Office of Audit Services
Region I
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JAN 27 2003

CIN: A-01-02-00515

Mr. Michael J. Daly
President
Baystate Health System
759 Chestnut Street
Springfield, Massachusetts 01199

Dear Mr. Daly:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Medicare Bad Debts Claimed by the Baystate Medical Center for Fiscal Year Ended September 30, 1999." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5)

To facilitate identification, please refer to Common Identification Number A-01-02-00515 in all correspondence relating to this report.

Sincerely yours,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Mr. Joseph Tilghman
Regional Administrator, Region VII
Centers for Medicare and Medicaid Services
Richard Bolling Federal Building
601 East 12 Street, Room 235
Kansas City, Missouri 64106-2808

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF MEDICARE BAD DEBTS CLAIMED BY THE BAYSTATE MEDICAL CENTER FOR FISCAL YEAR ENDED SEPTEMBER 30, 1999

JANET REHNQUIST
Inspector General

JANUARY 2003
A-01-02-00515

Office of Inspector General

http://oig.hhs.gov

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EXECUTIVE SUMMARY

BACKGROUND

The Medicare program reimburses hospitals for bad debts associated with uncollectible Medicare deductible and coinsurance amounts if the bad debts meet Medicare reimbursement criteria. To be eligible for reimbursement, the hospital must show that; (1) the bad debts are related to Medicare covered services and derived from unpaid deductible and coinsurance amounts, (2) reasonable collection efforts were made, (3) the debt was actually uncollectible when claimed as worthless, and (4) sound business judgment established there was no likelihood of recovery in the future. Hospitals are required to offset their bad debt claims in the event that previously written off bad debts are collected.

OBJECTIVE

The objective of our audit was to determine the reasonableness of about $1.2 million in inpatient and outpatient Medicare bad debts claimed by the Baystate Medical Center (Hospital) for Fiscal Year (FY) ending September 30, 1999.

RESULTS OF REVIEW

We reviewed Hospital financial records for a sample of 138 Medicare bad debt claims totaling $151,858. Our analysis showed that 18 claims valued at $54,986 in bad debt charges did not meet Medicare reimbursement requirements. Specifically, we identified:

- $41,505 in bad debts lacking sufficient collection efforts,
- $12,392 in bad debts for non-covered services, and
- $1,089 in bad debts not adequately documented.

We also found that the Hospital understated its bad debt recoveries and should have offset its Medicare bad debt claim by an additional $96,801. In total, the Hospital overstated its bad debt reimbursement by $151,787.

RECOMMENDATIONS

We recommend:

- the Hospital strengthen it procedures to ensure that its claims for reimbursement of Medicare bad debts are properly reported in accordance with Medicare regulations, and
- the Medicare Fiscal Intermediary (FI), Mutual of Omaha, apply the net reduction of $151,787 to the Hospital's FY 1999 Medicare cost report.

The Hospital, in its December 24, 2002 response to our draft report (see APPENDIX), generally agreed with our audit findings and has instituted a number of steps to strengthen its policies and procedures for identifying and writing off bad debts. However, the Hospital disagreed with our findings for two atypical bad debts it claimed. We brought these claims to the attention of the FI and the State Medicaid Agency who concurred with our findings. Accordingly, we believe our recommended disallowance of these claims is appropriate.

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INTRODUCTION

BACKGROUND

Medicare policy states that beneficiaries should share in defraying the costs of care through various deductible and coinsurance payments. The Medicare program reimburses hospitals for bad debts associated with uncollectible Medicare deductible and coinsurance amounts if the bad debts meet Medicare reimbursement criteria. Generally, such bad debts must meet the following criteria, as set forth in Title 42 Code of Federal Regulations (CFR) Section 413.80 (e):

- the debt must be related to covered services and derived from deductible and coinsurance amounts,
- the provider must be able to establish that reasonable collection efforts were made,
- the debt was actually uncollectible when claimed as worthless, and
- sound business judgment established that there was no likelihood of recovery at any time in the future.

Reimbursement for Medicare bad debt was reduced by 40 percent in Fiscal Year (FY) 1999 per Section 1861(v)(1)(T) of the Social Security Act.

Many Medicare beneficiaries have a third-party responsible for their deductible and coinsurance liabilities. For instance, a state Medicaid agency may be responsible for coinsurance and deductibles of individuals dually eligible for Medicare and Medicaid coverage. However, if the state Medicaid agency denies payment on the Medicare deductible and coinsurance of an eligible Medicaid recipient in accordance with its state plan, the provider is not required to exert further collection efforts upon the individual. Such crossover bad debt claims can be claimed for Medicare reimbursement if Medicare regulations are met.

