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Medicare Bad Debt Checklist for PFS/Revenue Cycle Teams

Like it seems with everything in healthcare, Medicare Bad Debt is complex with a lot of rules to follow to allow for reimbursement. This checklist is an attempt to help providers remove some complexity around Medicare Bad Debt.

History of Medicare Bad Debt

With the implementation of Medicare Part A (facility charges), beneficiaries (patients) were made responsible for the payment of coinsurance and deductibles. Shortly after this implementation, Medicare recognized that beneficiaries may fail to pay a deductible or coinsurance, which could lead to non-Medicare patients bearing those costs. Because of this, Medicare introduced a program where if a beneficiary did not pay for their services, Medicare would then reimburse the hospital for the non-payment, as long as:

1. The bad debt was related to “covered services” and derived from the deductible and coinsurance amounts.
2. The hospital established that “reasonable collection efforts” were made.
3. The bad debt was uncollectible when claimed “worthless.”
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

Providers receive reimbursement for 65% of the amount reported on their Medicare cost report from the Medicare program (minus sequestration to governmental programs).

Categories of Medicare Bad Debts - There are three categories of Medicare bad debts:

- Indigent dual eligible - State Medicaid determined - often referred to as crossovers.
- Indigent non-dual eligible - provider determined - Financial Assistance.
- Non-indigent, often referred to as traditional or self-pay.

Checklists

Indigent Requirements

1. **Medicaid/Dual Eligible** - Providers may deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid under a State's Title XIX Medicaid program as either categorically needy individuals or medically needy individuals. To be considered a reasonable collection effort for dual-eligible beneficiaries efforts must include:

☑ **Medicaid Requirements** - Must determine whether the State's Medicaid Program (or a local welfare agency, if applicable) is responsible to pay all or a portion of beneficiary's Medicare deductible or coinsurance amounts; must submit a bill to its Medicaid to determine the State's cost sharing obligation to pay all or a portion of the applicable Medicare deductible or coinsurance; must submit the Medicaid remittance advice information on the cost report, must reduce

allowable Medicare bad debt by any amount that the State is obligated to pay, either by statute or under the terms of its approved Medicaid State plan, regardless of whether the State actually pays its obligated amount to the provider; and may include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

☑ **Required Remittance Advice** - If a provider does not receive a Medicaid remittance advice because the State does not permit the Medicare provider's Medicaid enrollment for the purposes of processing a beneficiary's claim, or because the State does not generate a Medicaid remittance advice, the provider must submit to its contractor all of the following auditable and verifiable documentation:

- The State's Medicaid notification stating that the State has no legal obligation to pay the provider for the beneficiary's Medicare cost sharing.
- A calculation of the amount the State owes the provider for Medicare cost sharing.
- Verification of the beneficiary's eligibility for Medicaid for the date of service.

The provider must reduce allowable Medicare bad debt by any amount the State is obligated to pay, regardless of whether the State actually pays its obligated amount to the provider; and may include the Medicare deductible or coinsurance amount, or any portion thereof that the State is not obligated to pay, and which remains unpaid by the beneficiary, as an allowable Medicare bad debt.

☑ **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.

2. **Financial Assistance** - An indigent non-dual eligible beneficiary is a beneficiary who is determined to be indigent or medically indigent by the provider and is not eligible for Medicaid as categorically or medically needy. To be considered a reasonable collection effort for financial assistance beneficiaries:

☑ **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.

☑ **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.

☑ **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. Some states have enacted regulations (Oregon HB3320) that prevents requesting assets as part of the financial assistance application process. Regardless, Medicare requires it and without asset determination it will be denied in audit.

☑ **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.

Non-Indigent "Uncollectible" Requirements

1. **Reasonable Collection Efforts** - To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients.

☑ **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."

☑ **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.
Examples:

- **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.
- **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.

Documentation is a MUST - All communications with patients need to be documented (most will keep a record in the patient accounting system or access to the collection agencies CRM). This includes Medicare and non-Medicare accounts.

☑ **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.)

2. **Balance Thresholds**

☑ **Small Balance** - Does the hospital's Billing and Collection policy specifically call out balance thresholds for write-off? In a 2003 publication by CMS it allows accounts under $10.00 to be written off and claimed as Medicare Bad Debt so long as it follows the hospital's policy. Program Memorandum (cms.gov)

☑ **Large Balance** - Many hospital programs use the "sound business judgment" argument in their Billing and Collection policy to write off all self-pay balances greater than $1500.00 (2024 Part A deductible is $1632.00) after reaching eighteen months (18 months to allow for one "tax return" season and credit bureau reporting) but it is required to be in the policy and follow non-indigent requirements.

3. **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. ProbateFinder is an expensive service that does a relatively good job of finding probates for an organization. A good collection agency has an internal process or works with ProbateFinder (may charge extra for this service) to determine if there is a probate to be filed on your behalf. 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.

☑ **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.

4. **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.

Other Items

☑ **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.

☑ **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.

☑ **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.

☑ **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.

☑ **Exhibit 2a** - In January 2024, CMS updated the Cost Reporting worksheet for Medicare Bad Debt. The new worksheet is called Exhibit 2a - https://www.cms.gov/files/document/medicarebd-2552-10-hospital-exhibit-2a-template.xlsx-0. The updated worksheet went from 13 data fields to over 24 with an inpatient vs outpatient version. It also includes a comment section that allows for additional documentation.

☑ **Back to the Future Payments II** - Any payment on the account made by the beneficiary or a responsible party, after the write-off date but before the end of the cost reporting period, must be used to reduce the final bad debt for the account claimed in that cost report. Any payment received after reported must be discounted on future cost reports.