MEDICARE BAD DEBT AS IT RELATES TO THE REVENUE CYCLE PROCESS

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Today's Topics

- Medicare Bad Debt Defined
- Write-off and Documentation Requirements
- Policy and Procedural Considerations
- Implications of Final Rule Clarifications and Codifications
- Accounting Treatment
- Strategies and Cross-Departmental Collaboration
- Participant Questions (Time Permitting)

Defining Medicare Bad Debt

- Claimed on provider's annual Medicare cost report
- 65% reimbursement from the Medicare program
- Basic Criteria:
  - Related to covered services and derived from deductible and coinsurance amounts
  - Requires reasonable collection efforts
  - Debt was actually uncollectible when claimed as worthless
  - Sound business judgement established that there was no likelihood of recovery at any time in the future

Medicare Bad Debt Exclusions

- All coinsurance and deductible amounts related to physician services (PPS- professional review codes billed on a UB) and amounts paid on a fee schedule (i.e., DME, ambulance, laboratory and therapy services) should be excluded from your Medicare bad debt listings.
- Some other exclusions include:
  - Medicare advantage bad debt
  - Coinsurance and deductibles related to non-covered service items
  - Non-Medicare recipients and self-pay & non-Medicare contracted providers
  - Presumptive charity
  - Other amounts (copays, TPLs, share of cost, spend down)

Regulatory Authority

- Primary Regulatory Authority:
  - 42 CFR 413.89
  - Provider Reimbursement Manual
- MAC Processes and *Interpretations*
- The latest reporting requirements are outlined in the 2021 IPPS Final Rule, which clarifies and codifies Medicare bad debt reporting requirements.

  Federal Register/Vol. 85, No. 182
- New Paperwork Reduction Act (PRA) *Exhibit 2A* for supporting Medicare bad debt

Three Types of Medicare Bad Debt

- Traditional (***Non-indigent***)
  - Beneficiary is not indigent or eligible for Medicaid
  - Reasonable collection efforts required

- Crossover (***Indigent dual-eligible***)
  - No patient liability
  - Beneficiary is eligible for both Medicare and Medicaid
  - Medicare is primary
  - Providers must bill Medicaid for deductible and coinsurance (final rule exception)

- Indigent (***Indigent non dual-eligible***)
  - No patient liability
  - Beneficiary is not eligible for Medicaid
  - Indigency determined by taking into account a patient's total resources

Documentation Requirements

Supporting documentation requests **vary by type and by MAC.**

By type:

- **Non-indigent** ("traditional") support may include:
  - Collection agency reports
  - A/R write off & patient notes
  - Remittance advices (Medicare and other payors)
  - Billing and collection policy
- **Indigent dual-eligible** ("crossovers") support may include:
  - A/R write-off (bad debt write-off vs. contractual write-off)
  - Medicare remittance advice (identifies deductible/coinsurance)
  - Medicaid remittance advice (Medicaid liability)
- **Indigent non dual-eligible** ("indigent") support may include:
  - Hospital-specific indigence policy and financial assistance applications
  - Income and asset verification
    - Bank statements
    - W-2's and/or tax returns

Bad Debt Log Requirements – Historical

Present Requirements
Patient Name
HIC # or MBI #
Dates of Service
Indigency Determination
Medicaid # (if applicable)
Date of First Bill
Write off Date (bad debt)
Medicare Remit Date
Deductible / Coinsurance from Remit
Total Bad Debt

Bad Debt Log Requirements – Proposed

Proposed Additional Requirements (Paperwork Reduction Act – effective FYB 10/1/2020)	
Header: CCN	Source of payment(s)
Header: Provider name	Medicaid remit date
Header: Fiscal year end	Provider comments
Header: Preparer name	Recoveries (after write-off - current or prior period)
Header: Date prepared	Fiscal year bad debt was claimed (recoveries)
Patient account #	Collection agency (Y/N)
Secondary remit date	A/R write-off date
Patient responsibility	Date returned from collection agency
QMB status (Y/N)	Date all collection efforts ceased (internal/external)
State Medicaid liability	Payments received (before write-off)

Proposed List Format- *Exhibit 2A*

DRAFT FORM CMS-2552-10 4004.2 (Cont.)

