Changing Requirements for Medicare Bad Debt Reviews?

Hospitals, skilled nursing facilities, and home health agencies in several states are facing challenges related to new requirements imposed during Medicare bad debt audits and desk reviews—and more states may soon be similarly impacted.

Background

Medicare reimbursable bad debt is an established, and often significant, source of additional reimbursement for many hospitals. Providers annually submit their Medicare bad debt listings to their assigned Medicare Administrative Contractor (MAC), along with their Medicare cost report. Providers are then reimbursed a portion (currently 65%) of the total allowable bad debt that is incurred and unpaid by Medicare beneficiaries.

Medicare makes interim payments for bad debts based on the prior-year’s filed cost report and the results of the most recently audited cost report. These payments are based on the amount of bad debt expected for the following year.

Whether or not the MAC performs a review (and which type of review) depends on scoping thresholds as defined by the Centers for Medicare & Medicaid Services (CMS). In accordance with the CMS Provider Reimbursement Manual (Pub. 15-2), Section 308, the debt must meet specific criteria to be an allowable bad debt:

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 uncollectible when claimed as worthless.
4. Sound business judgment determined that there was no likelihood of recovery in the future.

Tracking Bad Debt

The majority of hospital accounting systems write off bad debt balances and archive these amounts in a bad debt sub-ledger for tracking of any potential recoveries. This removes the bad debt account from the hospital’s accounts-receivable ledger and removes the accrued balance of the account from the hospital’s bad debt allowance.
The sub-ledger is used for accounting purposes and serves a valuable function in assisting hospital staff with measuring collection efforts and activities, tracking the aging of accounts, and monitoring potential future recoveries. The sub-ledger has no lingering impact on the hospital’s income statement or balance sheet and is not reflected on financial statements because the accounts have been deemed worthless.

**Palmetto’s New Approach**

At least one MAC, Palmetto GBA, which processes Medicare Part A claims for North Carolina, South Carolina, Virginia, and West Virginia, has begun rejecting Medicare bad debt listings due to a “zero balance policy” and/or the provider’s accounting treatment of account balances.

In the past, MACs have consistently allowed bad debt regardless of accounting treatment, and have accepted dual-eligible adjustment as a Medicaid contractual to represent that the account has been deemed worthless. However, Palmetto GBA appears to have implemented the following new requirements:

1. **It has adopted a “zero balance policy”** that requires the accounts receivable balance on all Medicare bad debt accounts to be equal to zero prior to inclusion on the bad debt listing.
2. **Medicare/Medicaid crossover (dual-eligible) bad debts** must be written off to a bad debt adjustment code. In other words, the bad debt must be written off to an expense account rather than a contractual account.

In September 2018, the North Carolina, South Carolina, Virginia, and West Virginia hospital associations sent a letter to CMS officials raising concerns about Palmetto GBA’s increased focus and scrutiny of Medicare bad debt and requested clarification of Palmetto’s policy reinterpretation. The letter addresses the lack of notice or justification for a retroactive implementation of the policy.

The letter references the Provider Reimbursement Manual (PRM) Chapter 3 and 42 C.F.R. related to Medicare bad debt. It draws attention to the lack of language regarding the specific accounting treatment of the uncollectible sub-ledger’s account balance after it is written off from active accounts-receivable as a bad debt expense. Agency rules require that administrative offices give regulated parties fair notice of requirements imposed upon them.

Therefore, the implied new interpretation of the bad debt regulations “should not be applied retroactively to disallow the costs at issue because the Providers did not have fair notice at the time of the different view of the law.” The joint letter asserts that a provider must first be afforded fair notice of the new interpretation with “ascertainable certainty” prior to the MAC’s application of the requirement.

The joint letter to CMS also explains how the auditors could potentially verify the provider’s sub-ledger by requesting proper supporting documentation.

**How to Respond**

Inconsistencies abound with the enforcement of Palmetto’s new “zero balance” policy and dual-eligible adjustment code requirements relative to the text and purpose of the Medicare statute and the PRM. While we are not aware of other MACs adopting a similar policy, hospitals should consider the impact in the event their assigned MAC adopts the same reinterpretation. Revenue cycle collaboration is key.
to a successful reimbursement claim, and evaluating current processes and practices can assist in enhancing payment. Finance personnel should maintain regular communication with the business office to address issues affecting Medicare bad debt, including accounting treatment, recoveries, timely billing, collection effort, and write-off procedures.

In the past, hospitals could reopen past cost reports to claim bad debt reimbursements from prior fiscal years, based on new and material information. However, MACs have been more restrictive regarding this practice. Additionally, reimbursement for Medicare bad debt eventually may be discontinued given Medicare budget cuts.

Thus, taking steps to accurately and efficiently identify reimbursable bad debts is particularly important now while the funds are still available. The complexity of data collection contributes to denials and missed reimbursement opportunities. Critical measures include keeping accurate records, maintaining standard procedures and required elements, engaging in mock audit procedures, and tracking throughout the year.

Healthcare entities should proactively educate their executives and board members about new requirements and financial reporting impacts related to the implementation of the Financial Accounting Standards Board’s Accounting Standards Codification (ASC) Topic 606, *Revenue from Contracts with Customers*. Restrictions on what may be reported as bad debt and the fundamental changes to the way in which hospitals recognize revenue based on the new accounting standard will need to be considered for cost reporting purposes. Hospitals should review their bad debt policies and determine if changes are necessary due to the introduction of the implicit price concession concept.

PYA’s team of healthcare industry experts can help optimize Medicare bad debt reimbursement for your facility (in compliance with regulations), assist with cost reporting, develop best practices related to bad debt policy and procedures, perform mock audits, or advise on other reimbursement matters. For more information, or if you would like assistance with any matter involving reimbursement, healthcare compliance, or financial reporting, contact a PYA executive below at (800) 270-9629.

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