1

Medicare Bad Debts

- Medicare deductibles and/or coinsurance:
  - Hospital services only (not physician)
  - RHCs
- Paid at 65% of the amount claimed
- Excludes:
  - Noncovered services
  - Fee schedule services
  - Co-pays
  - Professional fees
    - Method II billing
- High audit probability

2

Medicare Bad Debts

- Three types:
  - Reasonable collection efforts
  - Medicaid secondary payor (crossovers)
  - Written off under ~~charity care~~ indigent care
    - Clarification states that charity care is not allowable but indigent care is

3

Polling Question 1

Which types of Medicare bad debts is your facility claiming?

- A – All three types
- B – Only crossovers
- C – No idea
- D - None

4

4

Reasonable Collection Effort

- Deemed uncollectible using the hospital's normal collection efforts
- Treated similarly to other payors, and billed with the intention of receiving payment for at least 120 days:
  - 120 days from date the bill was first sent to beneficiary to date it was deemed uncollectible and written off of the hospital's books
    - Clarification – 120 days starts over after each payment
- Sound business judgment established there was no likelihood of recovery at any time in the future
- Must have auditable support
  - Including the 120 days collection efforts

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Must Bill Patient Within Set Time Frame

- Bad debts are to be "worthless" to be claimed and paid by Medicare
- "Reasonable" was never defined

New! Must bill patient within 120 days of the latest of these:

- Date of Medicare RA
- Date of the secondary payer's RA
- Date of noncoverage by secondary payor

6

6

Recommended Steps

- Update your Medicare bad debt policy to reflect the 120 day rules
  - Starts over each time a patient makes a payment
  - Amount of time from RA to patient
- Devise a way in the patient detail to prove these dates
  - They are both 120 day rules, so devise a way not to get confused on which we are talking about

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Collection Agencies

- Treat Medicare the same as other payors
  - Can pull back differing amounts, but not just all Medicare
- Collection agencies must be trying to collect (reasonable collection efforts apply here!!)
  - Must be able to prove collection efforts
  - No reasonable collection effort – collection agency expense now not allowable
- The 120 day rule applies to them too

8

Recommended Steps

- Update your collection agency contracts to include:
  - Collection efforts for Medicare and non-Medicare are conducted in the same manner
  - Accounts will not be pulled back until at least 120 days after the last payment
  - Collection efforts will be with the intent to collect
- Request a copy of their collection policy to share with Medicare

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Polling Question 2

Do you have your audit documentation from your collection agencies ready?

A- Yes

B – No

C – No idea

10

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Crossovers

- Type of indigent bad debt:
  - Medicaid is responsible for payment of deductible and coinsurance
  - Must be billed and denied by Medicaid
  - Not subject to the 120-day rule
- Can claim partial and full writeoffs
- Auditable support
  - Copy of Medicaid RA

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Medicare Bad Debt – ~~Charity Care~~ Indigent Care (don't call it charity!)

- Type of indigent bad debt:
  - Written off under the hospital's indigent care policy
  - This is often overlooked by hospitals
  - Not subject to the 120-day rule
- Can claim partial and full writeoffs
- Auditable support
  - Are you following your indigent policy?
  - Do you have copies of patient data?
  - Is there support that it was approved?

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Indigent Care versus Charity Care

- Medicare pays for bad debts
- Medicare sees charity as a discount not a bad debt
  - Charity "allowance" is noted as "reductions of charges"
  - Bad debts are amounts "uncollectible from accounts and notes receivable"

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Indigent Care Requires an Asset Test

- CMS Publication 15-1 §312
  - Medicare defines "should" as "must"
  - Provider **should** take into account a patient's total resources…an analysis of assets"
    - "only those convertible to cash and unnecessary for the patient's daily living"
    - Retroactive
  - Other requirements (not changed)
    - Must be determined by provider
    - No one else is legally responsible
    - Patient's file should contain the documentation supporting the claim of indigency (who determined and documents used)

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One Policy or Two?

- If your current charity application requires an asset test:
  - Rename charity "indigent" applications
  - Rename charity policies as "indigent" policies
- If your current charity application does NOT require an asset test:
  - Devise a separate indigent care policy/Medicare bad debt policy
- In both cases:
  - Devise wording in the patient detail that says "indigent bad debt"
  - Ensure all are in a bad debt account on the general ledger.

15

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Polling Question 3

Does your indigent policy include an asset test?

A – Yes

B – No

C – No idea

D – I think you mean charity care policy

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Other Rules

- Must write off in the same manner as other payors
- Must be returned from collections
  - Must have actual collection effort by agency
    - Do you have proof?
- Must be supported by auditable evidence
- Must be claimed in the year it is written off (or returned from collections)

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Same Method as Other Payors

- Issue: collection on $50-$1,400 Medicare coinsurance or deductible compared to $10,000 self-pay amount
- Sent to collections
- Payment schedule
- Called back from collections

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Medicare: the Same Strategies

- Call back from collections based on amount
- Call back based on account activity (120-180 days of no activity)
- Max amount of time to collect on an account (above is better, of course)

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Documentation Issues

- Date written off not in cost report year
- Date written off missing
- Reasonable collection effort for fewer than 120 days (after last payment)
- Not billed to Medicaid
- Includes coinsurance for physicians (Method II issues)
- Error rate extrapolated
  - Over 35%

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Recommendations

- Track throughout the year
- Use identifier in system
- Keep back up data
- Separate spreadsheets
- Use excel formulas
- Devise return from collection plan to optimize collections and payment on Medicare bad debts
- Have formal policies (and follow them)

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Recommendations

- Indigent care should be reflected as indigent bad debt
  - In the patient ledger
  - On the general ledger
  - On the application
  - On the policy
- ** *or implicit price concessions*
- Medicare bad debt should be reflected as bad debt
  - In the patient ledger
  - On the general ledger
- Add asset test to policy
  - Remember liquidate-able assets not necessary for their daily living

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Polling Question 4

Where does your Medicare bad debt write offs currently track to on your general ledger?

