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Maximizing Returns on Medicare Bad Debt: Essential Insights for Revenue Cycle Teams

2024

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-2023 - $2 Billion in Placements!

Americollect's Purpose – Reduced Healthcare Costs for ALL!
-2023 - $377 Million in Recovery!

2 Services -

Early Out Solutions

Bad Debt Collections

BETTER PATIENT EXPERIENCE

ADVANCED TECHNOLOGY

HEALTHCARE FOCUSED

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Disclaimer

- I am not an attorney, this is not legal advice
- I am offering information obtained from various sources deemed credible by Americollect and in some instances myself
- Opinions will be shared that are my own
- Please vet this information and explore these sources and others as well for accuracy
- Information changes quickly, opinions can change too

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Agenda -

1. BIG Deal
2. Finance and Revenue Cycle Teams
3. Basics of Medicare Bad Debt
4. Checklist
5. Advice

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Baby Boomers

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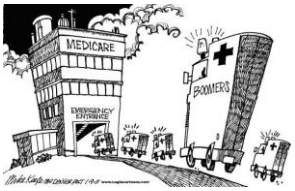

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Medicare

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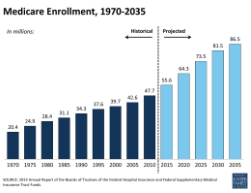

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Medicare / Medicare Advantage

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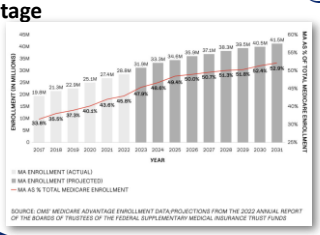

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Why Big Deal?

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65%

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Finance & Revenue Cycle

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Finance &
Revenue Cycle (FRC)

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Background

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Medicare Bad Debt Rules

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"Costs of Services Covered by Medicare Will Not Be Borne By Individuals Not Covered By Medicare."

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Medicare Bad Debt Rules

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In order to qualify for reimbursement, hospitals must comply with:

a) certain collection efforts,
b) certain record keeping, and
c) certain reporting requirements.

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Criteria for Medicare Bad Debt

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Generally, a Medicare bad debt must meet all of the following criteria to be allowable:

a) The debt must be related to covered services and derived from deductible and coinsurance amounts.
b) The provider must be able to establish that "**reasonable collection efforts**" were made.
c) The debt was actually **uncollectible** when claimed as worthless.
d) **Sound business judgment** established that there was no likelihood of recovery at any time in the future.

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2 Types of Medicare Bad Debt

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1. Indigent = No "Reasonable Collection Efforts"
2. Traditional/Uncollectible = YES "Reasonable Collection Efforts"

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Indigent - Medicare Bad Debt

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1. Dual Eligible for Medicaid = 59% of Medicare Bad Debt Claimed*
2. Financial Assistance Application Method
3. Deceased or Bankrupt

- Verify all other eligibility has been checked.
- Maintain this documentation.
- This dismisses the requirement to do - "Reasonable Collection Efforts"

*http://www.aha.org/content/13/fs-baddebt.pdf

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Indigent - Medicare Bad Debt

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Dual Eligible for Medicaid

- Medicare Primary and Medicaid Secondary
- Can be claimed as soon as Medicaid remittance is received
- Usually requires the least amount of audit support
- Medicaid remittance claim status of "paid" not "denied"

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Indigent - Medicare Bad Debt

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Financial Assistance Application Method

- Most follow the hospital's written financial assistance policy (CANNOT be presumptive)

Hospital's reason for financial assistance approval must be thoroughly supported:

a. Assets (convertible to cash)
b. Income – W2

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Indigent - Medicare Bad Debt

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Bankruptcy

Documented by "Discharge Debtor" notice from the courts.

- Chapter 13- Need to file Proof-of-Claim

Deceased

"No Estate" documentation via the probate court or file probate.

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Reasonable Collection Effort - Medicare Bad Debt

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a. Must issue a bill shortly after discharge or death,
b. Must send a collection statement(s), and
c. Listing with collection agency

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Reasonable Collection Effort - Medicare Bad Debt

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a. Refer all uncollected charges of "like amount" to collection agency.

"Like amount" can be specify:

1. Balance Size
2. Aging

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Reasonable Collection Effort - Medicare Bad Debt

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Patient's files need documentation of the following:

a. Statement(s)
b. Follow-up letters (Final Notice)
c. And Telephone Calls

NOT just hospitals and early out, but also collection agencies!

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Reasonable Collection Effort - Medicare Bad Debt

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"Presumption of Non-collectability"

a. Only after 120 days from the date of the first statement, the debt may be deemed uncollectible for the purposes of Medicare Bad Debt.
b. 120-day clock restarts upon receipt of payments.

120 days is all encompassing of Hospital, Early Out, and Bad Debt****

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Checklists -

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Checklists -

Dual Eligible for Medicaid = 59% of Medicare Bad Debt Claimed*

☑ Must have - Remittance advice information

☑ Or reduce the amount by the amount Medicaid is required to pay!

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Checklists -

Dual Eligible for Medicaid = 59% of Medicare Bad Debt Claimed*

☑ **Backdated Medicaid** - If Medicaid is backdated and it is a Medicare account, provider must re-adjudicate the account and follow the steps above to receive a remittance.

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Checklists -

Financial Assistance

☑ **No Declaration** - Must not use a beneficiary's declaration of their inability to pay their medical bills or deductibles and coinsurance amounts as sole proof of indigence or medical indigence.

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Checklists -

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Financial Assistance

☑ **Income Analysis** - Providers are required to complete an income analysis in the financial assistance application process to qualify Medicare accounts for indigency status. A majority of organizations use the Federal Poverty Level Guidelines (FPL) with a sliding scale for eligibility for qualifications. Previous years W-2 or current paystubs are typically the supporting documents needed for eligibility. The income and supporting evidence being requested must be documented in the Financial Assistance Policy and in accordance with 501r.

