

# Value ~ Added

A Publication of the Feeley & Driscoll, P.C. Health Care Services Group

## Working with CMS on Bad Debt Reimbursements

The Centers for Medicare and Medicaid Services (CMS) allow reimbursement for bad debts related to the unpaid deductibles and coinsurance of Medicare beneficiaries. Currently, CMS reimburses most Hospitals 70 percent of the bad debts of Medicare beneficiaries, while non-hospital providers continue to receive full reimbursement. In order to receive consideration from CMS, the Provider must meet specific criteria and guidelines for the reimbursement of bad debts. You can find these guidelines in Chapter 3 of the Provider Reimbursement Manual (PRM).

In general, CMS guidelines stipulate that an allowable Medicare bad debt is the uncollectible Medicare deductible and coinsurance that meets the specific criteria of PRM Section 308. These specific criteria require:

- the debt must be related to covered services
- the debt claimed is Medicare deductibles and coinsurance only
- the hospital has made reasonable and consistent collection efforts
- the debt was actually uncollectible when claimed, with no likelihood of future recovery

### The “120-Day Rule”

According to PRM Section 310, reasonable collection effort is defined as “the issuance of a bill shortly after patient discharge (or death), followed by subsequent billings, collection letters, telephone calls and/or personal contact.” All of the above must represent genuine rather than token efforts to collect the unpaid debt. Also, the effort must be consistently applied to all patient-related debts, Medicare and non-Medicare. In addition, CMS deems the unpaid deductible and coinsurance as uncollectible if reason-

**Working with CMS on Bad Debt Reimbursements (continued)**  
*page 2*

**External and Internal Benchmarking for Better Performance**  
*page 2*

**Federal Register Summary**  
*page 3*

**Supplemental Compliance Program Guidance for Hospitals**  
*page 4-5*

**Discounts for Underinsured and Uninsured Patients**  
*page 6*

**Tax Updates for Exempt Organizations**  
*page 6*

**Coding Corner: Modifier 91**  
*page 8*



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able collection effort has been applied for more than 120 days. This is often referred to as the “120-day rule”. PRM Section 310.2 basically states that if the Provider has pursued reasonable and customary attempts to collect the debt, with the debt remaining unpaid over 120 days from the date the first bill is mailed to the beneficiary, then the debt is presumed as uncollectible. Still, the Provider must provide adequate proof that “sound business judgment establishes” the debt as uncollectible or worthless.

### Indigent Beneficiary

The “120-day rule” is the customary standard applied except where the beneficiary is considered indigent. CMS deems a Medicare beneficiary as indigent when the individual has been determined as eligible for Medicaid. Otherwise, for purposes of determining an account as an allowable Medicare bad debt, the Provider must apply normal methods for determining a patient’s indigence. Upon determining indigence, with no evident improvement in the beneficiary’s financial condition, the debt may be deemed uncollectible without application of the “120-day” rule.

### Other Stipulations

Finally, CMS stipulates that the uncollectible deductible and coinsurance amount must be recognized as allowable bad debts in the cost report period in which the debt is deemed worthless. Also, reimbursable bad debts claimed must be reduced by prior and/or current period amounts recovered by the Provider.

### Changes in Recent Years

Historically, State Medicaid reimbursement plans have reimbursed hospitals for the deductible and coinsurance amounts for the patient “dually” eligible for Medicare and Medicaid coverage. Typically, subsequent to adjudication of the Medicare claim, the Medicare deductible and/or coinsurance would “crossover” to the State for Medicaid payment consideration. In recent years, State Medicaid programs have changed reimbursement policies and reimbursed hospitals at significantly lower levels. Most recently, State Medicaid reimbursement plans have eliminated any “crossover” payment. In such cases, the unpaid portion of the Medicare deductible or coinsurance not satisfied by the Medicaid “crossover” payment can be claimed as an allowable Medicare bad debt.

### Necessary Documentation

To the extent that the Provider follows the general guidelines above and creates the required bad debt listing to accompany the submission of the annual Medicare cost report, the Medicare bad debts claimed should be supported and documented by the following:

- a copy of the Medicare remittance advice

- proof of collection effort (including but not limited to, the dates and number of bills mailed, written correspondence, telephone call and collection agency detail)
- a copy of Medicaid remittance advice, if applicable
- write-off dates
- indigence, if applicable

### Prospective Payment System Methodologies

Many Medicare program reimbursements have moved or are moving to prospective payment methodologies. Typically, these methodologies continue to allow for the separate settlement of inpatient and outpatient Medicare bad debts. As State Medicaid Plans continue to reduce or eliminate “crossover” payments, many hospitals are experiencing significant increases in the volume of unpaid Medicare deductible and/or coinsurance amounts. The results are increased balances eligible for settlement via the annual Medicare cost report. Accordingly, hospitals must have appropriate procedures to capture the unpaid patient liability, properly identify allowable Medicare deductible and coinsurance amounts, and maintain the necessary supporting documentation.

