Optimizing Return on Hospital Medicare Bad Debt... While Passing the Auditor’s Review

Rudy Braccili Jr. MBA, CRCE
Member HFMA & AAHAM
Boca Raton Regional Hospital

- 400 bed acute care hospital
- $375M annual net revenue
- 14,600 inpatient discharges per year
- 37,000 E/D treated and released visits per year
- 395,000 outpatient visits per year
- 65 – 70 % Medicare
Boca Raton Regional Hospital

- 11 off site O/P diagnostic centers
- Lynn Cancer Center
- Lynn Women’s Health Institute
- Teaching facility in July 2014 with FAU
- Marcus Neuroscience Center opening September 2014
## Boca Raton Regional Hospital  Medicare Bad Debt

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<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<td>$506,025</td>
<td>$902,599</td>
<td>$615,083*</td>
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What To Claim On The Bad Debt Log?

- Bad debts attributable to *unpaid Medicare co-insurance and deductible amounts* associated with covered charges are reimbursable by the Medicare program.

- Not reimbursable - Balances resulting from:
  - Self administrable drugs
  - Private room out of pocket charges
  - Non-covered charges (ABN, out of benefits etc.)
  - Professional services
  - Fee schedule-based services (Outpatient Lab)
  - Accounting bad debt reserves
What To Claim On The Bad Debt Log?

- Amounts not paid by patient after reasonable collection efforts
- Amounts not paid by supplemental Medicaid (IP co-insurance, OP deductible/co-insurance where Medicare paid more than Medicaid would have paid as a primary payer)
What To Claim On The Bad Debt Log?

Include:

- Unpaid due to deceased (and no estate funds)
- Unpaid due to discharged bankruptcy
- Unpaid due to qualified hospital charity
- Fees paid to collection agencies on partial pays
What To Claim On The Bad Debt Log?

- Amounts not paid by patient when hospital collection policy was not followed

- Amounts not paid by supplemental Medicaid due to “patient not eligible”, “untimely filing” or “services not covered”

- Unpaid due to deceased where probate was opened and hospital failed to submit claim

- Unpaid pending/dismissed bankruptcy
What Are Hospitals Required To Do?

- Follow a well documented comprehensive collection policy which:
  - Addresses balances owed by the patient “similarly”/identically regardless of primary insurance:

  Cannot process Medicare related balances differently than non-Medicare related balances
What Are Hospitals Required To Do?

- Follow a well documented comprehensive collection policy which:
  - Addresses use of collection agency:

  When accounts get placed
  Which accounts get placed
  When accounts get returned
  Which accounts get returned
What Are Hospitals Required To Do?

- Follow a well documented comprehensive collection policy which:
  - Addresses use of collection agency:
    - Return exceptions—skips, bankruptcies, deceased
    - Work efforts not distinguished by payer class
    - Is a 2nd placement vendor engaged?
What are Hospitals required to Do?

- Follow a well documented comprehensive collection policy which:
  - Addresses use of collection agency:
    - Best to have all agency notes, & statement dates posted back to hospital’s PA system
    - Best to maintain all agency close reports on agency letterhead at hospital for audit purposes
    - Best to have agency provide separate (BUT EQUAL) Medicare vs. non-Medicare close reports
What are Hospitals Required To Do?

- Follow a well documented comprehensive collection policy which:
  - Addresses use of collection agency:

  Recommend closing (and removing from credit bureau) balances ≤ $1,500. on day X...

  ...While continuing collection efforts (and maintaining with credit bureau) balances > $1,500.
Best Practice Recommendations...

Recommend providing (1\textsuperscript{st} & 2\textsuperscript{nd}) agency with separate “balance due buckets” at time of placement:

A) “Coinsurance” amount due  
B) “Deductible” amount due  
C) “Other” amount due

Provide agency with payment proration guidelines e.g. apply partial payments equally to each “amount due” bucket.

Require agency to report at closing any unpaid amounts for each respective amount due bucket.
What Are Providers Required To Do?

- Hospital must have, and follow a well documented comprehensive collection policy which:
  - addresses credit bureau reporting

If agency places with credit bureau, cannot claim on cost report until account is removed from the credit bureau

If hospital places with credit bureau directly, can claim on cost report without removing from the credit bureau
What Are Providers Required To Do?