EXHIBIT 2A

LISTING OF MEDICARE BAD DEBTS

PROVIDER NAME: _____	*CCN:* _____	*FYE:* _____	*PREPARED BY:* _____
BAD DEBTS FOR (CHOOSE ONE): ___ *INPATIENT* ___ *OUTPATIENT*			*DATE PREPARED:* _____
CLAIM TYPE (CHOOSE ONE): ___ *NON-DUALLY ELIGIBLE* _____ *DUALLY ELIGIBLE/CROSSOVER*			

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

Source: The Provider Reimbursement Manual-Part 2 Chapter 40 Section 4004.2 *"Hospital and Hospital Health Care Complex Cost Report Form CMS-2552-10"*

Proposed List Format - *Exhibit 2A* continued

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

Rev. 40-51

Source: The Provider Reimbursement Manual-Part 2 Chapter 40 Section 4004.2 *"Hospital and Hospital Health Care Complex Cost Report Form CMS-2552-10"*

Presumptive Eligibility

- For indigent non dual-eligible claims, presumptive eligibility tools alone are insufficient:
  - Use of a sliding scale
  - Federal poverty level thresholds
  - Credit scoring systems
- Providers should review their current financial assistance policies to ensure they include provisions to satisfy Medicare guidelines for indigency determination:
  - Income and asset verification (only liquid assets)
    - Liabilities & expenses verification no longer required
      - Can be used to further assist with indigency qualification
  - Financial assistance applications
  - Provider determination (rather than patient declaration)
  - Verify no source other than patient would be legally responsible

Presumptive Eligibility

- The 2021 IPPS Final Rule indicates the "*criteria for other indigence programs, such as charity care, may have different program or policy requirements than Medicare bad debt. Medicare does not pay providers directly for charity care, whereas Medicare bad debt amounts may be allowable, and directly paid to various provider types, without the providers performing a reasonable collection effort if the beneficiary qualifies for indigence.*"*

  ***Source: Federal Register/Vol. 85, No. 182 page 58998**

- Provider "*must maintain and furnish, upon request, to its Medicare contractor, documentation (for example, a Policy for Determination of Indigence) describing the method by which indigence or medical indigence was determined and the beneficiary specific documentation which supports the provider's documentation of each beneficiary's indigence or medical indigence.*"**

  ****Source: § 413.89(e)(2)(ii)(B)**

- Once indigence is determined, bad debt can be deemed uncollectible without applying a collection effort.

Policy Alignment

- Only non-indigent (traditional) Medicare bad debt requires patient billing and collection effort. Providers should:
  - Ensure no separate policy exists for Medicare billing & collections, since collection effort must be similar between Medicare beneficiaries and non-Medicare beneficiaries.
  - Meet CMS' other "reasonable" collection effort requirements
    - Timely billing
    - Subsequent billings, collection letters and/or telephone calls or personal contacts
    - 120-day rule

Similar Collection Effort

- If non-Medicare bad debt is sent to a collection agency, then Medicare bad debt of "like amount" should also be sent to the collection agency.
  - The "like amount" may include uncollected patient charges above a specified minimum amount
  - If sending non-Medicare but not Medicare, this determination must be made based on the amount of uncollected charges and not the class of the patient (Medicare vs. non-Medicare).
  - Collection agency must use similar collection practices for both Medicare and non-Medicare patients
  - Medicare bad debt should be recalled/returned from collections in a similar manner

2021 IPPS Final Rule

CMS' intention is to clarify and codify longstanding CMS policy that has been the subject of litigation and PRRB appeals related to inconsistently treated Medicare bad debt.