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## External and Internal Benchmarking for Better Performance

Benchmarking isn't new, in fact, it's been around for a long time. Used appropriately, *benchmarking* can be one of your most effective management tools. As your hospital faces increasing competition, reduced reimbursement and other operating issues, *both external and internal* benchmarking can help you set priorities and goals.

Historically, good managers have always wanted to know how they compare to industry standards, past performance, or the competition. What should you benchmark? Anything that helps you learn your relative position—wait times in the Emergency Department, patient satisfaction, average days revenue in accounts receivable, labor productivity in almost any department. This external benchmarking helps you know where you stand versus the industry, best practices and/or the competition.

Internal benchmarking can also be highly effective. You can track how productivity changes month to month, or year to year. You can even identify internal best practices. In addition, once you establish a productivity goal or standard, you can use internal benchmarking to track progress toward your goal. It can also help you identify when productivity deteriorates and short-term action is necessary.

# Federal Register Summary

## Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts for 2005

9-9-04 (Vol. 69, No. 174, Pages 54671-54673)  
*Agencies:* Centers for Medicare & Medicaid (CMS), HHS  
*Action:* Notice.

This notice announces the inpatient hospital deductible and the hospital and extended care services coinsurance amounts for services furnished in calendar year 2005 under Medicare's Hospital Insurance Program (Medicare Part A). The Medicare statute specifies the formulae used to determine these amounts.

## Part A Premium for 2005 for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement

9-9-04 (Vol. 69, No. 174, Pages 54673-54674)  
*Agencies:* Centers for Medicare & Medicaid (CMS), HHS  
*Action:* Notice.

This notice announces the Hospital Insurance premium for calendar year 2005 under Medicare's Hospital Insurance program (Part A) for the uninsured, not otherwise eligible aged (hereafter known as the "uninsured aged") and for certain disabled individuals who have exhausted other entitlement. The monthly Medicare Part A premium for the 12 months beginning January 1, 2005 for these individuals is \$375. The reduced premium for certain other individuals as described in this notice is \$206. Section 1818 (d) of the Social Security Act specifies the method to be used to determine these amounts.

## Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility

9-9-04(Vol. 69, No. 174, Pages 54674-54684)  
*Agencies:* Centers for Medicare & Medicaid (CMS), HHS  
*Action:* Notice.

In accordance with section 1839 of the Social Security Act (the Act), this notice announces the monthly actuarial rates for aged (age 65 and over) and disabled (under age 65) enrollees for the Part B account in the Medicare Supplementary Medical Insurance (SMI) trust fund for 2005. It also announces the monthly Part B premium to be paid by enrollees during 2005. The monthly actuarial rates for 2005 are \$156.40 for aged enrollees and \$191.80 for disabled enrollees. The monthly Part B premium rate for 2005 is \$78.20. (The 2004 premium rate was \$66.60). The 2005 Part B premium is equal to 50 percent of the monthly actuarial rate for aged enrollees, or about 25 percent of Part B costs for aged enrollees.

## Home Health Prospective Payment System Rate Update for Calendar Year 2005

9-22-04 (Vol. 69, No. 204, Pages 62123-62162)  
*Agencies:* Centers for Medicare & Medicaid (CMS), HHS  
*Action:* Final Rule.

This final rule sets forth an update to the 60-day national episode rates and the national per-visit amounts under the Medicare prospective payment system for home health agencies. As part of this final rule, CMS is also rebasing and revising the home health market basket to ensure it continues to adequately reflect the price changes of efficiently providing home health services. In addition, CMS is revising the fixed dollar loss ratio, which is used in the calculation of outlier payments. This final rule will be the first update of the home health prospective payment system (HH PPS) rates on a calendar year update cycle. HH PPS was moved to a calendar year update cycle as a result of the provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

## Medicare/Medicaid Reimbursements and Overpayments

10-1-04 (Vol. 28, No. 1, Page 233)  
*Agency:* Office of the Secretary of Family and Social Services  
*Action:* Proposed Rule.