- Hospital must have, and follow a well documented comprehensive collection policy which:
  - addresses use of collection agency

Recommend including all requirements in agency contract.
What Are Providers Required To Do?

- Hospital must **submit a bill on or shortly after discharge/death** of the beneficiary to the party responsible for the patient’s personal financial obligations.

**FCSO Auditor Test 1**

≤ 90 days from Mcare remit to 1st bill to supplemental or patient (if no supplemental)

Document (and claim) exceptions to the above rule which caused the delayed billing...e.g. Medicare requested records or patient failed to notify hospital timely of correct insurance
What Are Providers Required To Do?

Hospital must submit a bill on or shortly after discharge/death of the beneficiary to the party responsible for the patient’s personal financial obligations.

**FCSO Auditor Test 2**

≤ 60 days from Supplemental EOB to 1st bill to patient
What Are Providers Required To Do?

- Auditor Test 3: Attempts to collect the debt must last a minimum of 120 days
  - Clock starts when patient has initially been notified of the accurate (COINS/DED) amount
  - The 120 days is inclusive of hospital, early out and bad debt collection attempts
What Are Providers Required To Do?

- Attempts to collect the debt must last a minimum of 120 days
  - The 120 day min. must apply to all payers
  - Documented exceptions are allowed e.g. skips
  - Ensure all “Write-off” or “Close report” dates are > 120 days from Last Medicare remit date...or include a comment for auditor
What Are Providers Required To Do?

- Only debts deemed uncollectible during the specific fiscal year being reported may be claimed on that fiscal year’s log.

- If uncollectible debts are identified by a specific write-off code, posting date of that write-off must be within the fiscal year being reported.

- If uncollectible debts are identified when returned from collection agency, the agency close report date must be within the fiscal year being reported.
What Are Providers Required To Do?

Hospital must off-set current (most recently completed) fiscal year log totals with:
- Recoveries received within the fiscal year on accounts claimed on (any) prior year logs
- Recoveries received within the fiscal year on accounts claimed on current year log
- Changes to co-insurance or deductible amounts filed on prior year(s) logs...brought about by Medicare (RAC and other) recoups, and Medicaid (2nd Medicare) recoups
What Are Providers Required To Do?

- **Required** bad debt log data elements:
  - Beneficiary name
  - HIC number
  - Discharge date
  - Indigence status
  - Date of 1st bill to beneficiary or supplemental
  - (Last or Qualifying) Medicare remit date
What Are Providers Required To Do?

- **Required** bad debt log data elements:
  - Amount of deductible and co-insurance
  - Write-off amount (amount being claimed)
  - Write-off date (posting date or close report date)
  - Medicaid remit date (if applicable)
  - Medicaid (number if applicable)
  - I/P or OP indicator
Best Practice Recommendations...

- Additional “Internal” data elements:
  - Account number
  - Admit date
  - Admitting FC
  - Current FC
  - Ins1, 2 & 3 plan code & policy number
  - Total charges per last Mcare remit
  - Hosp Total charges
  - Total Medicare pymt
  - Total ins pymt
  - Total patient pymt
  - Grand total pymt
  - Total Mcare Adj Amt
  - First, last, “qualifying” Medicare remit dates
  - Total non-Mcare Adj Amt
Best Practice Recommendations...

- Additional “Internal” data elements:
  - Account balance
  - File indicator (BD v AR)
  - Date of 1st stmt to patient
  - Date account transferred to early out agency
  - Date account returned from early out agency
  - Date account transferred to collection agency
  - Date account returned from collection agency
  - Reason account was returned from agency if < 120 days from placement
  - Date of 1st bill to supplemental insurer
Best Practice Recommendations...

- Additional “Internal” data elements:
  - Date supplemental bill auto crossed over from Medicare to supplemental payer
  - Date of initial supplemental payment (including zero pays)
  - “Include on cost report” Y or N indicator
  - Unpaid co-insurance as of fiscal year-end date
  - Unpaid deductible as of fiscal year-end date
  - Medicaid remit date (including zero pays)
  - Medicaid payment amount
Best Practice Recommendations...

