NEXSEN | PRUET

Staying Ahead of Changes to the Bad Debt Rule

Related Professionals

Jenna K. Godlewski*
843.720.1720
JGodlewski@nexsenpruet.com

Practices

Health Law

06.18.2020

CMS has made dramatic rule changes that reduce administrative barriers to assist Medicare providers during this public health emergency. Many Medicare providers are struggling to maintain financial viability due to a decrease in non-COVID-19 related services and significant increases in costs for personal protective equipment.

Providers are not alone in feeling the financial impacts of this pandemic. Medicare beneficiaries face an increased risk of contracting COVID-19, but may be unable to pay their portion of treatment due to high unemployment rates and a depressed economy.

In the midst of this economic crisis facing Medicare providers and beneficiaries, CMS has proposed to tighten the requirements for "bad debt reimbursement" when Medicare beneficiaries are unable to pay their coinsurance and/or deductibles. Currently, 42 CFR § 413.89 states that Medicare will pay providers a portion of bad debt (usually around 65%) if the provider has established that "reasonable collection efforts were made" and "sound business judgment" concluded that there was no likelihood of recovery in the future. CMS has previously given little guidance to providers on how to meet these standards, and this lack of clarity has caused significant litigation. CMS now proposes to clarify the bad debt statute as part of its inpatient prospective payment system rules update. (85 Fed. Reg. 32,866-32,876 and 32, 895-32,896 (May 29, 2020).

Under the proposed rule, the requirements to prove "reasonable collection efforts" are:

→ In-house efforts by the provider must be utilized. In addition, if an outside collection agency is used to pursue collections for non-Medicare patients, then a collection agency must be used for Medicare patients with comparable debt amounts.

→ A bill must be sent to the beneficiary or responsible party within 120 days following the date of the Medicare remittance advice or the date of the remittance advice from the beneficiary's secondary payor,

whichever is later.

- → After the bill is sent, evidence must be kept of genuine collection efforts which includes subsequent billings, collection letters and telephone calls.
- → Before seeking reimbursement from Medicare, 120 days of collections efforts must have passed. A new 120 day period begins every time a partial payment is made.
- → A documented collection policy and process must be implemented, and a patient account file must be kept that contains the written collection evidence.

The proposed rule also includes additional clarification on the "sound business judgment" that must be used in determining whether a beneficiary is unable to pay. A beneficiary's assertion that they can't pay is insufficient and the beneficiary's total assets must be examined, not just income. The provider must have a specific indigency policy and have an application that all beneficiaries claiming indigence must fill out.

It is important to note that when this rule passes, the changes will be retroactive. While these changes place more burdens on providers, the good news is that the steps that must be taken for Medicare collections are now better defined. Providers must act quickly to ensure that their collection procedures are compliant with the proposed rule, so they do not lose out on reimbursement from Medicare.