Amends 405 IAC 1-1-5 and 405 IAC 1-105-2 to specify that a hospital has 60 days after the date of an overpayment notice to repay the overpayment or to file an appeal to comply with P.L.78-2004. Amends 405 IAC 5-1-5 to update language regarding coding sources. Amends 405 IAC 5-3-13 to eliminate the prior authorization requirement for certain services and to specify that orthodontic procedures for members under 21 years of age for cases of craniofacial deformity or cleft palate are subject to prior authorization. Amends 405 IAC 5-9-1 to allow Medicaid reimbursement for evaluation and management services for 50 office visits per rolling quantities greater than a one-month supply if the recipient is a Medicare beneficiary and if Medicare allows reimbursement for that quantity. Amends 405 IAC 5-19-10 to specify that Medicaid reimbursement is available for corrective shoe features. Amends 405 IAC 5-26-5 to correct an Indiana Administrative Code reference.

## Retaining Medical Records

11-1-04 (Vol. 28, No. 2, Page 655)  
*Agency:* Office of the Secretary of Family and Social Services  
*Action:* Proposed rule.

Amends 405 IAC 1-5-1 to increase the required time providers must retain medical records.

# Supplemental Compliance Program Guidance for Hospitals

The Department of Health and Human Services Office of the Inspector General (HHS-OIG) was established by Congress in 1976 to identify and eliminate fraud, abuse, and waste in HHS programs and to promote efficiency and economy in departmental operations. The OIG is responsible for conducting audits, evaluations, and both criminal and civil investigations for all HHS agencies. These functions are performed by the OIG's Office of Audit Services (OAS), Office of Evaluation and Inspections (OEI), and Office of Investigations (OI), respectively.

Feeley & Driscoll's OIG Update is a compilation of the latest and greatest additions to the OIG's Web site, listed in approximate order of greatness rather than lateness. Enjoy.

## I. Introduction

- The complete Supplemental Compliance Program Guidance for Hospitals can be found at the following link: <http://www.oig.hhs.gov/fraud/docs/complianceguidance/012705HospSupplementalGuidance.pdf>
- This document is meant to supplement, rather than replace the OIG's 1998 CPG for the hospital industry (<http://oig.hhs.gov/authorities/docs/cpghosp.pdf>).

### A. Benefits of a Compliance Program

- A successful compliance program addresses the public and private sectors' mutual goals of reducing fraud and abuse; enhancing health care providers' operations; improving the quality of health care services; and reducing the overall cost of health care services.
- An effective compliance program demonstrates a hospital's good faith effort to comply with applicable statutes, regulations, and other Federal health care issues.

### B. Application of Compliance Program Guidance

- The OIG strongly encourages hospitals to identify and focus their compliance efforts on those areas of potential concern or risk that are most relevant to their individual organizations.

## II. Fraud and Abuse Risk Areas

### A. Submission of Accurate Claims and Information

- The most common and longstanding risks associated with claims preparation and submission are listed as the following:

#### 1. Outpatient Procedure Coding

- Hospitals should review their outpatient documentation practices to ensure that claims are based on complete medical records and that the medical records support the levels of service claimed.

#### 2. Admission and Discharges

- Hospitals have a duty to ensure that admission and discharge policies are updated and reflect current CMS rules.

#### 3. Supplemental Payment Considerations

- In certain limited situations, hospitals may claim payments in addition to, or in some cases in lieu of, the normal reimbursement available to hospitals under the regular payment systems.

#### 4. Use of Information Technology

- The implementation of the OPPTS increased the need for hospitals to pay particular attention to their computerized billing, coding, and information systems.

### B. The Referral Statutes: The Physician Self-Referral Law (the "Stark" Law) and the Federal Anti-Kickback Statute

#### 1. The Physician Self-Referral Law

- For more information about the Stark law and applicable regulations, including exceptions, go to: <http://cms.gov/medlearn/refphys.asp>

## **2. The Federal Anti-Kickback Statute**

- The anti-kickback statute is a criminal prohibition against payments made purposefully to induce or reward the referral or generation or Federal health care program business.

## **C. Payments to Reduce or Limit Services: Gainsharing Arrangements**

- “Gainsharing” typically refers to an arrangement in which a hospital gives physicians a percentage share of any reduction in the hospitals costs for patient care attributable in part to the physicians’ efforts.

## **D. Emergency Medical Treatment and Labor Act (EMTALA)**

- For further information on the EMTALA, go to: <http://www.cms.gov/providers/emtala/emtala.asp>

## **E. Substandard Care**

- For more information about substandard care and the OIG’s requirements, go to: <http://www4.law.cornell.edu/uscode/42/1320a-7.html>

## **F. Relationships with Federal Health Care Beneficiaries**

- Hospital’s should familiarize themselves with the OIG’s August 2002 Special Advisory Bulletin on Offering Gifts and Other Inducements to Beneficiaries. To read this report, go to: <http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf>

## **G. HIPPA Privacy and Security Rules**

- For more information on this privacy rule and how it may apply to your provider, go to: <http://www.hhs.gov/ocr/hipaa/>.