Retroactive (effective prior to and after 10/1/2020)	Prospective (effective 10/1/2020)
Definitions (3 types)	Timely billing – defined as 120 days
Write-off (120-day rule) – payments reset this clock	Indigency determination requirements
Billing mechanisms (emails texts, etc.)	ASC Topic 606 terminology adopted
Similar collection effort clarified	
Medicaid "Must Bill" policy – alternative documentation	
Recoveries clarified	
Technical corrections	
All deemed "longstanding" policy	

Final Rule - Retroactive by Type

2021 IPPS Final Rule – **Retroactive** Medicare Bad Debt Clarifications.

- **Non-indigent** ("traditional" or "regular"):
  - Reasonable collection effort clarified:
    - Emails, phone calls & text messages are valid mechanisms for billing
    - CMS 120-day rule:
      - Write-off must occur at least 120 days after first bill date
      - 120-day clock resets upon receipt of any partial payment
  - Medicare bad debt recoveries clarified:
    - Payments received on an amount that was previously claimed and paid as a Medicare bad debt, in a prior cost reporting period
    - Payments received in the current cost reporting period for bad debts claimed in the current cost reporting period
    - Include in period received

Final Rule - Retroactive by Type

2021 IPPS Final Rule – **Retroactive** Medicare Bad Debt Clarifications.

- **Non-indigent** continued:
  - Similar collection effort clarified
    - Effort must be similar to effort put forth to collect comparable amounts from non-Medicare patients.
    - Based on amount (not class)
    - Recalled/returned similarly

      Note: All collection effort must cease prior to write-off
  - Providers must maintain and, upon request, furnish the following verifiable documentation to its assigned MAC:
    - Bad debt collection policy which describes the collection process for Medicare and non-Medicare patients
    - The patient account history documents (collection actions/patient notes)
    - The beneficiary's file with copies of the bill(s) and follow-up notices.

Final Rule - Retroactive by Type

- **Indigent Dual-eligible** ("crossovers"):
  - PRM Section 312 "must-bill" policy (subject to frequent litigation)
    - **QMB** beneficiaries require State billing (Medicaid RA)
    - Alternative Medicaid RA documentation
      - When State does not process a Medicare crossover claim and issue a Medicaid RA – provider must submit:
        - State Medicaid notification evidencing lack of obligation or notification of the provider's inability to enroll (Title XIX).
        - Documentation setting forth the State's liability, or lack thereof, for the Medicare cost sharing
          - May require calculation of what the state owes for cost-sharing
        - Documentation verifying the beneficiary's eligibility for Medicaid for the date of service
- **Indigent Non dual-eligible** beneficiary defined as "*a Medicare beneficiary who is determined to be indigent by the provider and not eligible for Medicaid as categorically or medically needy*."

Prospective Changes (effective 10/1/2020)

2021 IPPS Final Rule – **prospective** Medicare Bad Debt Revisions

- **Timely billing** (**non-indigent only**):
  - **Prior to 10/1/2020** – provider must issue a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations "*on or shortly after discharge or death of the beneficiary*."
  - **On or after 10/1/2020** – provider must issue the bill "*on or before 120 days after the latter of*" one of the following:
    - The date of the final Medicare remittance advice that generates the beneficiary's cost sharing amounts
    - The date of the remit from the secondary payer, if any
    - The date of the notification that the secondary payer does not cover the service(s) furnished to the beneficiary

Prospective Changes (effective 10/1/2020)

- **Indigent Non dual-eligible** bad debt:
  - Must evaluate the beneficiary's total resources
    - Income and asset verification
      - Only assets convertible to cash and unnecessary for the patient's daily living
    - Liability & expense verification no longer required, but can be used to further assist with indigency qualification
    - Completed financial assistance applications
  - Provider must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill (e.g., legal guardian or state Medicaid program).
  - No longer a need to conclude "that there has been no improvement in the beneficiary's financial status."
  - Provider determination (rather than patient declaration)
  - Presumptive eligibility tools alone are insufficient

Prospective Changes (effective 10/1/2020)

- Accounting Standards Update (ASU) Topic 606, Revenue from Contracts with Customers, **terminology**:
  - Topic 606-published May 2014 and implemented in 2018
  - April 4, 2019 MLN SE article – served as notification
  - **Prior to 10/1/2020**, Medicare bad debt **"***must not be written off to a contractual allowance but must be charged to an* ***expense account*** *for uncollectible accounts***"** (reduction in revenue).
  - ***On and after 10/1/2020**, Medicare bad debt **"***must be recorded in the provider's accounting records as a component of net patient revenue" and "must not be written off to a contractual allowance account but must be charged to an* ***uncollectible receivables account*** *that results in a reduction in revenue***"** (implicit price concessions).

