



The Challenges of Medicare Bad Debt Reimbursement



To Our Healthcare Clients and Friends:

Reimbursement issues concerning Medicare Bad Debt (MBD) continue to present significant challenges for providers. Interpreting recent court decisions, the potential revision of bad debt policies in association with returning accounts from collection agencies and determining how to best accumulate and complete MBD listings, are some of the key concerns facing providers on this important topic. In this article we will provide the history of MBD, highlight recent court decisions, outline the various MBD challenges and provide the IMA Consulting insights.



BACKGROUND



Medicare beneficiaries receiving hospital services are generally obligated to pay deductibles and coinsurance amounts for those services. In some cases, these amounts are not paid by beneficiaries, causing the potential scenario of the costs of these hospital services being passed on to non-Medicare patients. To prevent this scenario, the Medicare program reimburses providers for these bad debts.

Certain criteria must be met in order for unpaid Medicare deductibles and coinsurance to be reimbursable in the Code of Federal Regulations at 42 CFR 413.89(e). These criteria include:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts;
2. The provider must be able to establish that reasonable collection efforts were made;
3. The debt was actually uncollectible when claimed as worthless;
4. Sound business judgment established that there was no likelihood of recovery in the future.

Sections 308 and 310 of the Provider Reimbursement Manual (PRM) also address these criteria.

Reasonable Collection Efforts

Reasonable collection efforts are addressed in PRM 310 which requires that a provider's effort to collect Medicare patient deductibles and coinsurance amounts be similar to those efforts to collect comparable amounts from non-Medicare patients. Inconsistent collection efforts across different patient payers will likely result in the disallowance of MBD.

Another key component of reasonable collection effort in Section 310(A) of the PRM permits the provider's collection efforts to include the use of a collection agency in addition to, or in lieu of subsequent billings, follow-up letters and telephone and personal contacts. Finally, Section 310(2) of the PRM notes that, if after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date of the first bill, the debt may be deemed uncollectible. Based on this guidance, providers relying on this idea of "presumption of noncollectibility" have for years claimed MBD on their cost reports when accounts are sent to the outside collection agency (OCA). However, in recent years, CMS has been very aggressive in disallowing MBD at an OCA, reasoning that, in cases where the account is still at the OCA, regulations regarding whether the account is actually uncollectible and whether sound business judgment regarding likelihood of non-payment was used, are not satisfied. CMS believes that if an account is sent to an OCA, there is still a likelihood of payment.

Some protections exist for providers from disallowances for their MBD associated with accounts sent to an OCA. In 1987, CMS issued a "Moratorium for Bad Debts" which allowed providers to claim MBD sent to an OCA if the Fiscal Intermediary (FI) allowed the provider to do so prior to August 1, 1987. CMS however, has attempted to restrict the Moratorium in several ways, including the contention it does not apply in situations where a provider undergoes a change in ownership, has a change in provider number or has a change in intermediaries. Another attempt is to assert that a provider has changed its bad debt policy meaning policy previously accepted is no longer valid. More recently, in May of 2008, CMS issued a "joint signature memo" which instructed FI's to disallow MBD remaining at an OCA even if the FI had been allowing these types of MBD in past audits. CMS noted that the MBD would only be allowable once the accounts are returned to the provider as uncollectible. In the memo, CMS asserted that its position had always been that MBD would only be allowed once accounts were returned from the OCA, even prior to the Moratorium. Accordingly, since that was the rule in the first place, the safeguards in the Moratorium were not available, and any provider claims for MBD still at the OCA should be disallowed.

Recent Court Cases

Several recent court cases address the allowability of MBD at an OCA. In *Battle Creek Health Systems v. Leavitt* (6th Cir. 2007) the U.S. Court of Appeals for the Sixth Circuit ruled that accounts at an OCA may not be claimed as MBD until they are returned to the provider. In *Dameron Hospital Association v. Leavitt* (ED Cal 2007), the U.S. District Court for the Eastern District of California ruled that the Moratorium prevented the FI from disallowing a provider's MBD. Notably, the Court ruled in this case that since the FI had final settled the cost report which included payment for the provider's MBD (including those claimed that were still at the OCA) this was acceptance of the provider's bad debt policies. Finally, *Foothill Hospital v. Leavitt* (DDC 2008) also held that the Moratorium prevented the FI from disallowing MBD that had been referred to an OCA but not yet returned to the provider. More specifically, this case held that the Moratorium prevents CMS from revising its bad debt policies after August 1, 1987.

While a couple of these court cases have been favorable to hospitals, uncertainty in the provider community exists regarding the claiming of MBD on cost reports. What is clear is that CMS has taken the position that any MBD claimed for accounts at an OCA will be disallowed unless the provider meets the requirements of the Moratorium. Otherwise, the MBD are not allowable until the accounts are returned to the provider.

CHALLENGES

The position of CMS presents providers with a couple of significant challenges in analyzing and reporting their MBD. First is the issue of preparing an accurate, well-supported MBD listing that ensures all appropriate reimbursement is claimed and that will also prevail upon audit. The second issue is the actions that should be considered with cost reports already filed but not audited, and cost reports already audited that include disallowances. In short, providers will need to address the issue of returning accounts at the OCA in a manner that allows them to claim all appropriate MBD.



