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I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which Tenet Healthcare Corporation or an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility in which Tenet Healthcare Corporation or an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Facility”) (collectively, “Tenet”).

II. PURPOSE:


The purpose of this policy is to ensure compliance with the Medicare requirements for the reimbursement of bad debts arising out of unpaid deductibles and coinsurance related to hospital services provided to Medicare beneficiaries under the Traditional Medicare Plan.¹

III. DEFINITIONS:

- A. **“Crossover Claim”** means a claim for Medicare Part A and/or B deductibles and coinsurance submitted to a Medicaid agency on behalf of a Dual Eligible Beneficiary.
- B. **“Crossover Bad Debt”** means an unpaid deductible or coinsurance amount resulting from a properly billed and adjudicated Crossover Claim.
- C. **“Dual Eligible Beneficiary”** means a patient who qualifies, in some way, for both Medicare Part A and/or B and Medicaid coverage.
- D. **“Traditional Medicare Bad Debt”** means an unpaid deductible or coinsurance amount for which the patient is personally liable.
- E. **“Traditional Medicare Plan”** means health insurance benefits payable under Parts A and B of Title XVIII.²
- F. **“Revenue Cycle Management Organization” (“RCMO”)** means the organization responsible for the identification, billing, collection and management of hospital patient service revenue.

¹ Hospital inpatient services covered under Parts A and B, and hospital outpatient services covered under Medicare Part B.

² U.S.C. §§1395-1395ccc, subchapter XVIII, chapter 7, Title 42

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IV. POLICY:

Under Medicare, costs of covered services furnished to Medicare beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than Medicare beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs.³ Medicare beneficiaries enrolled in the Traditional Medicare Plan are generally responsible for both deductible and coinsurance payments for medical services and supplies. When Medicare patients, or Medicaid agencies in the case of Dual Eligible Beneficiaries, fail to make these payments to certain providers, the Medicare Program will reimburse those providers if reasonable collection efforts have been made.⁴ Congress authorized the Secretary of Health and Human Services to promulgate regulations to ensure that hospitals would not be forced to shift these costs to non-Medicare patients.⁵ In order to qualify for reimbursement, hospitals must comply with a network of collection, record keeping, and reporting regulations and rules.

The Centers for Medicare and Medicaid Services (CMS), through its regulatory and sub-regulatory guidance, has established strict policies governing the reimbursement of Medicare bad debts. Failure to adhere to these regulations and guidance can result in lost reimbursement, sometimes several years after the reimbursement was claimed or earned. It is the responsibility of the hospital Chief Financial Officer and RCMO to ensure that the policies and procedures set forth below are diligently followed.

All Tenet Medicare providers that are eligible to claim reimbursement for unpaid Medicare Part A and/or Part B deductibles and coinsurance⁶ (collectively, the “Tenet Entities”) shall have processes, procedures, and internal controls designed to:


- Identify all unpaid Medicare deductibles and coinsurance that satisfy the

³42 CFR §413.89(d); In determining reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs is reduced 30 percent (42 CFR§413.89(h)(4)).

⁴ Medicare reimbursement for uncollected deductible and coinsurance does not apply to services paid under the Medicare Physician Fee schedule, Ambulatory Surgery Centers fee schedule, or the Durable Medical Equipment fee schedule.

⁵42 USC §1395x(v)(1)(A)(i).

⁶Providers which are eligible for Medicare bad debt reimbursement include hospitals, skilled nursing facilities and home health agencies.

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requirements to be claimed as a Medicare Bad Debt;

- Ensure that the billing and collection requirements established by CMS as outlined below that pertain to Medicare bad debts are satisfied; and
- Accumulate and preserve the required information and evidence of collection effort prior to any claim for Medicare bad debt reimbursement being submitted for reimbursement.⁷


Such processes, procedures and internal controls must include effective means and controls to ensure that Medicare reimbursement is claimed only for amounts which are eligible for Medicare bad debt reimbursement.

