justice (DOJ) records freeze in place that requires indefinite retention of records, including the demand letter. Medicare contractors should follow current guidelines regarding the freeze as well as all other existing record retention guidelines. Additionally, per CMS' policy for recognizing accounts receivable, Medicare contractors are to ensure that they retain copies of a demand letter(s) sent (Non-MSP and MSP). The demand letter provides documentation or evidence of the actual debt and recovery efforts taken. It must be kept in each case file with other associated case documents or correspondence for use in responding to inquiries or appeals, if the case is referred to the DOJ, referred for debt cross servicing, or requested by Office of Inspector General or General Accounting Office during audits or reviews. An exception to this rule would be in the case of an MSP electronic demand letter(s) and/or case file. Electronic versions are allowable only if the letter(s) and all associated correspondences can be produced within 14 calendar days.

42. Under Section B of the Forms CMS-751A/B and CMS-M751A/B, what should be recorded on lines 3d and 4d –Referred for Cross Servicing? Is it what has been put into the DCS system, or what is eligible for DCC or not in process yet? What should be recorded on lines 3e and 4e – Other Status?

Non-MSP: Lines 3d and 4d – Referred for Cross Servicing should reflect all delinquent debt eligible for referral for cross servicing that CO has actually transmitted to DCC through the DCS. Once CO has transmitted the debt to DCC, it will update DCS by changing the status code of the debt to "UJ" indicating that the debt has been referred to the DCC for further collection efforts. Additionally, CMS will generate a weekly report of the debts transmitted to DCC that week and send the report to the Medicare contractor. The Medicare contractor should review the report to ensure

that the debts they referred were transmitted and the amounts are accurate. The report must be signed by the Medicare contractor's CFO and returned to CO within 10 calendar days of the report.

MSP: Lines 3d and 4d – Referred for Cross Servicing should reflect all delinquent debt eligible for referral for cross servicing that the Medicare contractor has inputted into the DCS system. Medicare contractors should use any DCS transmission reports, when received, as additional support of their reporting.

Non-MSP and MSP: Lines 3e and 4e – Other Status reflects delinquent debt eligible for cross servicing that has not been transmitted to DCC, debts not considered for referral, or debts that are ineligible for referral (e.g., debts under $25 – in which this amount should be footnoted in the remarks section of the Forms CMS-751A/B).

43. Are credit balances included in MSP or do they only pertain to Non-MSP?

Credit balances may be related to MSP or Non-MSP and must be reported to the appropriate reports.

44. In the frequently asked financial reporting questions and answers document that was supplied at the conferences, question #4 states that payments received in excess of what was demanded can be applied to older debt for the same debtor. How is "older debt" defined? Do Medicare contractors apply excess payment to a demand that has not reached 30 days yet?

For MSP and Non-MSP, older debt is defined as other outstanding debt for the same debtor, regardless of the age of the debt. Excess payments can be applied to both principal and interest, with monies being applied to outstanding interest first then principal, to the oldest known debts of the debtor. For example, if a debtor had two other known debts, one with a demand date of June 1, 2001, and one with a demand date of April 1, 2001, apply the excess payment to the debt with the April 1, 2001, demand date. If the demand has not reached 30 days, hold the excess payment amount until the 30 days are met. If no additional payments are received, apply the money accordingly.

NOTE*:* For MSP GHP based debt where the debtor is the insurer, excess payments can only be applied to other debts involving the same employer.

45. Are Contractor Performance Evaluation (CPE) reviews considered external or internal adjustments?

Any adjustments identified via a CPE review would be recorded on Line 5a, Auditor/Consultant Adjustments since these were errors found by someone outside of the Medicare contractor's organization.

<u>Questions Applicable to the Forms CMS-C751A/B & CMS-MC751A/B</u>

46. Should debt that has been referred to the DCC be recommended for reclassification to CNC status?

Yes. Debt that has been referred to the DCC should also be recommended for CNC reclassification since the debt/account receivable will remain in the Medicare contractors' ending balance, even after referral to DCC. Therefore, it is the contractor's responsibility to monitor debt for CNC status. If debt referred to DCC later becomes eligible for CNC reclassification, the Medicare contractor must follow the transfer to CNC approval process outlined in the Medicare contractor instructions. Refer to MIM §1960.19 and MCM §4960.12 for the Non-MSP CNC process and MIM §1960.20 and MCM §4960.13 for the MSP CNC process.

