Overview of Medicare Bad Debts

Rural Health Clinic Update Seminar

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Kraft Healthcare Consulting LLC

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Medicare Bad Debts

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- 42 Code of Federal Regulation (CFR) §413.89/Provider Reimbursement Manual (PRM) 15-1 § 308

- Allowable Medicare Bad Debts:

  - Bad debts resulting from deductible and coinsurance amounts of covered services which are uncollectible from Medicare beneficiaries

  - Currently reimbursed at 65%

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Middle Class Tax Relief and Job Creation Act of 2012

- Signed into law February 22, 2012 by President Obama
  - Federal Register Published November 9, 2012
  - Reimbursement Reduction of Medicare Bad Debts

Middle Class Tax Relief and Job Creation Act of 2012

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	2012	2013	2014	2015 & later
Hospitals	70%	65%	65%	65%
SNF & Swing Bed (non-full Dual Eligibles)	70%	65%	65%	65%
SNF & Swing Bed (Full Dual Eligibles)	100%	88%	76%	65%
Critical Access Hospitals	100%	88%	76%	65%
ESRD Facilities	100%	88%	76%	65%
CMHC, FQHC, RHC	100%	88%	76%	65%

§308-Criteria for Allowable MCR Bad Debt

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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 at any time in the future.

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§310-Reasonable Collection Effort

- Important Note: Effort to collect MCR coinsurance and deductibles must be similar to the effort put forth to collect comparable amounts from non-Medicare patients

§310-Reasonable Collection Effort

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- Must involve:
  - The issuance of a bill on or shortly after discharge of the beneficiary

New clarifying language as of CMS Final Rule 2021:

It must involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after: (1) The date of the Medicare remittance advice; or (2) the date of the remittance advice from the beneficiary's secondary payer, if any; whichever is latest.

  - "Genuine" collection effort
    - Subsequent billings, collection letters, telephone calls, etc.
  - The use of a collection agency in addition to or in lieu of above

Note:

You must document the collection effort in the patients file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

Delays in sending a timely first bill could result in the disallowance of the bad debt claim.

§310-Reasonable Collection Effort

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- Collection agency fees are an allowable administrative cost to the provider, BUT
- the full amount collected by agency must be credited to the patient's account and the collection fee be charged to administrative cost.

- Example:
  - Collection from MCR Beneficiary $40
  - Agency Fee $20

  - Must record $40 to the patient's AR balance, then record $20 as administrative costs. Cannot claim agency fee as MCR bad debt.

§310-Reasonable Collection Effort

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- Reasonable and customary efforts have been made to collect the bill (§308 criteria #2) and the debt remains unpaid for more than **120 days from the date of the first bill** is mailed to beneficiary, the debt can be deemed uncollectable.

- Any payments received from the beneficiary will re-start the 120 day uncollectability timeframe.

§312- Indigent Patients

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- If patient is deemed indigent by provider standards, and provider concludes no improvements in beneficiary's financial condition, the debt may be deemed uncollectable without applying the §310 procedures.
- Provider Internal Policy
  - Must be determined by provider not the patient
  - Must analyze assets, liabilities, expenses, and income
  - Must determine no other source other than the patient would be legally responsible
  - Patient's file must contain documentation supporting determination

§322- Medicare Beneficiaries with Medicaid Secondary

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- Most states participate in title XIX state plans
  - If obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts **are not allowable** MCR Bad Debts
  - States do not have an obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan. These amounts **are allowable** as MCR bad debts.

§322- Medicare Beneficiaries with Medicaid Secondary

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- In some instances, the State has an obligation to pay, but either does not pay anything or pays only part of the deductible or coinsurance because of a State payment "ceiling."
- In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 (indigent) are met.

Must Bill Policy for Dual Eligible Beneficiaries

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- Section 1905(p)(3) of the Social Security Act (Act) imposes liability for cost sharing amounts for Qualified Medicare Beneficiaries on the States
- Section 1902(n)(2) allows states to limit that amount to the Medicaid rate and essentially pay nothing toward dual eligibles cost sharing if the Medicaid rate is lower than what Medicare would pay for the service
- In these instances, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the **provider bills the State, and the State refuses payment with a State Remittance Advice**

§314-Accounting Period for Medicare Bad Debts

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- Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless
- The provider should have the usual accounts receivable records-ledger cards and source documents to support its claim for a bad debt for each account

§316-Recovery of Bad Debts

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- Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period
- If recoveries are made in a subsequent reporting period for bad debts reimbursed in a prior period, reduce reimbursable costs in the recovery period by the amount received
- Do not reduce reimbursable costs in the subsequent period more than you were actually reimbursed in the prior period

Currently Effective Log

04-06 EXHIBIT 5 1102.3 (Cont.)

LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

PROVIDER _____ PREPARED BY _____

NUMBER _____ DATE PREPARED _____

FYE _____ INPATIENT _____ OUTPATIENT _____

(1) Patient Name	(2) HIC. NO.	(3) DATES OF SERVICE		(4) INDIGENCY & WEL. RECIP. (CK IF APPL)		(5) DATE FIRST BILL SENT TO BENEFICIARY	(6) WRITE-OFF DATE	(7) REMITTANCE ADVICE DATES	(8)* DEDUCT	(9)* CO-INS	(10) TOTAL
		FROM	TO	YES	MEDICAID NUMBER						

* THESE AMOUNTS MUST NOT BE CLAIMED UNLESS THE PROVIDER BILLS FOR THESE SERVICES WITH THE INTENTION OF PAYMENT. SEE INSTRUCTIONS FOR COLUMN 4 - INDIGENCY/WELFARE RECIPIENT, FOR POSSIBLE EXCEPTION

Rev. 6 11-37

Anticipated to be Effective after Transmittal 18

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														
BENEFICIARY NAME		*MBI OR HICN*	*PATIENT ACCT. NO.*	*DATES OF SERVICE*		*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*
LAST	*FIRST*			*FROM*	*TO*			*MEDI-CARE*	*MEDI-CAID*				
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*
TOTAL													

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.*

Notable Changes

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- New Medicare Bad Debt Exhibit 2A
  - New Medicare bad debt template would increase the required columns from 10 to 25

1. Medicare Beneficiary Name – Last (1a)
2. Medicare Beneficiary Name – First (1b)
3. Medicare Beneficiary MBI or HICN (2)
4. Medicare Beneficiary Patient Account Number
5. Medicare Beneficiary Dates of Service – From (3a)
6. Medicare Beneficiary Dates of Service – To (3b)
7. Medicaid No. (4b)
8. Deemed Indigent (4a)
9. Remittance Advice Date – Medicare (7)
10. Remittance Advice Date – Medicaid
11. Secondary Payer Remittance Advice Received Date
12. Beneficiary Responsibility Amount
13. Date First Bill Sent to Beneficiary (5)
14. A/R Write Off Date
15. (a) Collection Agency Information – Sent (Y/N)
15. Collection Agency Information – Return Date
16. Collection Effort Cease Date (6)
17. Medicare Write Off Date
18. Recoveries Only – Amount Received
19. Recoveries Only – Medicare FYE Date
20. Medicare Deductible (8)
21. 9 Medicare Coinsurance (9)
22. Current Year Payments Received – Amount
23. Current Year Payments Received - Source
24. Allowable Bad Debts (10)
25. Comments

Bad Debt Log Checklist

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- Do not include accounts that were claimed in prior years
- Do not duplicate accounts for the current year *(this could occur if a claim is cancelled and subsequently re-billed)*
- Ensure the bad debt relates to unpaid Medicare deductible and coinsurance only
- Do not include Medicare HMO bad debts
- Ensure the bad debt is net of any payments received from the beneficiary or other third party payers. Be able to provide third party remittance advices or proof that deductible/coinsurance is not covered

https://med.noridianmedicare.com/web/jea/audit-reimbursement/audit/bad-debt

Bad Debt Log Checklist

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- For inpatient dual eligible bad debts, ensure that all charges are billed to Medicaid
- For outpatient dual eligible bad debts, ensure that at least all charges with associated coinsurance are billed to Medicaid
- Ensure that Medicaid is billed timely and a remittance advice showing payment or a valid rejection is available
- Ensure that indigent bad debt claims are fully documented with respect to the determination of the beneficiary's total resources
- For non-indigent, non-dual eligible accounts ensure that collection activity is documented in the file. If accounts are sent to a collection agency, be able to provide clear evidence that accounts were returned from collection
- For deceased patients, ensure that the determination that there was no estate available is fully documented. A statement from a surviving family member that there is no estate is not acceptable.

https://med.noridianmedicare.com/web/jea/audit-reimbursement/audit/bad-debt