V. PROCEDURE:


- A. The Tenet Entities shall, without exception, adhere to all of the following in the identification and reporting of and accounting for Medicare bad debts:
1. Generally, a bad debt must meet all of the following criteria to be allowable:
 - a. The debt must be related to covered services and derived from deductible and coinsurance amounts.
 - b. The provider must be able to establish that reasonable collection efforts were made.
 - c. The debt was actually uncollectible when claimed as worthless.
 - d. Sound business judgment established that there was no likelihood of recovery at any time in the future.⁸
 2. What is included as a Medicare bad debt:
 - a. Inpatient Part A deductibles and coinsurance for inpatient services provided in:
 - (1) Acute facilities/hospitals reimbursed under the Medicare Inpatient Prospective Payment System;

⁷Claims for Medicare bad debt reimbursement are made through the provider's annual Medicare cost report.

⁸42 CFR §413.89(e)

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- (2) Rehabilitation hospitals and units reimbursed under the Medicare Inpatient Rehabilitation Prospective Payment System;
 - (3) Psychiatric hospitals and units reimbursed under the Medicare Inpatient Psychiatric Prospective Payment System;
 - (4) Long term care hospitals reimbursed under the Medicare Long Term Acute Care Hospital Prospective Payment System; and
 - (5) Skilled nursing facilities and units reimbursed under the Medicare Skilled Nursing Prospective Payment System.
- b. Medicare Part B deductibles and coinsurance for:
- (1) Hospital Outpatient services reimbursed under the Medicare Outpatient Prospective Payment System; and
 - (2) Inpatient services in hospitals and units described in Subsection V.A.2.a. of this policy covered under Part B where the patient does not have Part A coverage or Part A coverage is exhausted.
- c. Subsequent recoveries from patients, insurers, or Medicaid on amounts previously claimed as a bad debt are offset against total bad debts in the period collected.
3. Exclusions – the following are not Medicare bad debts:
- a. Charges for non-covered items and services;
 - b. Charges for personal items;
 - c. Amounts derived from unpaid deductibles and coinsurance for services paid for under a reasonable charge-based methodology or a fee schedule such as but not limited to, outpatient therapy


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services, services of physicians, suppliers, certified registered nurse anesthetists, and nurse practitioners.⁹

- d. Part A deductibles and coinsurance that have been waived under an approved waiver program. Please refer to Regulatory Compliance Policy COMP-RCC 4.02 Waivers of Co-Payments and Deductibles for additional guidance on waiving Medicare deductibles and coinsurance.
 - e. Deductibles and coinsurance for non-hospital (*e.g.*, physician, freestanding diagnostic, ASC, and durable medical equipment) services and supplies.
 - f. Copayments related to claims paid under Medicare Part C (*i.e.*, Medicare Advantage).
4. Collection Effort – The collection efforts and procedures and documentation required to satisfy CMS’s requirements for Traditional Medicare Bad Debts and Crossover Bad Debts are different.
- a. Traditional Medicare Bad Debts
 - (1) Reasonable Collection Effort - Pursuant to the criteria set forth by CMS at 42 CFR 413.89(e) and sections 308 and 310 of the Medicare Provider Reimbursement Manual (PRM)¹⁰, a provider must establish that reasonable collection efforts were made, establish that the debt was worthless when claimed as a bad debt, and use sound business judgment to establish that there is no likelihood of recovery at any time in the future. According to CMS, 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. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient’s personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts

⁹71 FR 69712; 42 CFR §413.89(i);

¹⁰CMS Publication 15-1

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with this party which constitute a genuine, rather than a token, collection effort. The provider’s collection effort may include using or threatening to use court action to obtain payment.” *Until a provider’s reasonable collection efforts have been completed, including both in-house efforts and the use of a collection agency, unpaid deductible and coinsurance amounts cannot be recognized as a Medicare bad debt.*

(2) Use of Collection Agencies

(a) Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The “like amount” requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency’s practices may include using or threatening to use court action to obtain payment.

(b) CMS deems the use of a collection agency to be part of the provider’s ongoing collection effort, and as long as the debt remains with a collection agency, the debt cannot be deemed “uncollectible.”