- Additional “Internal” data elements:
  - Supplemental Remit date
  - Deceased w/o (code, amt, date) indicator
  - Bankruptcy w/o (code, amt, date) indicator
  - Charity w/o (code, amt, date) indicator
  - Comments (internal)
  - Comments for auditor
  - Amt claimed on PY log
  - Amt claimed on PY (-1) log
  - Amt claimed on PY (-2) log....etc
  - (Current FY w/o amt) – (PY’s w/o amt)
Best Practice Recommendations...

- “Internal” Auditors QA data elements:
  - Reason # of days from Medicare remit date to date of 1st bill to beneficiary or supplemental insurer is > 90
  - Reason # of days from Medicare remit date to w/o date is < 120
Best Practice Recommendations...

- Begin by running 2 reports:
  A) A report of all accounts where Medicare is primary, and a deceased, charity, bankruptcy or Medicaid adjustment was posted to the account within the prior fiscal year.
  
  B) A report of all Medicare primary accounts closed and returned by the (final) collection agency within the prior fiscal year.
Best Practice Recommendations...

- Have I.S. populate the 2 reports (spreadsheets) with as many data elements (from prior slides) as “electronically” possible.

- Label each column as “reliable” (Pt name, discharge date, account balance etc…) or “needs validation” (Medicare remit date, unpaid coinsurance amt, unpaid deductible amt, deceased w/o amount, include on cost report indicator…etc)
Best Practice Recommendations...

- Have a dedicated PFS Medicare expert validate data in columns on spreadsheet. **If you don’t have one available....hire one...it is more than worth it!**
Best Practice Recommendations...

- Create a team to include I.S./Financial Analyst (spreadsheet master), PFS director, Medicare billing/collection supervisor, PFS expert assigned to project – “THE VALIDATOR”

- Meet weekly from fiscal year end close to final completion of log. Log is due ~ 5 months after fiscal close date. Meetings should address expert’s questions/exceptions from validation process
Best Practice Recommendations...

- Perform some spreadsheet reasonability tests prior to log submission:
  - Compare “W/O amount” to “COINS/DED amount”
  - Compare “COINS/DED amount” to “Total charge amount”
  - If ‘Y’ in “include on cost report” column…ensure debit value in “W/O amount” column
Best Practice Recommendations...

- Perform some spreadsheet reasonability tests:
  - Ensure all prior year recoveries have a credit amount in W/O column
  - Ensure all crossover accounts have a Medicaid policy number and Medicaid remit date listed
  - Other...
Best Practice Recommendations...

- Corrections noted during validation process should be updated/notated in PA system
- Maintain auditable records, documentation
- Refrain from reporting any accounts presently under review by RAC or other auditing entity until final (after all appeals) outcome is known
- Do not exclude credit balance accounts from initial report runs as the credit may have been the result of an erroneous financial transaction
Best Practice Recommendations...

- Ensure accuracy of all Medicare contractuals

- Series accounts may need to be separated per claim date

- Use Medicare bad debt (unpaid Medicare Advantage COINS/DED amounts) as a negotiating tool with MA plans

- CMS manual section 310.1 allows inclusion of collection agency fees (paid on collection of Medicare COINS/DED amounts) on cost report
Best Practice Recommendations...

- Generate safety net reports:
  - Medicare primary, Medicaid/Medicaid HMO secondary accounts where a Medicaid payment (including zero pays) is present but no Medicaid (log qualifying) adjustment code was posted to the account….but possibly should have been
  - Medicare primary, Medicaid secondary accounts which were paid by Medicare but no Medicaid payment (including zero pays) was ever posted to the account...but possibly should have been
Best Practice Recommendations...

- Prior to each year’s log submission...run a report to identify any payments, adjustments or other financial transactions posted within the fiscal year to accounts claimed on PY cost report logs.

- Prior to each year’s log submission...match current FY log vs. PY logs to ensure no duplicate entries, and to off-set prior year submissions with changes which were posted in the current FY.
BRRH Medicare Bad Debt Team Acknowledgement!

- Shannon McCord, PFS Collector Analyst
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- Veronica Small, PFS Director
- Donna Burkel, PFS AR Manager
Thank you!

Questions?