The Medicare Provider Reimbursement Manual (PRM), Section 310.B, requires that the provider's collection effort be documented in the patient's file. The PRM Section 1102, requires that listings be maintained of beneficiaries whose uncollected accounts were claimed as bad debts.

The Baystate Medical Center (Hospital) is a 587 bed acute care hospital located in Springfield, Massachusetts. During FY 1999, the Hospital submitted for Medicare reimbursement about $1.2 million in bad debt charges for inpatient and outpatient services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our review was made in accordance with generally accepted government auditing standards. The objective of the audit was to determine the reasonableness of Medicare bad debts claimed by the Hospital for FY 1999.

During FY 1999, the Hospital claimed reimbursement of $1,154,123[1] in Medicare bad debts on its cost report filed on March 15, 2002. The Hospital included both inpatient and outpatient bad debts on the FY 1999 cost report. Therefore, we included a review of both inpatient and outpatient bad debts in this audit.

We limited consideration of the internal control structure to those controls concerning bad debts submission because the objective of our review did not require an understanding or assessment of the complete internal control structure at the Hospital.

To accomplish our objective, we:

- reviewed criteria related to the reimbursement of Medicare bad debts,
- reviewed Hospital controls over the submission of bad debts for Medicare reimbursement,
- evaluated Hospital policies and procedures regarding the collection of deductibles and coinsurance,
- employed a stratified random sampling approach consisting of two strata. Stratum 1 consisted of a random sample of 100 bad debts valued at less than $1,000. Stratum 2 consisted of all 38 bad debts in the population valued at $1,000 or more,
- performed detailed audit testing of the supporting Hospital and patient records for the 138 bad debts selected in the sample,
- reviewed the accuracy and completeness of bad debt recovery amounts, including interviews with collection agency personnel, and
- interviewed state Medicaid personnel regarding Medicaid crossover claims.

Our fieldwork was performed from March 2002 through July 2002, at the Hospital in Springfield, Massachusetts. We also performed limited audit work at the Fiscal Intermediary's (FI's) offices, the Massachusetts State Medicaid Agency, and various collection agencies contracted by the Hospital.

The Hospital's response to our draft report is appended to this report (see APPENDIX).

[1] The 40 percent reduction per Section 1861(v)(1)(T) of the Social Security Act results in a total of $692,474 eligible for reimbursement.

FINDINGS AND RECOMMENDATIONS

In FY 1999, the Hospital submitted for Medicare reimbursement $1,154,123 in claims for bad debts. We reviewed the Hospital's supporting documentation for a sample of 138 bad debt claims totaling $151,858. We found that 18 claims valued at $54,986 in bad debt charges did not meet Medicare reimbursement requirements.[2] Specifically, we identified:

- $41,505, representing 3 claims, for bad debts ineligible for Medicare reimbursement through lack of sufficient collection efforts,

- $12,392, representing 9 claims, for bad debts not reimbursable by Medicare, and

- $1,089, representing 6 claims, for bad debts ineligible for Medicare reimbursement through lack of sufficient support in the Hospital's records.

We also found that the Hospital understated its bad debt recoveries and should have offset its Medicare bad debt claim by an additional $96,801. In total, the Hospital overstated its bad debt reimbursement by $151,787. The results of our review are discussed in detail below.

INSUFFICIENT COLLECTION EFFORTS

Our audit disclosed that the Hospital needs to strengthen its internal controls to ensure that reasonable collection efforts were taken prior to writing-off a bad debt as uncollectible. The PRM, Section 308 states, "A debt must meet these criteria to be an allowable bad debt...The provider must be able to establish that reasonable collection efforts were made." In addition, the PRM Section 310.2 states, "…If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible." Also, under the terms of PRM, Part 1, Section 314, "Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless."

We identified 3 claims, which were ineligible for Medicare reimbursement as they lacked sufficient collection efforts. Specifically we found:

- 2 claims, totaling $39,750, were identified by the Hospital as Medicaid crossover claims requiring no further collection efforts. We reviewed these two cases with the State Medicaid Agency and found that these beneficiaries lacked Medicaid eligibility, thus requiring full collection efforts, and

[2] A portion of our review included the analysis of a random sample of bad debt claims. Our review did not identify enough errors to project at a reasonable precision level. Therefore, we did not project our findings to the population but, instead, reported such errors at face value for recommended recovery.

- 1 claim, totaling $1,755, was written off as uncollectible prior to the required 120 day period.

As a result, we concluded that $41,505 in bad debt charges did not meet Medicare's criteria for reimbursement for insufficient collection effort.

