
# MEDICARE BAD DEBTS

Northwest Ohio HFMA
February 14, 2018

# AGENDA

- Understanding Medicare Bad Debts (MBD)
- Medicare Bad Debt Categories
- Medicare Administrative Contractor (MAC) Audit

# UNDERSTANDING MBD

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- Medicare deductible & coinsurance amounts which remain unpaid by Medicare beneficiaries
- Reimbursable by Medicare if certain criteria are met
- Relate to specific deductible & coinsurance amounts
- Currently reimbursed @ 65% of **allowable** write-offs
  - See PRM-1, Chapter 3, 302.2

# UNDERSTANDING MBD (CONTINUED)

- Medicare bad debt is not:
  - Coinsurance and deductible amounts for services paid on a fee schedule
    - Ambulance, laboratory and therapy services
    - Durable Medical Equipment
- Coinsurance and deductible amounts related to
  - Physician Services
    - PPS – professional review codes (96X,97X, and 98X) billed on UB
- Self pay or any other non-Medicare recipients
  - Unpaid charges are not reimbursable by Medicare

# UNDERSTANDING MBD (CONCLUDED)

- Non-Medicare contracted providers
  - Bad debts for services occurring at non-certified sub-providers
- Medicare Advantage Plans (MA)
  - Should not be reported on the Medicare bad debt logs
  - Not reimbursable under the traditional Medicare contract
  - Include MA bad debt reimbursement during contract negotiations with the individual MA plans

## ASK FOR IT!

# MA CONTRACT NEGOTIATIONS

**SECUREHORIZONS MEDICAREDIRECT™**
**Private Fee-For-Service (PFFS) PLANS**
**Frequently Asked Questions**
**Live Secure. Be Secure.™**
**Bad Debt Submission**

Q: **Can providers be reimbursed for bad debt associated with the PFFS enrollees?**
A: Yes. Providers must make reasonable and customary collection efforts before categorizing a patient account as uncollectible (bad debt). Charges for non-covered services are not eligible for bad debt reimbursement.
Q:**How long before a request can be made for reimbursement?**
A: Providers may submit a request for bad debt no less than 120 days from the date the enrollee received the first bill for the claim in question.
Q:**What should the request for reimbursement include?**
A: Providers must completely fill out the bad debt submittal form, listing only the amount of cost sharing for covered services assessed under the enrollee's Secure Horizons Medicare Direct benefit plan that could not be collected from the enrollee, net of any partial amount(s) collected. Please note that documentation of billing and collection efforts may be requested during processing.
Q:**Where can I obtain the form?**
A: The form can be downloaded from www.securehorizons.com. Under Resources, click on Information for Providers. Next, click on Secure Horizons Medicare Direct and then Proceed. Select the "Bad Debt" form from 2007 Secure Horizons Medicare Direct documents.

www.unitedhealthcareonline.com

# MA CONTRACT NEGOTIATIONS (CONCLUDED)

Aetna will make additional payments for bad debt to facilities eligible for bad debt reimbursement in accordance with the Centers for Medicare and Medicaid Services (CMS) guidelines set forth in Chapter #3 of the CMS Provider Reimbursement Manual (Publication 15-1 - CMS Provider Reimbursement Manual - Part 1) ("CMS Guidelines"). In accordance with CMS Guidelines, Aetna will reimburse such eligible facilities a percentage of uncollectible bad debt that results from unpaid Aetna Medicare Open Plan (PFFS) member out-of-pocket costs.

**What types of facilities can submit a request for Bad Debt reimbursement to Aetna?**
Hospitals may submit a request for "eligible" bad debt reimbursement to Aetna after making reasonable and customary collection efforts. As outlined in CMS Guidelines, facilities will receive 70% of their eligible bad debts, with the exception of Critical Access Hospitals, Rural Health Clinics and Federally Qualified Health Centers. Critical Access Hospitals, Rural Health Care clinics, and Federally Qualified Health Centers will receive 100% of their eligible bad debts.

**What is eligible Bad Debt?**
"Eligible bad debt" is defined as uncollected cost sharing (i.e., copayments, deductibles or co-insurance) that was applied to covered services rendered by the eligible facility under the Aetna Medicare Open Plan that an Aetna Medicare Open Plan member is directly responsible to pay, and that the eligible facility was unable to collect from the member despite reasonable efforts.

**When can Bad Debt be submitted to Aetna?**
Eligible facilities may submit a request for eligible bad debt to Aetna no less than 120 days from the date the Aetna Medicare Open Plan member received the first bill for the claim in question.