For Non-MSP, debt that was referred to DCC before April 1, 2001, that is being reported by CO will be recommended for CNC status by the CO Division of Financial Reporting and Debt Referral.

47. Who is CMS's Claims Collection Officer? Is there more than one person?

Currently, the Claims Collection Officer for CMS is the Deputy Director for the Accounting Management Group. No, there is not more than one person.

48. As required, Medicare contractors have submitted packages requesting CMS approval to reclassify debt to CNC status. At what point should the ROs forward the CNC approval lists back to the contractor?

Medicare contractors must not remove debts from their Form CMS-751A/B until they receive the signed approval letter from CMS. In accordance with MIM §1960.19 and MCM §4960.12, ROs are required to submit CNC packages to CO no later than 45 days after the end of each quarter. CO will return approved listings to the ROs within 30 days of receipt. Approved reports will be returned to the contractors through the ROs. Upon receipt, the debts would be reclassified to CNC by reflecting the principal and interest amount on Line 6c, Transfers Out to CNC with a corresponding entry on Line 2, New CNC Debt of the Form CMS-C751A/B.

49. How do you book interest that has accrued since the submission of a request to have debt reclassified as CNC? Will CO update the interest amount?

Medicare contractors must continue to accrue interest for debt that has been reclassified as CNC. Additionally, CMS recognizes that systems continue to accrue interest automatically. Therefore, the interest submitted with a recommendation for CNC may differ from the interest shown in the Medicare contractor's system at the time the Medicare contractor receives approval for CNC. The CMS approval of the principal and interest recommended for CNC is sufficient support for the subsequent reclassification, including any additional accrued increase since the date of the request sent to CMS as long as the principal amount remains the same.

50. If a transfer for CNC was submitted in July, and a response has not been received regarding the approval, would an internal adjustment be made in the new fiscal year? How would you handle this?

CNC debt is referred not transferred, therefore it stays on the Medicare contractors' books. Consequently, approval "between fiscal years" is not an issue because Medicare contractors should not do anything with this CNC debt until they have received approval from CO and ROs. Once approval is received, record the approved amounts (principal and appropriate interest) in Line 6c, Transfers Out to CNC of the Forms CMS-751A/B or CMS-M751A/B and Line 2a, New CNC Debt of the Forms CMS-C751A/B or CMS-MC751A/B.

51. Do Medicare contractors need approval to reclassify amounts to CNC?

Yes. For Non-MSP the applicable RO as well as CO's Debt Collection Branch must approve debts that are to be reclassified as CNC. Refer to MIM §1960.19 and MCM §4960.12). For MSP reporting, the applicable RO will approve debts to be reclassified. Refer to MIM §1960.20 and MCM §4960.13.

52. If a collection is received between request and approval of CNC reclassification, what should happen?

RO should be notified of the collection because the account receivable would no longer meet CNC requirements. RO would notify CO if necessary.

53. If interest accrues on the CNC reclassification date, where would the additional interest be reported – on the Form CMS-751A/B or CMS-M751A/B –or – on the Form CMS-C751A/B or CMS-MC751A/B?

The additional interest should be reported on the Form CMS-751A/B or CMS-M751A/B on Line 3, Interest Earned. Then the principal and all interest accrued as of the transfer date should be shown on Line 6c, Transfers Out to CNC and Line 2, New CNC Debt of the Form CMS-C751A/B or CMS-MC751A/B.

54. If a collection deposited at another location is posted to a CNC receivable, should the receivable be removed from CNC status and re-established as a regular account receivable on the Form CMS-751A/B or CMS-M751A/B?

According to the answer given under question #1, Medicare contractors will deposit and reissue any monies received where the accounts receivable is at another Medicare contractor location. Therefore, the situation in this question would not apply.

55. Is there anything that precludes MSP CNC?

All MSP debt that has been reported on the Form CMS-M751A/B report and that is 180 days delinquent must be recommended for reclassification to MSP CNC.

56. Clarify MSP debt eligible for CNC reclassification.

MSP accounts receivable must be 180 days delinquent as of the last day of the quarter prior to the quarter in which the CNC recommendation is submitted for RO approval. "All MSP accounts receivable" means all, without regard to whether the debt is GHP based or liability/no-fault/workers' compensation based and without regard to the type of debtor (employer, insurer, beneficiary, provider/supplier, etc.).

