**Maximizing Recovered Revenues from**

**Medicare Bad Debt Claims**

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Hospitals and health systems have lost significant revenue due to the impact of the COVID-19 pandemic. Recovering every dollar owed to the provider has been and will be paramount to ensuring financial health and viability for the healthcare enterprise.

**Medicare Bad Debt**

Medicare provides reimbursement for roughly $3.5B of unpaid deductible and coinsurance amounts per year to hospitals for Medicare Bad Debt. However, U.S. hospitals underreport their Medicare Bad Debt by an average of 6% – 7% each year. Underreporting is a symptom of a variety of potential factors, including failure to adapt to changing regulations, data confusion that happens from system upgrades, integration nuances created from affiliation and merger activity, and more. These factors drive connectivity gaps in a hospital’s revenue cycle and reimbursement reporting, leading to errors.

Every hospital in the U.S. typically has over $1M in recoverable net revenue that has gotten lost in the shuffle. Since many organizations do not have the staff or expertise to identify and collect these lost revenues, they are missing millions in recoverable cash that is rightfully theirs. That is where working with an expert partner helps; however, it is critical to select the *right* partner.

**The Challenge for a Large Academic Medical Center**

A large academic medical center selected a software provider (Vendor A) to partner with them on identifying bad debt from uncollectible Medicare accounts (Medicare Bad Debt) to file on their cost report with the Centers for Medicare and Medicaid Services (CMS). The medical center had average yearly deductible and coinsurance amounts of over $26 million and an average claimed Medicare Bad Debt rate of over $6 million.

Vendor A installed its software at the medical center in 2015 to produce the Medicare Bad Debt logs to be filed with the associated cost reports for FY 2016 – 2018, theoretically addressing the drivers of connectivity gaps noted above. In 2018, the medical center engaged Vendor B to perform a “second look” to ensure that no value was being missed by Vendor A’s software.

**The Solution and Results**

Using their unique project approach of technology and industry expertise, Vendor B conducted a detailed data analysis on Vendor A’s previous years’ logs. Not only did the analysis reveal significant missed value, but also a very large compliance issue relating to the timing of crossover claims was uncovered for FY2016. Almost $500,000 in crossover accounts were claimed in FY2016, when they should have been claimed in FY2017. Had this issue been flagged during audit, the medical center would have been at risk of having their entire crossover benefit for FY2016 disallowed, which would have resulted in a $2.5M gross / $1.625M net (Medicare pays 65%) hit to reimbursement. Vendor B was able to fix the accounts and amend the impacted cost reports prior to an audit, and the medical center received reimbursement in full for those accounts.

In addition to correcting the compliance issue, Vendor B identified an additional $2.3M of missed Medicare Bad Debt value for FY2016 – FY2018:

* FY2016: $423,659
* FY2017: $727,179
* FY2018: $1,160,143

This value was added to the Medicare Bad Debt logs, and the affected cost reports were amended. In Figure 1, the “FY2016 Lookback Additions” not only fixed the issue for FY2016 but also added $423,659 of revenue that Vendor A had missed.

*Figure 1: FY2016 Lookback Additions*

**Categories**

**Additions**

Agency IP

$67,631

Agency OP

$92,422

Bankruptcy OP

$1,750

Financial Assistance IP

$29,941

Financial Assistance OP

$117,869

Crossover 2 IP

$19,877

Crossover 2 OP

$22,990

Crossover IP

$19,288

Crossover OP

$43,069

Deceased IP

$5,531

Deceased OP

$3,291

**Grand Total**

**$423,659**

Provider As Filed Log

$7,411,560

Lookback Additions

$423,659

Provider Amended Log

**$7,835,219**

Vendor B also recognized that the cost reports for FY2013 and FY2014 were still within the allowable period to reopen and, therefore, these years were added to the scope of their work. Vendor B identified $2.3M in missed Medicare Bad Debt for FY2013 and FY2014, which was added to the reopening requests for both years.

Vendor A’s process and software were noticeably incomplete and not modified to meet the most recent regulations, further building the case that the best outcome is the result of technology in the hands of an expert partner like Vendor B, not just by relying on technology alone.

Based on the additional reimbursement identified and process improvement opportunities brought forth to the provider, Vendor B replaced Vendor A as the Primary Medicare Bad Debt vendor to compile the logs necessary for cost reporting filing each year.

**Identifying the Right Vendor**

Regardless of whether a provider is looking to make changes to how Medicare Bad Debt is identified on their cost report, or merely to ensure that their current process is up to best practice standards by performing a second look, it is imperative to identify the right vendor. Since most hospitals and health centers do not have the staff or time to deal with audits and compliance issues, selecting a vendor that can create correct logs that hold up to the scrutiny of a CMS audit while also leveraging the power of analytics technology is critical. Look closely at the vendor’s track record of providing support, regulatory expertise, and solving audit challenges for maximum reimbursement to the healthcare provider. Particularly relating to performing a second look at the provider’s Medicare Bad Debt reporting processes, partner with a vendor that finds audit-proof value 100% of the time, while also identifying opportunities to improve processes to ensure Medicare Bad Debt reporting is maximized year over year.

Ask the vendor whether they:

* Ensure that correct documentation is delivered to CMS
* Provide yearly comprehensive agency reconciliation
* Deliver human expertise to examine and augment findings in the logs
* Provide audit support
* Stay up to date with changes to Medicare regulations
* Help hospital/health system partners rewrite their policies and procedures to better meet CMS regulations

With thorough expertise in recovering Medicare Bad Debt reimbursements, the right vendor can take on the burden of compiling accurate, audit-proof logs that maximize cash back to the hospital and restore confidence that every dollar is accounted for.