INSIGHTS

Preparing Complete, Accurate and Auditable MBD Listings

In preparing the MBD listing that is filed with the cost report, different types of claims can be included.

1. Self pay coinsurance and deductible amounts returned from the OCA

If the Moratorium does not apply, self pay coinsurance and deductible amounts returned from the OCA during the fiscal year of the cost report filing should be included.

2. Medicare patients with Medicaid as secondary insurance

Providers may have Medicare patients with Medicaid as secondary insurance ("dual eligibles"). In Section 1905(p)(3) of the Social Security Act, payment for deductibles and coinsurance is required from the States for dual eligible patients. In Section 1902(n)(2) of the Act, a State is allowed to limit the liability to the Medicaid rate. Essentially this means that a State is not required to pay any portion of a deductible or coinsurance, if the amount paid by Medicare exceeds the amount Medicaid would have paid. Providers may claim these amounts as MBD as long as they bill the State and receive a remittance advice back indicating zero payment.

3. Indigent, bankrupt or deceased patients

Providers should also claim MBD for patients they determine to be indigent and not eligible for payment from any other source. The determination of indigence should be established by the provider using its customary methods including analyzing assets and liabilities, income and expenses and extenuating circumstances of the Medicare beneficiary. Once indigence is determined and documented, providers may consider the debt uncollectible without applying the requirements of PRM 310 noted earlier. Providers should also be aware they may be able to claim MBD for certain beneficiaries that have claimed bankruptcy or deceased beneficiaries.

Form CMS-339 (Provider Cost Report Reimbursement Questionnaire) which is completed as a part of the cost report submission includes an exhibit that can be used to list the MBD claimed. Exhibit 5 includes the following information for each item on the list: name, HIC number, dates of service, an indigency/welfare flag, date of first bill sent, write-off date, remittance advice dates, and amount of coinsurance and/or deductible claimed. Providers should also be sure to offset the total amount claimed by any recovery of bad debt from prior periods. Please also note that for the dual eligibles, it is very important to include the valid Medicaid ID number.

Two key considerations when developing complete, accurate and auditable MBD listings are as follows:

1. Constant and clear communication between the provider's patient financial services (PFS) staff and Medicare reimbursement staff is critical. Medicare reimbursement staff must understand PFS policies related to bad debt processing and PFS staff must be fully educated by the Medicare reimbursement staff on the latest Medicare regulations. This multidisciplinary approach ensures that those two departments most responsible for accurate, appropriate claiming and collection of MBD are fully aware of each other's responsibilities.
2. An easy to follow audit trail of the recording of MBD transactions in the provider's patient accounting system is another key consideration. A clear trail will help the Medicare audit go much smoother for both provider Medicare reimbursement staff and the auditor.

Cost Reports and Returning Accounts from the OCA

As to cost reports already filed, in the event the Moratorium does not apply, a provider with unaudited cost reports has the option of modifying its MBD listing by removing all accounts it claimed that were at the OCA. The provider may then resubmit this listing to the FI. This step may require the amending of the cost report. The provider should then have its accounts at the OCA sent back and claim them in the period recalled.

With audited cost reports, there are cases where a provider's MBD is disallowed for accounts at the OCA. In these cases, the provider should recall these accounts from the OCA and claim them in the period recalled. Alternatively, providers could challenge the disallowance on the audited cost report using arguments from Dameron or Foothill cases mentioned previously, although the time and expense of such an approach should be taken into consideration.

Prospectively, if the provider does not meet the requirements of the Moratorium, it may want to analyze the ramifications of changing its bad debt policies in order to claim MBD in the year recalled. The accounts at the OCA should be reviewed to determine what time period comprises the most likely expectation of payment. For instance, a provider may determine upon review that payments on accounts at the OCA rarely occur after a two year period. The provider could decide to revise its bad debt policy whereby any open account at the OCA, whether Medicare or non-Medicare, would be recalled after this two year period. Under this policy, the provider would claim the MBD in the period recalled.





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The time period selected by the provider is important, as Medicare and non-Medicare bad debts are required to be treated the same as noted earlier. The provider needs to ensure the time period chosen is sufficient for the best likelihood of payment, collection efforts end on these non-Medicare accounts once the claims are recalled.

Some key considerations when bringing accounts back from the OCA are as follows:

1. Determining the criteria of accounts that are to be returned from the OCA. This criteria includes the length of time the accounts are worked at the OCA, the length of time since last payment and the balances of the accounts.
2. Determining which party will determine the return of the accounts. Will the provider give the OCA a list of eligible accounts on a periodic basis? Or will the OCA provide a list of eligible accounts based on meeting the criteria as noted above? Either way, it is important for the provider to post a transaction in its patient accounting system for a returned account, as notes or memos may not be accepted by the Medicare auditor.
3. Renegotiation of the provider's contract with the OCA may be appropriate. This renegotiation could include the criteria for the returned accounts and a clause that accommodates any unforeseen future changes in MBD regulation or process.

SUMMARY

Clearly, the shifting landscape of MBD reimbursement presents significant challenges to providers. Hopefully, the information and insights noted above will assist you in ensuring that you are paid appropriately for this critical Medicare reimbursement area.

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We are pleased to have had the opportunity to provide this information to you. If you have any questions or need assistance related to MBD, please contact me at (616) 826-9586 or Paul Soper, Partner at (616) 340-0618.

Truly yours,

Mark Taylor
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