For GHP-based MSP accounts receivable where the demand was issued to the employer, insurer, or third party administrator, GHP, or other plan sponsor, the debt includes all of the claims in a demand to a debtor for a particular beneficiary. For GHP Data Match recoveries, this would be all of the claims associated with a particular Mistaken Payment and Recovery Tracking System (MPaRTS) Report ID, although a single cover letter might have been issued for multiple beneficiaries' Medicare reimbursed claims. For duplicate primary payment recovery demands to a provider/supplier (including physician), the debt includes all claims in the recovery demand regardless of the number of beneficiaries involved. For liability, no-fault, or WC, the debt includes all claims in the recovery demand to a particular beneficiary (or with respect to a particular beneficiary if the demand is issued to someone other than the beneficiary).

57. For the first quarter of FY2002, will there be any new MSP CNC receivables to report?

Beginning October 1, 2001, if Medicare contractors submit requests for MSP CNC and receive approval from the RO before the close of the 1st quarter, then Medicare contractors would record the approved amount on Line 6c, Transfers Out to CNC on the Form CMS-M751A/B and Line 2, New CNC Debt of the Form CMS-MC751A/B.

58. Did CO approve any MSP CNC? Should this be reported on the Form CMS-MC751A/B?

Effective October 1, 2001, ROs will approve MSP CNC debt and this should be reported by Medicare contractors on their Form CMS-MC751A/B. Before October 1, 2001, CO accounted for MSP CNC debt for the Treasury Report on Receivables for reporting purposes. However, these debts remained active on the Medicare contractor's CMS-M751A/B. There is no adjustment for the Medicare contractor or any other action required with respect to the MSP CNC reporting previously done by CO.

59. Who approves MSP CNC reclassification requests?

The Associate Regional Administrator – Division of Financial Management at each RO will approve MSP CNC.

60. How will RO return approval of MSP CNC reclassification to the Medicare contractors?

Medicare contractors may receive written approval of MSP CNC reclassification requests by e-mail where the RO is approving the entire recommended list, as the approval can be sent without including privacy protected information. Where the RO is denying any of the recommended reclassifications, it will send its approvals/denials by fax, if necessary to meet the time frames for

RO approval. (Any denial would normally require identification by HICN or other privacy protected information that cannot be sent over the Internet.) In either situation contractors will also receive a hard copy signed and dated by the Associate Regional Administrator – Division of Financial Management for each RO. (See MIM §1960.20 and MCM §4960.13.)

61. Why is there a difference between how MSP and Non-MSP debt is handled regarding CNC?

There are differing regulatory and statutory bases, which create and affect MSP vs. Non-MSP debts. Additionally, unlike the situation for Non-MSP debt, CMS has no ongoing direct payment relationship with most MSP debtors. For most Non-MSP debts, CMS can recoup from future payments. This is not true for MSP debt. These are the primary reasons for any differences in CNC requirements for MSP vs. Non-MSP debt.

Questions Applicable to DCIA

62. If a Medicare contractor receives a collection (check or offset) for a debt that is at DCC, should CMS or DCC be notified? How?

Yes, notification should be sent to CO. The Medicare contractor would initiate the Collection Reconciliation/Acknowledgement form to notify CO for Non-MSP debts only. See Question #1 for additional instructions.

MSP notifications are made by the Medicare contractor recalling/pulling back the debt from the DCC (PSC or Treasury). The Medicare contractor would need to go into the DCS to accomplish this. MSP collections received on debt previously referred should be recorded on their Form CMS-M751A/B either in Line 4a, Cash/Check Collections or Line 4b, Offset Collections depending on the method of repayment.

63. If there are collections by Treasury or the DHHS PSC (including its contractor) on debt that has been sent to DCC, who will notify Medicare contractors and how will this notification be performed?

Medicare contractors will be notified of collection on MSP debt that has been sent to DCC in the same manner that collections on Non-MSP debt sent to DCC are handled. If there are collections on MSP debt that has been sent to DCC, CO's MSP unit will notify Medicare contractors via the Collection Reconciliation/Acknowledgement Form. The RO will be copied on the correspondence.

64. How should interest be handled on DCC cases? Where should Medicare contractors report accrued interest, when transferring interest to DCC?

Principal and interest are not transferred to DCC. Medicare contractors would **refer** debt to DCC and keep the debt on their books. The debt continues to accrue interest as normal even if the debt is at Treasury for cross servicing, at a Treasury approved private collection agency (PCA), or at TOP.

65. A question was raised about changing the due date of the monthly MSP DCIA Status Report from 15th of the month to the 30th of the month. Would CMS be responsive to this change?

