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MEDICARE BAD DEBTS:
Are You Losing Money?

Recent court and administrative decisions limiting Medicare reimbursement for bad debts highlight some significant pitfalls that can cause bad debts to be disallowed. Two major areas of concern are: (1) Medicare patient accounts that remain at outside collection agencies ("OCA") subsequent to writing off the accounts as bad debts, and (2) bad debts for dual eligible patients where providers do not bill the state Medicaid programs for cost-sharing prior to writing off the patient accounts as bad debts. In both instances, Medicare reimbursement is being disallowed by intermediaries pursuant to directives of the Centers for Medicare & Medicaid Services ("CMS").

BAD DEBTS AT OCA

A number of recent judicial and administrative decisions have held that a Medicare patient account may not be claimed as a bad debt while it remains at the OCA. The basis of each decision was that while patient accounts are at a collection agency, they are not "actually uncollectible" nor has "sound business judgment established that there was no likelihood of recovery at any time in the future." These decisions were reached despite CMS' own rules giving providers discretion to write off bad debts after 120 days and providing for offsets of subsequently-collected bad debts. Thus, if a patient account is written off and claimed as a bad debt while it remains at a collection agency, it will be disallowed, unless the provider meets the criteria for the moratorium on bad debt disallowances.

HOW TO PROTECT BAD DEBT REIMBURSEMENT

If the cost report has not been audited, providers can consider withdrawing their bad debt lists for claims at an OCA, recalling all patient accounts from the OCA that can be deemed worthless, and then claiming these accounts as bad debts in the year that they are returned by the OCA. But in recalling "worthless" patient accounts from the OCA, providers should try to apply the same standards to Medicare and non-Medicare patient accounts so that intermediaries do not view such action as constituting inconsistent collection practices. Once the accounts deemed worthless have been recalled in this fashion, the case for allowing these bad debts should be strengthened. For those years where the bad debts have already been audited and disallowed, a provider should seriously consider whether it wants to appeal this issue.

"MUST-BILL" POLICY

Beginning with providers' 2004/2005 cost reports, intermediaries have been directed by CMS to disallow bad debts related to Medicare and Medicaid dual eligible patients where providers did not bill the state Medicaid program for the Medicare co-payment and deductible and, therefore, did not receive a remittance advice denying Medicaid payment prior to claiming the bad debt. This guideline, which is effective for all fiscal years beginning on or after January 1, 2004, is referred to as the "must-bill" policy. The must-bill policy is not new. It existed prior to November 1995, when it was replaced by the alternate documentation policy, which provided that CMS would accept alternate documentation in lieu of billing the state Medicaid program. In October 2003, CMS reverted back to the must-bill policy, which is currently in effect.

There are good arguments to challenge CMS' reversion back to the must-bill policy.

WHAT CAN PROVIDERS DO?

As the intermediaries complete their audits of the 2004/2005 cost reports, providers will begin to receive adjustments disallowing dual eligible bad debts where there were no billings to state Medicaid programs. Hospitals should consider preserving their appeal rights. There are good arguments to challenge CMS' reversion back to the must-bill policy. The regulations permit providers to claim bad debts when the debts were related to Medicare-covered services, reasonable collection efforts were made, the bad debts were uncollectible when claimed, and sound business judgment established that there was no likelihood of recovery. Thus, when payment limits under a state Medicaid program preclude payment for the Medicare deductible and co-payment amounts, a bad debt would meet the regulatory requirements for Medicare reimbursement regardless of whether the bill is submitted or not. There is nothing to be gained by submitting bills to the state Medicaid program, and CMS should not be permitted to add this requirement to those in the regulations.

However, until there is favorable court precedent on this issue, providers that have not been billing state Medicaid plans for Medicare co-payments and deductibles should evaluate whether such billing can be carried out, balancing considerations regarding the feasibility of such billing against the potential lost amount of Medicare reimbursement for bad debts.

If you have a question on this material, or would like to discuss legal services, please contact us at healthcare@duanemorris.com.

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