(3) Indigent Patients - Medicare rules provide that if a facility/hospital can establish *prior to admission or shortly before discharge* that a patient is financially indigent or medically indigent, the normal collection effort described above may be bypassed. The amount due for Medicare deductible and coinsurance may be written off and claimed as a Medicare bad debt. For the purposes of this policy,

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CMS has established the following criteria to establish indigence:¹¹

- (a) If a patient is qualified under the Medicaid/Medi-Cal program, the facility can accept this as evidence of indigence; *however the Medicaid/Medi-Cal program must be billed for the deductible and coinsurance.* Any unpaid deductible and coinsurance may be written off without further collection effort as a Medicare bad debt. Please refer to the discussion of Medicaid/Medi-Cal crossover bad debts in Subsection V.A.4.b., below.
- (b) If the patient is not Medicaid/Medi-Cal eligible, indigence may be determined according to the following:
 - (i) *The determination of indigence must be made by facility personnel and not the patient. A declaration of inability to pay signed by the patient is unacceptable proof of indigence*; the Tenet Entity must consider all resources that would include, but not be limited to, the patient's assets, liabilities, income and expense. In making this determination, the Tenet Entity personnel must review information to support the patient's financial status such as tax returns, income statements, W-2s, etc. These items should be obtained and reviewed to support the patient's claim of indigence. Copies of this information must be retained in the patient's file to support the determination of indigence.
 - (ii) All possible sources of payment must be thoroughly investigated. This includes, but is not limited to, Title XIX (Medicaid/Medi-

¹¹ Generally, a Medicare beneficiary that satisfies the Tenet charity care policy may qualify as indigent for Medicare bad debt purposes; however, the determination must be made on a case- by-case basis and must include the appropriate documentation as required under this policy and Tenet's charity care policy.

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Cal) eligibility, local welfare agencies, Medigap insurance, secondary insurance, or the patient’s guardian who might be legally responsible for the patient's bills.¹²


- (iii) The patient’s file must be fully documented as to what steps were taken to support the determination of indigence.
- (iv) If the patient does not qualify as indigent under the aforementioned criteria, reasonable collection efforts as described in Subsection V.A.4.a.(1), above, must be used before the account may be written off and claimed as a Medicare bad debt.

b. Crossover Bad Debts

- (1) Where the State (*i.e.*, Medicaid) is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay may be included as a bad debt under Medicare, provided that the requirements of PRM §312 or, if applicable, PRM §310 are met.¹³
- (2) In some instances, the State has an obligation to pay, but either does not pay anything or pays only part of the deductible or coinsurance because of a State payment “ceiling,” such as the lower of what Medicaid would normally pay without Medicare involvement or the Medicare paid amount. In these situations, any portion of the deductible or coinsurance that the State does not pay

¹²Proof of eligibility for certain state programs that are income-based and are less restrictive than the hospital’s charity care policy (*i.e.*, are based on a lower percentage of the applicable Federal Poverty Level) may be used to establish indigence; however, the patient’s proof of eligibility for the program and the state’s eligibility requirements for the program must be maintained as evidence.

¹³A hospital that voluntarily elects to not accept Medicaid patients and that does not have a Medicaid provider agreement may not claim unpaid crossover deductibles and coinsurance as Medicare bad debts.

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may be included as a bad debt under Medicare, provided that the requirements of PRM §312 are met.

Example #1: Assume that Medicare determines that a provider is entitled to \$1000.00 with a \$200.00 copayment resulting in a Medicare payment of \$800.00. If, without Medicare involvement, the State would normally pay \$700.00, the State would pay nothing and \$200.00 may be included as a Medicare bad debt.

Example #2: Assume that Medicare determines that a provider is entitled to \$1000.00 with a \$200.00 copayment resulting in a Medicare payment of \$800.00. If, without Medicare involvement, the State would normally pay \$850.00, the State would pay \$50.00 and \$150.00 may be included as a Medicare bad debt.

- (3) Before the residual balance for deductible and/or coinsurance is written off and claimed as a Medicare bad debt, evidence of Medicaid/Medi-Cal payment must be received and retained for audit purposes.¹⁴
- (4) Medicaid payment denials due to non-eligibility of the patient or non-coverage of the service are not considered a crossover bad debt. The account must be considered “private pay” and normal collection procedures for Traditional Medicare Bad Debts in Subsection V.A.4.a. of this policy must be followed before the amount due may be claimed as a Medicare bad debt.
- (5) Medicaid claims payment denials due to untimely filing, billing errors, or other claim rejections may not be claimed as a Medicare bad debt.
- (6) A unique patient accounting adjustment code is to be used for Crossover Bad Debts. *This code must be used only for the unpaid deductible and coinsurance amount* and will automatically route the write-off to the appropriate balance sheet account. Amounts written off using these codes should not be entered on the bad debt log as a separate

¹⁴The required evidence is the Medicaid remittance advice indicating the amount paid (if any) by Medicaid.