## **H. Billing Medicare or Medicaid Substantially in Excess of Usual Charges**

- For more information on this topic, go to: <http://oig.hhs.gov/authorities/docs/FRSIENPRM.pdf>

## **III. Hospital Compliance Program Effectiveness**

- The following section outlines the important roles of corporate leadership and self-assessment of compliance programs.

## **A. Code of Conduct**

- Hospitals should endeavor to develop a culture that values compliance from the top down and fosters compliance from the bottom up

## **B. Regular Review of Compliance Program Effectiveness**

- This review should be conducted annually at the minimum, and should include an assessment of each of the basic elements individually, as well as the overall success of the program.
- The following factors are often observed in effective compliance programs:

### **1. Designation of a Compliance Officer and Compliance Committee**

### **2. Development of Compliance Policies and Procedures, Including Standard of Conduct**

### **3. Developing Open Lines of Communication**

### **4. Appropriate Training and Education**

### **5. Internal Monitoring and Auditing**

### **6. Response to Detected Deficiencies**

### **7. Enforcement of Disciplinary Standards**

## **IV. Self-Reporting**

- When the compliance officer, compliance committee, or a member of senior management discovers credible evidence of misconduct from any source and it violates criminal, civil, or administrative law, the hospital should promptly report the misconduct to the authorities, not waiting more than 60 days to report the violation.
- Voluntary reporting will demonstrate the hospital’s good faith and willingness to work with governmental authorities to correct and remedy the problem.
- To encourage providers to make voluntary disclosures, the OIG published the Provider Self-Disclosure Protocol, of which can be found here: <http://oig.hhs.gov/authorities/docs/selfdisclosure.pdf>

## Discounts for Underinsured and Uninsured Patients

Hospitals have long struggled with discounting charges to underinsured and uninsured patients. With the rapid increase of healthcare costs, insurance premiums and unemployment/underemployment, hospitals have faced ever-increasing pressure for discounting on private-pay balances. Fortunately, recent developments have raised public and government awareness of the issue.

### New OIG Documentation

In February 2004, the Department of Health and Human Services Office of Inspector General (OIG) issued a document in response to an inquiry by the American Hospital Association. The OIG document and a subsequent letter by the Secretary of HHS offered hospitals assurance that no federal regulations prohibit discounts for underinsured or uninsured patients. If you haven't read these documents in their entirety and a Frequently Asked Questions (FAQ) paper by the CMS, we suggest you do so. It will give you full understanding of the debate and issues.

### Discount Policies at Your Facility

In view of these developments and the public "hype" surrounding them, the private-pay discounting policies at your hospital should be re-examined (or developed if you don't have one). Following adoption of the policy by upper management, you should communicate it up-line to the Board and down-line to all personnel responsible for implementation.

Think about these steps when developing or evaluating the policy:

- Review charge structures to assure that charges are related to cost according to hospital policy
- Assure that charges are consistently recorded for all patients receiving like services, regardless of the payor
- Evaluate written policies related to charity, bad debts and collection efforts, to determine their connectivity to private pay discounts
- Determine information needs and methods for acquiring information from underinsured and uninsured patients, to make a determination about charity or discounted services
- Establish pre-determined discounting rates based on income, asset tests, available insurance, etc. that you'll use to qualify patients
- Assure consistent application of discounting policies to all patients
- Assign responsibility for decisions about private pay discounts
- Review accounting treatment of discounts, bad debts and charity to assure their identification and accumulation in the hospital's financial records

Policies involving discounts vary significantly between hospitals. The important thing is that your hospital has a policy and then implements it uniformly.

## Tax Updates for Exempt Organizations

*The IRS will require certain tax-exempt organizations to electronically file their income tax or annual information returns beginning in 2006.* For tax year 2005 returns that are due in 2006, the regulations require that corporations with total assets of \$50 million or more file their Forms 1120 and 1120S electronically. In addition, tax-exempt organizations with total assets of \$100 million or more will be required to file their tax year 2005 Form 990 electronically. The electronic filing requirements only apply to entities that file at least 250 returns, including income tax, excise tax, information and employment tax returns, during a calendar year.