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Checklists -

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Financial Assistance

☑ **Asset Analysis** - Providers are also required to complete an asset analysis in the financial assistance application process to qualify Medicare accounts for indigency status. Assets that are required to be checked are only those that are convertible to cash and unnecessary for the beneficiary's daily living. Providers need to have an asset limit set such as $20,000. Requests for bank statements and/or any convertible to cash accounts such as CDs or Money Market accounts should be used to support documentation needed for eligibility. The assets and supporting evidence being requested must be documented in the Financial Assistance Policy and in accordance with 501r.

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Checklists -

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Financial Assistance

☑ **No Other Payer** - Providers must determine that no source other than the beneficiary would be legally responsible for the beneficiary's medical bill, such as a legal guardian or State Medicaid Program. This needs to be documented in the Financial Assistance Policy.
☑ **Presumptive Eligibility** - Rarely will presumptive eligibility be allowable and most likely will be rejected during an audit due to no asset check being completed.
☑ **Timeline** - Extending financial assistance qualifications past the policy stated deadline, which is typically 240 days from the first mailed statement in accordance with 501r, will typically result in audits that deny the qualification for Medicare bad debts.

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Checklists -

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Complex Claims

☑ **Probates/Estates** - It is required to check for the estate of a deceased patient in order to qualify for Medicare Bad Debt. It is required to send a statement within 120 days after insurance has been adjudicated even if deceased. A statement from a surviving family member that there is no estate is not acceptable and will not hold up in an audit. There are 3,143 counties in the United States which make probate courts extremely hard to work with for larger organizations Also, make sure each hospital's Billing and Collection Policy and/or Financial Assistance Policy states:

- That a single probate check will occur after a patient is deceased to determine if an estate exists.
- What dollar balance will the probate be checked for ($20 bill for a probate isn't reasonable to check).
- What dollar balance will the probate be claimed for (probates may only pay pennies on the dollar). *All other accounts can be claimed on S10 if your hospital qualifies.

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Checklists -

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Complex Claims

☑ **Bankruptcies** - You are required to ensure your account is included in the bankruptcy in order to qualify for Medicare Bad Debt. Especially in Chapter 13 where pennies on the dollars are paid out. Does your Billing and Collection Policy and/or Financial Assistance Policy address bankruptcies?

- What dollar balance will a Pacer scrub be completed on?
- What dollar balance will Chapter 13 be claimed for (bankruptcies only pay pennies on the dollar)? *All other accounts can be claimed on S10 if your hospital qualifies.

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Checklists -

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Traditional/Uncollectible

☑ **Issuing a Bill** - It must involve the issuance of a bill within 120 days after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. Make sure your billing and collection's policy addresses mail returns. We suggest language such as - "It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for 'Reasonable Effort' will have been made."

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Checklists -

Traditional/Uncollectible

☑ **Other Collection Actions** - Does your billing and collection policy also address subsequent statements, collection letters, emails, texts, and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort? In the IPPS rules it states – ***"The provider's collection effort may include using or threatening to use court action to obtain payment."*** Be very careful to NOT be too prescriptive regarding which efforts will be used and when, along with NOT requiring efforts where efforts cannot be performed.

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Checklists -

Traditional/Uncollectible

Do NOT use "we will make a call on all accounts" which cannot be followed through on because there will be a percentage of accounts where calls cannot be completed due to lacking a working phone number.

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Checklists -

Traditional/Uncollectible

Do NOT use "we will send a notice on all accounts" which cannot be followed through on because there will be a percentage of accounts that are mail returned or without an address.

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Checklists -

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Traditional/Uncollectible

☑ **120-days of Collection Efforts** - Until a provider's reasonable collection effort (including the use of a collection agency ***as well as in-house efforts***) has been completed, Medicare bad debts may not be deemed as uncollectible. The regulation requires the 120-day collection effort to renew from each partial payment (does not require the same efforts but the account cannot be deemed uncollectible and claimed for an additional 120 days.)

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Checklists -

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Collection Fees –

☑ **Allowable Administrative Costs** - When a collection agency obtains payment on an account, the full amount collected must be credited to the patient's account (ASK for gross payments from your collection agency) and the collection fee charged to administrative costs. Administrative costs are allowed to be reimbursed. For example, where an agency collects $40 from the beneficiary, and its fee is 50 percent, the agency keeps $20 as its fee for the collection services and remits $20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency ($40) in the patient's account receivable and records the collection fee ($20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

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Checklists -

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Medicare Re-adjudicated –

If Medicare re-adjudicates claims, the entire billing process starts anew. If dual eligibility, Medicaid needs to be billed again and then written off to indigent. If non-Medicaid, a new statement, and collection process has to be started again. When claiming Medicare bad debt accounts that have been re-adjudicated, always use the most recent Medicare remittance date for the worksheet.

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Checklists -

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Small Balance –

If a process isn't in place for small balance insurance work and accounts are greater than six months without a statement sent, MAC can and will likely reject submission of those accounts during the audit. Make sure someone is working small balance accounts not a part of a write-off.

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Checklists -

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Audits to Compare Medicare Bad Debt to Non-Medicare Accounts –

MACs are beginning to request their own sample of Medicare to non-Medicare accounts. Each needs to be treated similarly in the samples.

Checklists -

Medicare Expense Mapped –

Providers typically use independent transaction codes for Medicare bad debt for tracking purposes unless end of year reclass occurs. Typically, providers map Medicare bad debts to general ledger expense accounts. Any manual changes to transaction can impact Medicare bad debt payments.