**How is Bad Debt Submitted to Aetna?**
Eligible facilities must completely fill out either the Aetna PFFS Bad Debt Web Form and submit, or print the Aetna PFFS Bad Debt Report (1 page) and fax to Aetna at 860-754-2171. Charges for services that are not covered under the Aetna Medicare Open Plan may not be listed in the Bad Debt Report.

www.aetna.com

# CRITERIA FOR CLAIMING MBD

- Must relate to deductible & coinsurance amounts of Medicare covered services
- Reasonable collection efforts must be met
- Debt was actually uncollectible & deemed worthless when claimed
- Sound business judgement utilized to determine no likelihood of future recovery
  - See PRM-1, Chapter 3, Section 308

# MEDICARE BAD DEBT CATEGORIES

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- Dual Eligible (Crossovers)
- Charity/Financial Assistance
- Bankruptcy/Deceased
- Traditional (Collection Accounts)

# DUAL ELIGIBLE

- Also referred to as Crossovers
- Medicare primary and Medicaid secondary
- CMS requires providers to bill Medicaid even if they know it will result in a “zero pay”
- Deductible & coinsurance can be written-off as soon as the Medicaid remit is received
- Patients should not be billed for deductible & coinsurance amounts unless there is a spenddown

# DUAL ELIGIBLE (CONCLUDED)

- Do not write-off the account until the Medicaid RA has been received
- Includes traditional Ohio Medicaid and out of state traditional Medicaid plans
- Medicaid MCOs are allowable
  - Aetna (Better Health of Ohio), Anthem Exchange, Buckeye, CareSource, Molina, Paramount Advantage, United Healthcare Community Plan and etc
- Be cautious of patients who participate in Medicare Secondary Payer (MSP) programs (i.e. QMB & SLMB)

# QMB

- Qualified Medicare Beneficiary (QMB)
  - Medicare Savings Program (MSP)
  - Helps to pay for Part A/B premiums, deductibles, coinsurance & copayments
  - Medicaid program that exempts patients from Medicare cost sharing
  - Patient can not be billed for Medicare deductible, coinsurance or copayments (hospital could face sanctions if patient is billed)

# SLMB

- Specified Low-Income Medicare Beneficiary (SLMB)
  - Medicare Savings Program (MSP)
  - Helps to pay for Part B premiums
  - Can possibly be billed for Medicare deductibles, coinsurances and copayments

# CHARITY/FINANCIAL ASSISTANCE

- Financial assistance (FA) approval must follow the hospital's written FA policy
- Consider patient's total resources
- Verify no other parties are legally responsible
- Maintain all documentation used to award charity
- Can not be included if reported on HCAP logs
- Write account off when charity is awarded
  - See PRM-1, Chapter 300, Section 312

# CHARITY/FINANCIAL ASSISTANCE (CONCLUDED)

- Financial counselors should spot potential issues with FA applications
- FA application should be thoroughly completed
  - Signed & dated by the patient
  - Documents to support income
  - Listing of monthly expenses
  - Pay attention to residual income
  - Power of Attorney documents if needed
- Involve MAC before going to a charity "scoring" system
  - Ensure "scoring" system will pass audit requirements
  - Obtain, in writing, what the MAC will allow

# EXAMPLE FA APPLICATION

DATES OF SERVICE: _____ _____ _____ _____

PATIENT ACCOUNT: _____ _____ _____ _____

PATIENT NAME: _____ SPOUSE OR PARENT NAME _____

SOCIAL SECURITY _____ DATE OF BIRTH _____

_____ ADDRESS _____ CITY

_____ STATE ZIP _____ PHONE (_____)

_____ CELL( ) _____

EMPLOYER _____ IF UNEMPLOYED, LAST DATE EMPLOYED _____

| DEPENDENT'S NAME | SOCIAL SECURITY # | DEPENDENT'S NAME | SOCIAL SECURITY # |
|---|---|---|---|
| _____ | - _____ | _____ | - _____ |
| _____ | - _____ | _____ | - _____ |
| _____ | - _____ | _____ | - _____ |

FAMILY INCOME (Gross Income before Taxes - Most Recent 12-Month Period)

| **Patient** | | **Spouse** | |
|---|---|---|---|
| Salary/Wage/Tips: | $_____ | Salary/Wages/Tips: | $ |
| Interest/Dividends: | $_____ | Interest/Dividends: | $_____ |
| Alimony: | $_____ | Alimony: | $ |
| Social Security: | $_____ | *Social Security: | $_____ |
| Pension/Retirement: | $_____ | *Pension/Retirement: | $ |
| Disability: | $_____ | Disability: | $_____ |
| Unemployment: | $_____ | Unemployment: | $_____ |
| Workers Comp: | $_____ | Workers Comp: | $_____ |
| Self Employed: | $_____ | Self Employed: | $_____ |

**Total Annual Household Income$**_____ **Average Monthly Household Income$**_____

(Please fill out completely, if does not apply please place a 0 on the line.)