**Unrelated Business Taxable Income of Tax-Exempt Organizations.** Under federal law, non-profit corporations are not subject to federal income tax unless they carry on a trade or business that is unrelated to the exempt purpose for which they are organized. Such organizations are subject to federal income tax on their unrelated business taxable income. Many states follow the

federal income tax treatment of such corporations. Massachusetts currently follows this treatment with respect to unincorporated non-profit organizations, but not with respect to incorporated entities and other entities treated as corporations that are exempt under IRC § 501. The proposed amendment brings the Massachusetts tax treatment of such organizations in line with the federal treatment. Corporations exempt from federal income tax under IRC § 501 will be subject to the Massachusetts corporate excise, but only on their unrelated business taxable income. For purposes of apportioning income that is subject to tax both within and without Massachusetts, a corporation may use the apportionment factors of G.L. c. 63, § 38, provided that the apportionment factors must be determined by reference only to the unrelated business activity of such corporation. Similarly, the credits allowed under Chapter 63 will be allowed only to the extent that they arise from the unrelated business activity of such corporations.

## Tell Us How We Can Help You

We would welcome the opportunity to answer your questions and discuss your needs. Please let us know how we can be of assistance. Just fill in this response form and fax (617) 742-0210, mail or go to the following page on our web site [www.fdcpa.com/hcresponseform.htm](http://www.fdcpa.com/hcresponseform.htm)

### Express Response Form

*I would like more information about your services for healthcare facilities:*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Medicare/Medicaid Reimbursement  | <input type="checkbox"/> APC/CDM Diagnostic Review            | <input type="checkbox"/> Personal Financial Services for Hospital Executives |
| <input type="checkbox"/> Compliance Review and Consulting | <input type="checkbox"/> Determination of Need (DON)          | <input type="checkbox"/> Sarbanes-Oxley Consulting                           |
| <input type="checkbox"/> HIPAA Readiness and Solutions    | <input type="checkbox"/> Dashboard Reporting and Benchmarking | <input type="checkbox"/> Physician/Hospital Arrangements                     |
| <input type="checkbox"/> Mergers and Acquisitions         | <input type="checkbox"/> Revenue Cycle Management             | <input type="checkbox"/> Managed Care Contracting                            |
| <input type="checkbox"/> Strategic Business Planning      | <input type="checkbox"/> Fraud Prevention Consulting          | <input type="checkbox"/> Joint Venture Development                           |
| <input type="checkbox"/> Financial Feasibility Studies    | <input type="checkbox"/> Dispute and Litigation Support       | <input type="checkbox"/> Psych PPS Planning and Evaluation                   |
| <input type="checkbox"/> Productivity Studies             | <input type="checkbox"/> Critical Access Hospital Services    |  |

*I would like more information about the other services you offer, especially those relating to:*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Audit Services | <input type="checkbox"/> Tax Services       | <input type="checkbox"/> Management Consulting |
| <input type="checkbox"/> ERISA Audits   | <input type="checkbox"/> Financial Planning |  |

- .....
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- I would like you to add the following to receive Value Added.

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### Contact Information

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Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



## Coding Corner: Modifier 91

On February 16, 2005, CMS issued additional provider guidance concerning the correct use of Modifier 91 “Repeat Clinical Diagnostic Laboratory Test”. As you know, Modifier 91 should be applied to laboratory services to indicate repeat services done *on the same day* for *the same patient*, when tests are repeated for the purpose of obtaining *medically necessary* subsequent test values. It **does not apply** to repeat testing because of laboratory errors, quality control or to confirm results.

CMS Medical Review identified, in a recent multi provider probe, what it believed was a need to clarify the application of Modifier 91 specifically when billed with the following HCPCS codes:

- 80101 (drug screen, qualitative: single drug class method e.g. Immunoassay, enzyme assay, each drug class)
- 87077 (culture, bacterial: aerobic isolate, additional methods required for definitive identification, each isolate)

Interestingly though CMS’ issue with the claims it reviewed was not the medical necessity of the service or the supporting documentation. In fact, with respect to

these claims it was *not* that the modifier was used incorrectly, but that it was used *unnecessarily*.

In this probe, it was found that billings for drug screening (HCPCS 80101) included modifier 91. Billing Revenue Code 301, with HCPCS 80101, 6 units describes charges for this series of test results per single drug class. The documentation reviewed (laboratory report) clearly indicated that six (6) drug classes were analyzed. In this situation therefore it was not necessary to attach modifier 91.

The guidance further states:

*“It is unnecessary to attach modifier 91 when billing for a culture (from any source) that has identified more than one organism growth. This concern was identified during this probe review. Billing Revenue Code 306, with HCPCS 87077, 2 units indicates billing for the culture of one source that results in multiple (2) organism growth on one culture plate.”*

The bottom line with respect to these codes and Modifier-91 is that the CPT descriptions for HCPCS 80101 and 87077 call for the indication of results for each class or isolate or plate, and therefore the use of Modifier-91 is redundant.