NON-COVERED SERVICES

Our audit disclosed that the Hospital needs to strengthen its procedures to ensure that only bad debt claims related to Medicare coinsurance and deductible amounts are included for reimbursement. Title 42 CFR Section 413.80 Subpart F, (d) states, "…Under Medicare… costs of services provided for other than beneficiaries are not to be borne by the Medicare program." Further, 42 CFR Section 413.80 (e)(1) states, "The debt must be related to covered services and derived from deductible and coinsurance amounts."

Our review of the billing and patient records for the 138 claims in our sample showed 9 claims for bad debts were not covered by Medicare. Specifically, we found:

- 6 claims, totaling $10,898, were for non-Medicare patients, and

- 3 claims, totaling $1,494, were for amounts other than covered coinsurance and/or deductible amounts identified on the Medicare remittance advice.

As a result, $12,392 in bad debt claims did not meet Medicare's criteria for reimbursement.

INSUFFICIENT DOCUMENTATION

Our audit disclosed that the Hospital needs to strengthen its procedures for documenting its efforts for collecting bad debts. The PRM Section 310.1B., states, "…provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc."

We found that, of the 138 Medicare bad debt claims selected for review, support for 6 claims did not show sufficient documentation of required collection efforts. Specifically, Hospital documentation did not show evidence of follow up letters, telephone calls or personal contact made to these patients in support of its collection efforts.

As a result, we concluded that $1,089 in bad debt charges did not meet Medicare's criteria for reimbursement.

OFFSET OF MEDICARE BAD DEBT RECOVERIES PREVIOUSLY WRITTEN-OFF AS UNCOLLECTIBLE

Our audit disclosed that the Hospital did not have effective procedures in place to accurately report Medicare bad debt recoveries as an offset to its claim for bad debt

reimbursement. According to the PRM Section 316, "Where the provider was reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursed costs in the period of recovery are reduced by the amounts recovered."

In FY 1999, Hospital records showed total bad debt recoveries of about $1.7 million, of which only $6,842 was attributed to Medicare recoveries. Because the Hospital had changed to a new computer system, part of this total was an estimate.

Our analysis of recovery logs from collection agencies and other Hospital supporting documentation showed that the Hospital's Medicare bad debt recovery offset appeared to be understated. In this regard, collection agencies did not fully identify Medicare's portion of the recoveries. In lieu of an actual Medicare bad debt recovery, we computed an estimate using an established estimation formula used by the FI in its prior audits at the Hospital. Using this formula, we computed estimated Medicare bad debt recoveries at $103,643. By reducing this amount by the offset claimed, we believe that an additional $96,801 should offset the Medicare bad debts claimed for reimbursement. The Hospital agreed with this estimate.

CONCLUSION

In FY 1999, the Hospital submitted for Medicare reimbursement $1,154,123 in claims for bad debts. We reviewed the Hospital's supporting documentation for a sample of 138 bad debt claims totaling $151,858. We also reviewed the reasonableness of the Hospital's offset of $6,842 in Medicare bad debt recoveries previously written-off as uncollectible. We found that the Hospital erroneously claimed a net total of $151,787 in bad debts; $54,986 in bad debts not meeting Medicare reimbursement requirements and $96,801 in additional recovery offsets which should have been netted from the total claim.

RECOMMENDATIONS

We recommend:

- the Hospital strengthen it procedures to ensure that claims for Medicare bad debts are properly reported in accordance with Medicare regulations, and

- the Medicare FI, Mutual of Omaha, apply the adjustment of $151,787 to the Hospital's FY 1999 Medicare cost report.

AUDITEE RESPONSE

In its December 24, 2002 response to our draft report (see APPENDIX), the Hospital generally agreed with our findings and recommendations. The Hospital emphasized that it routinely claimed Medicare bad debts in accordance with Medicare regulations and its internal policies and procedures with only a few identified exceptions. The Hospital agreed that its Medicare bad debt recoveries were understated but said that its new patient

accounting system, implemented during 1999, has significantly improved its bad debt recovery reporting capabilities. Moreover, the Hospital delineated in its response the various steps it instituted to further strengthen its policies and procedures for identifying and writing off bad debts.

The Hospital disagreed, however, with our findings related to two atypical bad debts it claimed. The Hospital stated that these two bad debts were allowable for Medicare reimbursement as they involved indigent patients not needing the required collection efforts prior to write-off.