**Family Resources/Assets**

Checking Account Balance $_____ Name of Bank _____

Savings Account balance $_____ Name of Bank _____

IRA/401K/403B_____ Name of Bank _____

**PROPERTY VALUE (House or personal property other than your residence)**

Description/Location_____ Market Value: $_____

# EXAMPLE FA APPLICATION (CONCLUDED)

Note: Residual income determinations are made based upon income & expenses.
Make sure patients are accounting for all of their monthly expenses on the application.

**Monthly Expenses**

| | |
|---|---|
| Housing | $ |
| Automobile | $ |
| Insurance | $ |
| Utilities (gas, electric, water) | $ |
| Health Insurance | $ |
| Medical | $ |
| Fuel | $ |
| House Hold Expenses | $ |
| Credit Cards | $ |
| Cell Phone | $ |
| Home Phone | $ |
| Cable | $ |
| Other (be specific) | $ |
| Other (be specific) | $ |
| Other (be specific) | $ |
| Other (be specific) | $ |
| **Total Monthly Expenses** | $ |

**Average Monthly Income from Page 1 $_____ Total Monthly Expenses Listed above $_____**

*I certify that the information provided by me in this application is correct and true to the best of my knowledge. I understand that if I give false information or withhold information, assistance may be denied or reversed at the discretion of YOUR Healthcare System.*

**Patient Signature:**_____ **Date:** _____

**Spouse Signature:**_____ **Date:** _____

# BANKRUPTCY

- Exonerated from the obligation to pay medical bills/debts
  - Chapter 7 – Fresh start; complete liquidation
- Write off after "Discharge of Debtor" notice is received
- Check "PACER" for notice
  - "Public Access to Court Electronic Records" (PACER)
  - https://www.pacer.gov

# BANKRUPTCY (CONCLUDED)

B18 (Official Form 18) (12/07)

## United States Bankruptcy Court

_____ District Of _____

In re _____,
*[Set forth here all names including married, maiden, and trade names used by debtor within last 8 years.]*
Debtor

Case No. _____

Address _____

_____

Chapter 7

Last four digits of Social-Security or other Individual Taxpayer-Identification No(s)(if any).: _____

Employer Tax-Identification No(s).(EIN) [if any]:_____

### DISCHARGE OF DEBTOR

It appearing that the debtor is entitled to a discharge, **IT IS ORDERED:** The debtor is granted a discharge under section 727 of title 11, United States Code, (the Bankruptcy Code).

Dated: _____

BY THE COURT

_____

United States Bankruptcy Judge

**SEE THE BACK OF THIS ORDER FOR IMPORTANT INFORMATION.**

# DECEASED

- Confirm the patient is actually deceased
  - Obtain/maintain death certificate
  - Obtain/maintain obituary
- Verify whether or not the patient has an estate
  - Contact probate court
- File a claim against the estate if one is found
- Don't rely on patient's family to be forthcoming with estate information

# DECEASED (CONCLUDED)

Letcher County Probate Court

156 Main Street #102

Whitesburg, KY 41858-7286

Re: Proof of estate for deceased individuals

To Whom It May Concern:

On behalf of Appalachian Regional Healthcare, please verify whether an estate has been opened for the below referenced deceased individuals who were patients at our hospital and who were all residents of Letcher County. If an estate has or has not been opened, please verify in the space provided below and validate with official county stamp (or other official proof documentation) and county signature and/or initials and mail to our office in the enclosed self-addressed stamped envelope.

| Patient Name | Patient DOB/DOD | Patient SSN | Estate Status |
|---|---|---|---|
| | | | |

Thank you for your prompt attention to this matter.

Sincerely,

# TRADITIONAL

- Constitutes patients whose accounts go through the normal collection process
- Balances remain unpaid at the end of the hospital's collection process
- Patient does not qualify for 100% charity or hasn't applied
- Patient could be Medicaid eligible with a spenddown
- Patient must **NOT** be a QMB

# TRADITIONAL (CONTINUED)

- Comparable collection effort across all payors
- Timely billing of patient
  - Issuance of bill should occur w/in 60 days of adjudication by Medicare or secondary/tertiary payors
- Consistent collection efforts
  - Provider must make a **genuine** (follow-up with other collection attempts) rather than a token collection effort
    - See PRM-1 Chapter 300, Section 310