*Per CMS, there is "*no change in the required criteria a provider must meet to qualify a beneficiary's bad debt account for Medicare bad debt reimbursement under Section 413.89*."

Action Steps and Strategies

- Communicate Final Rule clarifications and codifications.
- Evaluate the process of recording write-offs in the general ledger – all types (no contractual write-offs)
- Closely review all cost report communications.
- Request reopening for any denials related to retroactive clarifications (i.e., crossover alternative documentation or timely billing exceptions deemed material where phone calls, emails or text messages may not have been previously considered)
- Review billing and collections policies and procedures to ensure collection effort is similar between Medicare and non-Medicare beneficiaries (based on amount and not class) and ensure these are being recalled / returned from collections in a similar manner.
- Review financial assistance policy to determine if updates or additional policy may be needed to meet CMS requirements for claiming indigent non dual-eligible Medicare bad debt.
- Providers should evaluate their process for capturing first bill dates on their Medicare bad debt logs (consider all valid mechanisms)

Action Steps and Strategies

- Providers should review their recovery logs for accuracy
- Beware of financial class changes / premature write-off.
- Include all applicable write-off transaction codes.
- Maintain bankruptcy court filing documents for bankrupt patients
- Maintain probate (lack of estate or responsible party) for deceased patients
- Perform Medicaid eligibility verification (all indigent beneficiaries)
- To meet 120-day rule requirements related to partial payments:
  - Consider working with final collection agency to exclude accounts with recent payments (< 120 days) from recall until at least 120 days has passed from date of most recent payment.
  - Request system report with latest payment dates to identify accounts with recent payments (< 120 days) for use in crossmatching to final (non-indigent) bad debt logs. Eliminate these accounts and flag for inclusion on subsequent cost report.

Best Practices

- Collaborative effort between revenue cycle function and reimbursement function.
- Ensure accurate record keeping
- Follow Final Rule accounting treatment specifications and write-off all account balances.
- Prepare listings in exhibit 2A format
- Perform basic log testing procedures prior to cost report submission
- Remove any outpatient services paid on a fee schedule
- Separate bad debt listings by CCN and by type:
  - Three types of Medicare bad debt
  - Inpatient vs. outpatient vs. subunit

Additional Recommendations

- Discuss Medicare bad debt guidelines (reimbursement and revenue cycle)
- Implement critical controls and measures:
  - ❑ Track throughout the year
  - ❑ Maintain standard policies and procedures
  - ❑ Perform occasional mock audits
  - ❑ Review a sample of high dollar claims
  - ❑ Leverage technology and ensure data integrity
  - ❑ Benchmarking - to quantify opportunity and measure performance

Basic Log Testing Procedures – Checklist

- ❑ Perform a search for duplicates. Include accounts from prior year submission.
- ❑ Ensure all write-off dates fall within the current cost reporting period.
- ❑ Calculate to verify bad debt does not exceed total deductible + coinsurance.
- ❑ Foot and cross-foot the bad debt listing and include a summary.
- ❑ Confirm all required information is included.
- ❑ Perform the following calculations on the Traditional bad debt listings:
  - Timely Billing: Patients should be billed timely (utilize Final Rule clarification for calculation)
  - 120-Day Rule: Accounts should not be written off until at least 120 days after the patient's first bill date. Note than any payment resets the 120-day rule clock.


QUESTIONS?
COMMENTS?
CONCERNS?

Thank You!

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