ADDITIONAL OAS COMMENTS

We acknowledge the Hospital's efforts to strengthen its policies and procedures to ensure the proper claiming of Medicare bad debts. With regard to the Hospital's disagreement with our audit findings regarding the two above mentioned bad debt claims, we discussed the details of these claims with both the FI and the State Medicaid Agency. Both parties were in agreement with our conclusions. Accordingly, we believe our recommended disallowance of these claims is appropriate.

A P P E N D I X

Baystate
Medical Center
A Member of Baystate Health System
Springfield, Massachusetts 01199
413-794-0000

December 24, 2002

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region I
John F. Kennedy Federal Building
Boston, MA 02203

Re: Common Identification Number: A-01-02-00515

Dear Mr. Armstrong:

We have reviewed the draft of the report providing Baystate Medical Center (the "Medical Center") with the results of your audit entitled "Review of Medicare Bad Debts Claimed by the Baystate Medical Center for Fiscal Year Ended September 30, 1999" dated November 27, 2002. The report provided background on the treatment of Medicare bad debts, the objective, scope and methodology of your review, and your findings and recommendations.

Based on our review of the draft report, the Medical Center accepts and generally agrees with the findings disclosed therein. We feel that it is important, however, to put several of the Office Of Inspector General's (OIG) findings in context and to emphasize that the Medical Center routinely claimed Medicare bad debts in accordance with Medicare reimbursement regulations and its internal policies and procedures, with only a few identified exceptions.[1]

Most notably, it should be reiterated that two of the eighteen claims with which the auditors found problems accounted for more than 72% of the bad debt charges which did not meet Medicare's reimbursement requirements. Both of these claims related to unusual patient stays exceeding multiple years, which included both acute care and sub-acute care services. These patients exhausted their Medicare benefits and became eligible for Medicaid after being transferred to the sub-acute unit. Medicaid denied payment of the deductible and coinsurance amounts on the basis that the patients were ineligible for Medicaid during their acute stays. The OIG's position is that, since Medicaid denied

[1] While the OIG reviewed 138 bad debt claims for FY 1999 worth $151,858, Baystate Medical Center processed bad debt claims relating to 2,470 patient encounters and accounting for $1,154,213 in bad debts during that year.

payment of the deductible and coinsurance amounts, the Medical Center should have applied its established collection efforts and billed the patients prior to writing off the accounts. The Medical Center did not apply its normal collection efforts and bill the patients since it had established, based on Medicare regulations, that the patients were indigent at the time of discharge and therefore their accounts qualified as Medicare bad debts.

We agree with the OIG that the Medical Center underestimated Medicare bad debt recoveries during FY1999. However, the Medical Center wishes to point out that it did implement a major conversion to a new patient accounting system in 1999. The Medical Center recognized the limitations of its previous patient accounting system to report Medicare bad debt recoveries. The new system has enabled the Medical Center to significantly improve its bad debt recovery reporting capabilities.

Following the OIG's audit, the Medical Center has instituted a number of steps to further strengthen its already established policies and procedures for identifying and writing off bad debts. Specifically, the Medical Center has done the following:

1. The Medical Center has reviewed its bad debt log and revised its reporting format to a) ensure that the date of Medicare remits indicating that portion of a bill representing the deductible/coinsurance payment is recorded and that the deductible/coinsurance amount is recorded as a patient obligation, and b) ensure that the date and reference information regarding Medicaid remits, in the case of crossover patients where Medicaid has allowed a claim but paid nothing due to upper payment limitations, are recorded and tracked to ensure proper bad debt treatment.

2. The Medical Center has designed a bad debt cost report checklist which requires several levels of personnel within Patient Accounting and Payment Systems to review various aspects of the bad debt collection and recovery policies and procedures prior to approving the bad debt claims amount to be reported on the cost report. This checklist was formally adopted by the Medical Center on April 19, 2002 and will be used beginning with the FY2002 cost report.

3. The Medical Center has provided and will continue to provide additional training for its Patient Accounting staff to further enhance the quality and detail of documentation obtained and retained regarding collection efforts made via telephone, electronic mail or other means.

4. The Medical Center has enhanced its patient accounting system to generate Medicare bad debt recovery logs.

5. The Medical Center also is continuing its efforts to strengthen its internal procedures to ensure that no non-covered services are claimed as Medicare bad debts.

Baystate Medical Center remains committed to maintaining compliance with all Medicare rules and regulations related to bad debt. If I can be of any further assistance, please do not hesitate to contact me at (413) 794-2578.

Sincerely,

Peter Lyons

Peter Lyons
Vice-President Finance, Support Services

ACKNOWLEDGMENTS

This report was prepared under the direction of Michael Armstrong, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Robert Champagne, *Audit Manager*
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For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.