# TRADITIONAL (CONCLUDED)

- Reasonable collection effort
  - 120 days from first statement to write-off
- All payments will restart the 120 day clock
  - Even if there is a $1 payment made
- 120 days is not specific as to where, whom and how the account is being pursued
- Daily collection practices and written policy must agree

# COLLECTION AGENCY

- Send both Medicare and non-Medicare accounts with like balances
- Collection attempts must be similar for Medicare & non-Medicare accounts with like balances
- Once the account is returned to the hospital all collection efforts must cease
- Account detail should be maintained by agency to support collection activity on all accounts
- Best practice is to write accounts off to a zero balance once the account has been returned from the agency

# COLLECTION AGENCY (CONTINUED)

- Set clearly written close criteria with all collection agencies
  - Example criteria for **primary** agencies:
    - Deceased patients should be closed immediately
    - Patients w/discharged bankruptcies should be closed immediately
    - Close all accounts with balances <= $1000 & no payment activity for the last 6 months
    - Close all accounts with balances and no payment activity for the last 12 months
  - Example criteria for **secondary** agencies:
    - Close all accounts with balances and no payment activity for the last 12 months
- Ensure contract addresses close & return expectations

# COLLECTION AGENCY (CONCLUDED)

- Do not post notes at a guarantor level
- Do not apply charity write-offs at a guarantor level
- Perform a random test of agency accounts
  - Medicare & non-Medicare being handled the same
  - Like balances are being handled the same
  - Accounts are being closed timely
- Know your inventory of accounts with your agencies & their collection rates
- Claim the account once primary & secondary efforts have ceased

# MAC AUDIT

# MAC AUDIT

- Audit Request
  - MAC must have the final MBD logs prior to start of audit work
  - Will not accept changes to logs after start of audit
  - Support must be sent to MAC via mail, fax, or e-mail with file encrypted
  - E-mail without encryption will be denied
  - Provide all requested documents
  - MAC is not required to ask any further questions
  - Incomplete or missing support will result in errors and possible extrapolated adjustments

# MAC AUDIT (CONCLUDED)

- MBD Logs
  - Detail patient listing must tie to Medicare cost report
  - Separate inpatient and outpatient MBD logs
    - Crossover
    - Charity
    - Deceased
    - Traditional

# MEDICARE BAD DEBT LOG

| PATIENT: Account Number | PATIENT: Last Name | PATIENT: First Name | HIC. NO. | From | To | Indigency & Wel Recip (Yes/No) | Medicaid Number | DATE FIRST BILL SENT TO BENEFICIARY | WRITE-OFF DATE | MEDICARE REMIT DATE | DEDUCT | CO-INS | TOTAL WRITE-OFF | Section |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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# MAC AUDIT (CONTINUED)

- Audit Support
  - Hospital bad debt, Charity and Collection polices
  - UB-04
  - MSP questionnaires
  - Medicare & Medicaid RA
  - Secondary or tertiary payor RA
  - Charity application, approval & supporting documentation
  - Collection effort support (Internal, early out)
    - Copies of statements/letters
    - Phone call/personal contact notes
  - Current year recoveries for prior year bad debts must be netted against current year bad debts claimed

# MAC AUDIT (CONCLUDED)

- Audit Support (Cont.)
  - Obituary
  - Death certificate
  - Estate documentation
  - Discharge of Debtor notice
  - Documentation to support agency closed status
  - Collection agency collection efforts (Medicare and non-Medicare)

# QUESTIONS?

# PRESENTERS

**Dan Rice** joined Blue & Co. in September 2007. He serves as a Director in the Healthcare department. Mr. Rice is an honor's graduate of Western Kentucky University with a Bachelor of Science degree in Accounting. He has over twenty years of Healthcare accounting and consulting experience. He is a member of the Healthcare Financial Management Association and Institute of Management Accountants. Mr. Rice's primary responsibilities are responding to client needs for information and informing clients of opportunities and concerns regarding their reimbursement for bad debts and disproportionate share adjustments, along with Medicare/Medicaid appeals and cost report preparation.

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# PRESENTERS (CONTINUED)

**Michelle Trowell** joined Blue & Co., LLC in August 2009. Michelle is a Director with the reimbursement team, specializing in Medicare Bad Debt reimbursement. She is a graduate of Berea College. She brings with her over fifteen years of experience in Medicare auditing and consulting. Prior to joining Blue, Michelle worked as a Senior Consultant at a national accounting firm on their Medicare Bad Debt team. She also spent eight years as a Senior Medicare Auditor for a Medicare Administrative Contractor (MAC). Ms. Trowell currently serves on the Executive Committee, as Treasurer, for the Indiana chapter of the Healthcare Finance Management Association, where she will become chapter President in 2020-2021.

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