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report of Crossover Bad Debts that is driven by the unique patient accounting adjustment code will be created at the time the cost report is prepared.

c. Small Balances for Deductibles and Coinsurance

(1) In order for small balances related to deductibles and coinsurance to be reimbursed by Medicare, the Tenet Entity must demonstrate that reasonable efforts to collect the unpaid balance were made and that such efforts are applied uniformly to all patients.¹⁵

(2) Small balances which are below the small balance threshold are automatically written off and for which no collection effort will be made *may not be claimed as Medicare bad debts.*

Exception: Small balances related to unpaid Medicare deductibles and coinsurance for Dual Eligible beneficiaries may be claimed as bad debts; however, the billing criteria set forth in Subsection V.A.4.b.(3)-(6) of this policy must be satisfied.

d. Partial Payments/Payment Arrangements


The patient is expected to make payment in full when presented with the first bill. In those situations where partial payments are made by the patient, the following apply:

(1) Formal Payment Arrangements

(a) In those situations where the Tenet Entity has entered into a formal payment agreement with the patient and the patient is complying with the terms of the agreement, the account should be considered non-Medicare. *These accounts may not be posted to the Medicare Bad Debt Log.*

(b) Only if the patient actually defaults on the account and reasonable collection efforts were applied in

¹⁵CMS Program Memorandum A-03-044

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accordance with this policy may the unpaid balance be reported on the Medicare bad debt log.

(2) No Formal Payment Arrangements

If the Tenet Entity does not have a formal payment agreement with the patient and nominal or unacceptably low payments are received, the account may be considered a Medicare bad debt only after the Tenet Entity can demonstrate that reasonable collection efforts were made in accordance with this policy.

e. Secondary Insurance and Coordination of Benefits (Excluding Medicare Dual Eligible/Cross Over Claims)

(1) Secondary Insurance Contracts/Managed Care Agreements


Under certain arrangements, typically referred to as Medigap Select plans, Tenet Entities have a contractual obligation to accept the patient's secondary insurance payment as full satisfaction of the Medicare deductible and coinsurance. Under no circumstances shall any unpaid Medicare deductible and coinsurance arising out of these "payment in full" arrangements be written off as a Medicare bad debt or reported on the Medicare bad debt log, as they are not reimbursable by the Medicare Program.

(2) Other Secondary Insurance

If Tenet Entities do not have a contractual obligation to bill and accept secondary insurance, the secondary insurance billing is done as a courtesy and the patient and does not abrogate the patient's responsibility for payment of the deductible and/or coinsurance. Collection of the unpaid deductible and coinsurance must follow the procedures set forth in Subsection V.A.4.a. of this policy.

f. Traditional Medicare Bad Debt Logs

(1) Not less frequently than monthly, and not later than the third working day following the last day of the reporting month, Conifer will deliver to Tenet Government Programs

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electronic bad debt logs which contain all of the information required by CMS in a format approved by Government Programs.

- (2) The bad debt logs will include all Traditional Medicare Bad Debt amounts which were determined during the reporting month, after audit by Conifer and/or Tenet Government Programs, to satisfy all applicable Medicare bad debt criteria including, but not limited to, the criteria set forth in this policy, and relevant statutory, regulatory and sub-regulatory guidance.
- (3) The Conifer approval date entered on the file will establish the date on which the determination of non-collectability of the account was made.

B. Auditing and Monitoring

Tenet's Audit Services Department shall audit adherence to this policy.

C. Responsible Person


Each Tenet Entity's Chief Financial Officer is responsible for assuring that all individuals adhere to the requirements of this policy that these procedures are implemented and followed at his/her Tenet Entity, and that instances of noncompliance with this policy are reported to the Tenet Entity's Compliance Officer.

D. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Failure to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance management may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.

VI. REFERENCES:

- Quality, Compliance and Ethics Charter

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- Regulatory Compliance Policy COMP-RCC 4.02 Waivers of Co-Payments and Deductibles
- Medicare Provider Reimbursement Manual
- 42 U.S.C.§§1395-1395ccc
- 42 CFR §413.89
- 71 FR 69712
- CMS Program Memorandum A-03-044