CMS has determined that the due date will be changed from the 15th of the month to the 21st of the month for the monthly MSP DCIA Status Report.

66. Can you provide the contractor with a listing of Federal agencies for exemption identifications in the MSP DCIA process?

CMS is currently compiling a comprehensive list of Federal agencies. In the interim, use the following partial listing:

- Department of Health and Human Services
- Department of Agriculture
- Department of Commerce
- Department of the Interior
- Department of Education

- Department of Housing & Urban Development (HUD)
- Department of State
- Department of Transportation
- Social Security Administration (SSA)
- Department of Veterans Affairs (VA)
- Department of Defense
- Department of Energy
- Department of Labor
- Department of Justice
- Department of the Treasury
- Office of Personnel Management (OPM)
- Administration for Children and Families (ACF)
- Internal Revenue Service (IRS)
- GAO (Government Accounting Office)
- Office of the Inspector General (OIG)
- Office of Management and Budget (OMB)
- The Centers for Medicare & Medicaid Services (CMS)
- U.S. Supreme Court
- U.S. Judicial Circuit Courts of Appeal
- U.S. Court of Appeals for the Federal Circuit
- U.S. Court of Federal Claims
- U.S. Court of Appeals for the Armed Forces
- U.S. Court of Appeals for Veterans' Claims
- U.S. Tax Court
- U.S. Court of International Trade
- U.S. Federal Courts
- U.S. Sentencing Commission
- Federal Judicial Center
- Architect of the Capitol
- U.S. Botanic Garden
- U.S. House of Representatives
- U.S. Senate
- Office of the Clerk
- Congressional Budget Office
- Government Printing Office
- Library of Congress
- Office of Compliance
- Office of Technology Assessment
- Stennis Center for Public Service
- National Institute of Health, operating out of Rockville, MD, is a Federal entity.
- U.S. Postal Service

67. At what point do you recognize MSP debt as being referred to DCC?

Currently, MSP debts are recognized as referred to DCC when the debt is input into the DCS system. Refer to question #42.

<u>Questions Applicable to the Transferring of Accounts Receivable</u>

68. When the transfer process is initiated, should the transferring Medicare contractor stop recording interest? Is there a field on the transfer acknowledgement form that says that interest is accrued through a certain date? Is the accrual of interest up to the date that the transfer request is approved or is it up to the date the transfer is requested?

The transferring Medicare contractor is responsible for reporting accrued interest related to the transferred debt up to the date of receipt of the Transfer Request & Notification of Acceptance Form (TRNA) signed (Line 3) by the receiving Medicare contractor. The receiving Medicare contractor is responsible for reporting accrued interest related to the transferred debt after the accrued interest through date recorded in the documentation submitted by the transferring Medicare contractor up to the date of receipt of the signed (Line 4) copy of the TRNA.

Upon receipt of the TRNA, the transferring Medicare contractor will update its internal system to reflect the transfer of receivables and interest accrued through the date of receiving the approved transfer. The transferring Medicare contractor will update the TRNA to reflect the new interest amount and note the interest accrued through date. The transferring Medicare contractor will sign Line 4 and forward a copy to the receiving Medicare contractor and any additional documentation to acknowledge receipt of the formal approval for transfer. The receiving Medicare contractor upon receipt of the TRNA will update all internal system to reflect the transfer. The receiving Medicare contractor will accrue the additional interest if any, based on the accrued through date and date of receiving the TRNA.

NOTE*:* The principal amount approved by the receiving Medicare contractor will not change, but the interest amounts will differ. The interest amount recorded by the receiving Medicare contractor will always be equal to (if acknowledgement is received on the accrued through date) or greater than the amount recorded by the transferring Medicare contractor.

There is no current TRNA field to provide a place to record an accrued through date. The transferring Medicare contractor must provide this information after signing Line 4 of the TRNA and forwarding the copy to the receiving Medicare contractor to acknowledge receipt of the formal approval for transfer.

The interest recorded by the transferring Medicare contractor is up to the date of receiving a signed copy of the TRNA by the receiving Medicare contractor (i.e., up to the date the transfer request is approved). The interest recorded by the receiving Medicare contractor is up to the date of receiving a signed copy of the TRNA from the transferring Medicare contractor. The receiving Medicare contractor will report the interest reflected on the TRNA and the additional interest accrued up to the date of receipt of the TRNA.