A – Bad debt expense

B – Contractual adjustments

C – No idea

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Exhibit 2A — Medicare Bad Debts

- Separate exhibit for each type (regular, indigent, crossover) and by IP/OP/RHC
- Columns:
  1. Last name
  2. First name
  3. Medicare number
  4. Patient account/control number
  5. Admission date
  6. Discharge date
  7. Medicaid number (if crossover)
  8. "Y" for indigent but not crossover; "N" for all other
  9. Medicare remittance advice date
  10. Medicaid remittance advice date; "AD" if using alternative documentation
  11. Date remittance advice was received from secondary payer
  12. Amount the beneficiary is responsible
      1. Type "QMB" for a qualified Medicare beneficiary
      2. For Medicaid crossovers, the amount of state required cost-sharing

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Exhibit 2A — Medicare Bad Debts

- Columns continued

13. Date bill first sent to beneficiary; if QMB type "QMB"
14. Date written off
15. "Y" if sent to collections; if yes the data collection agency returned it
16. Date all collection efforts ceased (internal and external)
17. Date written off as a Medicare bad debt (date should match patient detail)
18. Recoveries for amounts previously claimed
19. Fiscal year the item in 18, if any, applies
20. Medicare deductible
21. Medicare coinsurance
22. Partial payments
23. Source of payment in #22
24. Allowable Medicare bad debt amount
25. Informational comments "wow was this a lot of work"

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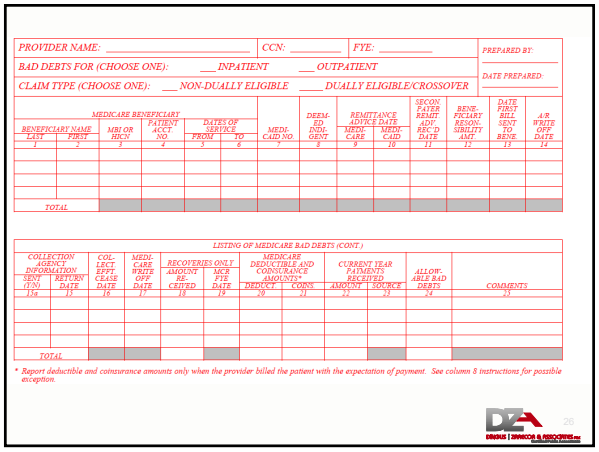

PROVIDER NAME: _____ CCN: _____ FYE: _____

PREPARED BY: _____

DATE PREPARED: _____

BAD DEBTS FOR (CHOOSE ONE): ___ INPATIENT ___ OUTPATIENT

CLAIM TYPE (CHOOSE ONE): ___ NON-DUALLY ELIGIBLE ____DUALLY ELIGIBLE/CROSSOVER

MEDICARE BENEFICIARY								REMITTANCE ADVICE DATE					
BENEFICIARY NAME LAST 1	FIRST 2	MBI OR HICN 3	PATIENT ACCT NO. 4	DATES OF SERVICE FROM 5	TO 6	MEDI-CAID NO. 7	DEEM-ED INDI-GENT 8	MEDI-CARE 9	MEDI-CAID 10	SECON-DAYER REMIT ADV REC'D DATE 11	BENE-FICIARY RESON-SIBILITY AMT. 12	DATE FIRST BILL SENT TO BENE. 13	A/R WRITE OFF DATE 14
TOTAL													

LISTING OF MEDICARE BAD DEBTS (CONT.)

COLLECTION AGENCY INFORMATION		COL-LECT-EFFT. CEASE DATE 16	MEDI-CARE WRITE OFF DATE 17	RECOVERIES ONLY AMOUNT RE-CEIVED 18	MCR FYE DATE 19	MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS*		CURRENT YEAR PAYMENTS RECEIVED		ALLOW-ABLE BAD DEBTS 24	COMMENTS 25
SENT (15) 15a	RETURN DATE 15					DEDUCT. 20	COINS. 21	AMOUNT 22	SOURCE 23		
TOTAL											

* Report deductible and coinsurance amounts only when the provider billed the patient with the expectation of payment. See column 8 instructions for possible exception.

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Polling Question 5

Are you going to change your policies or any other procedures from these changes

A – Yes

B – No

C – Probably should

D – I'll wait for an audit

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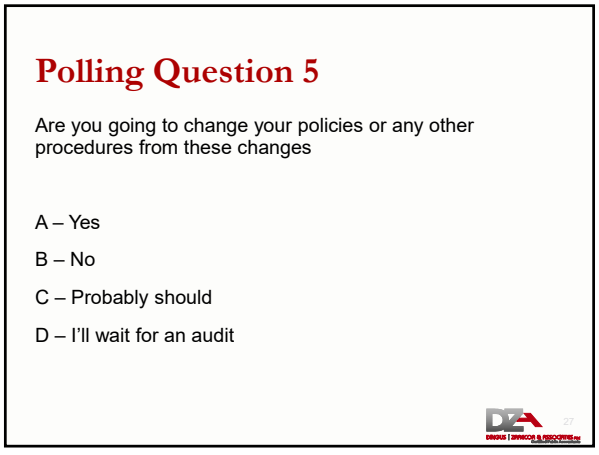

Questions?

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