NOTE*:* Debts at Treasury/DCC for cross-servicing and formerly reported by CO will not include the interest accrued to date when CO transfers the debt back to the Medicare contractor location. It will be the responsibility of the Medicare contractor to record the transfer as it appears on the TRNA prepared by CO, and then to increase the interest accrual amount through Line 5a, Adjusted Amounts of the Forms CMS-751A/B and CMS-M751A/B. Furthermore, the amount of the additional interest accrual should be footnoted in the respective report.

69. What happens in the middle of the account receivable transfer process?

The transferring Medicare contractor should contact the receiving Medicare contractor periodically throughout the entire transfer process. This will prevent the overstatement and understatement of receivables.

70. How do Medicare contractors ensure that the interest on the debt being transferred has not fallen off the books?

The receiving Medicare contractor's reported interest should always be equal or greater than the amount of interest reported by the transferring Medicare contractor. The transferring and receiving Medicare contractor are required to maintain detailed transaction level documentation to support accrued interest amounts and retain copies of the signed TRNA.

71. What are the types of receivables that might be transferred to CO or ROs?

CMS does not anticipate accounts receivables being routinely transferred to CO or ROs, with the exception of GHP settlement related debts that do not meet criteria for write-offs closed. However, CMS had to leave the reporting functionality there for any isolated cases, such as bankruptcy cases.

Questions Applicable to Calculating the Allowance for Uncollectible Accounts

72. Would Medicare contractors use the FY September 30 numbers for the preceding years to do the "5 Year Average" uncollectible accounts calculation?

Yes, the 5 year uncollectible accounts calculation uses the last 4 last preceding fiscal years ending September 30 and the current fiscal year to date for a total of 5 calculations.

73. Would Medicare contractors simply have to document that the providers are terminated/bankrupt for the individual account analysis?

No. Simply documenting that a provider is terminated/bankrupt is one step. Medicare contractors should also determine the exact amount of the Non-MSP terminated or bankrupt case and then include the amount in the allowance estimate.

74. What type of justification should be included on the matrix due semi-annually? What narrative is needed since the report shows the results of the three calculation methods, and the highest one chosen?

There are three calculations that are used to validate the allowance for uncollectible accounts. The Medicare contractor's original allowance calculation should be based on the historical uncollectible account percentage. Additionally, there are two ways to validate the reasonableness of the number based on historical uncollectible account percentage. The highest amount resulting from the three calculation methods may not be the amount that ensures that net receivables are reported at their net realizable value. Medicare contractors must consider all the variables related to the validation of the reported estimated allowance and provide the justification for the amount recorded on Line 8, Allowance for Uncollectible Accounts of the Form CMS-751A/B.

75. Will there be an inconsistency in calculating the allowance for uncollectible amounts if Medicare contractors can choose between three methods to calculate the allowance? Why did CMS not select one method and have all Medicare contractors use it?

In response to Medicare contractors' requests for a detailed allowance methodology, CMS developed a protocol for estimating allowance for uncollectible accounts. This protocol complies with FASAB's recommendation that losses on receivables should be recognized when it is more likely than not that the receivables will not be totally collected based on both: 1) specific account analysis, and 2) group analysis. The protocol outlines one methodology that includes three separate analyses to determine the most conservative allowance amount based on each contractor's provider history as well as other existing risk factors. CMS believes that the most conservative approach would be to select the highest amount, but still allow the contractor to select one of the other two calculations, as long as the reason for not using the highest amount is documented.

Questions Applicable to the Reporting of Unfiled Cost Reports as Accounts Receivable

76. Is there a time frame in which we should begin classifying unfiled cost reports as a true receivable?

No. Unfiled cost reports are not to be recorded as a true receivable. The unfiled cost report is to be reflected on the POR system only. The reported amount is based on the value of all payments made to the provider in, and subsequent to, the cost reporting period.

77. How should Medicare contractors go about reclassifying a receivable from the unfiled to a true receivable?

The receipt of an unfiled cost report, thereby being a filed cost report, would trigger the identification of a payable, receivable or both.

The *effective date* for this PM is effective July 31, 2002.

The *implementation date* for this PM is the date of issuance with the exception of FISS/RTS, which will be implemented January 1, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after December 1, 2003.

If you have any questions, contact Lataysheia Lance on (410) 786-0574.

ATTACHMENT

For clarification purposes, the following items/questions are scheduled for the January release for the VMS system.

1) Question 2 – Modify the system so that interest is properly assessed.