Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE INPATIENT BAD DEBTS AT MERCY CATHOLIC MEDICAL CENTER, CONSHOHOCKEN, PENNSYLVANIA FOR CALENDAR YEAR 1999

JANET REHNQUIST
INSPECTOR GENERAL

JUNE 2002
A-03-02-00002

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DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
OFFICE OF AUDIT SERVICES
150 S. INDEPENDENCE MALL WEST
SUITE 316
PHILADELPHIA, PENNSYLVANIA 19106-3499

June 7, 2002

Reference: Common Identification Number A-03-02-00002

Ms. Christine M. Ferreira
Manager – Reimbursement Department
Mercy Catholic Medical Center
One West Elm Street
Conshohocken, Pennsylvania 19428

Dear Ms. Ferreira:

This final report presents the results of an Office of Inspector General (OIG), Office of Audit Services (OAS) audit titled "Review of Medicare Inpatient Bad Debts at Mercy Catholic Medical Center, Conshohocken, Pennsylvania for Calendar Year 1999". We performed this review in conjunction with a nationwide audit of Medicare inpatient bad debts. The objective of our audit was to determine if Medicare inpatient bad debts claimed by Mercy Catholic Medical Center (MCMC) on its cost report for calendar year (CY) 1999 met Medicare requirements. The MCMC claimed inpatient bad debts of $543,285.

Our audit found that, for the most part, MCMC claimed inpatient bad debts on its CY 1999 cost report that met Medicare reimbursement requirements. We noted some minor exceptions to the amounts claimed and questioned $1,848 in bad debt claims. We questioned one claim for $1,080 because the entire claim amount was not related to unpaid deductible or coinsurance. The MCMC wrote off $1,844 for the claim, however; only $764 of that amount was attributable to the unpaid deductible. We questioned another claim for $768 that was duplicated on the hospital bad debt log. We are recommending that MCMC: (1) coordinate with the Fiscal Intermediary (FI) to adjust their CY 1999 cost report by $1,848 for overstated inpatient bad debts and (2) use the results of our audit to stress to its employees the need to use correct data in generating Medicare claims.

By letter dated May 29, 2002, MCMC responded to a draft of this report. The MCMC stated that it advised the FI that Medicare bad debts claimed on its CY 1999 cost report were overstated by $1,848. The MCMC stated it provided in-service training to employees responsible for preparing the Medicare bad debt log, specifically related to the minor clerical errors found within the scope of the audit. Also, MCMC indicated it

alerted and provided in-service training to management as to the nature of the clerical errors. We have included the MCMC response in its entirety as an Appendix of the report.

INTRODUCTION

BACKGROUND

Medicare policy states that beneficiaries should share in defraying the costs of inpatient care through various deductibles and coinsurance amounts. For example, during CY 2002 the Medicare patient is liable for a $812 deductible for each benefit period in which he/she is admitted to a hospital. The patient is also liable for a $203 a day coinsurance for the 61st through the 90th day of an extended inpatient stay. Historically hospitals have collected a certain percentage of Medicare coinsurance and deductible amounts from program beneficiaries.

Under Medicare policy, costs attributable to Medicare beneficiaries are not to be shifted to non-Medicare patients. This policy was adopted in 1966 when Medicare reimbursed hospitals retrospectively under reasonable cost principles. Beginning in 1983, inpatient hospital care was reimbursed under a prospective payment system (PPS). Under Medicare's PPS, bad debts are pass-through costs and continue to be reimbursed under reasonable cost principles. Hospitals claim reimbursement for these bad debts by submitting an annual Medicare cost report.

Under Section 1861(v)(1)(T) of the Social Security Act, the amount of allowable bad debt for cost reporting periods beginning during Fiscal Year (FY) 1998 was reduced 25 percent. For FY 1999 the amount of allowable bad debt was reduced 40 percent and for FY 2000 it was reduced 45 percent. For FYs subsequent to FY 2000 it will be reduced 30 percent.

Bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from beneficiaries can be reimbursed to hospitals if the bad debt meets the following criteria:

- 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.

Many Medicare beneficiaries have a third-party responsible for deductibles and coinsurance liabilities. Under certain circumstances, a State Medicaid agency may be responsible for individuals eligible for both Medicaid and Medicare, as well as other low income individuals. If the State Medicaid agency appropriately processes and denies payment on the Medicare deductibles and coinsurance, the provider is not required to exert further collection efforts upon the individual.

The Medicare Provider Reimbursement Manual (PRM), Section 310.B, requires that the provider's collection effort be documented in the patient's file, and PRM, Part II, Section 1102, requires that listings be maintained of beneficiaries whose uncollected accounts were claimed as bad debts. Allowable bad debts must relate to specific deductibles and coinsurance amounts. Under the terms of PRM, Part I, Section 314, uncollectible deductible and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless.

The MCMC is comprised of two community hospitals, Mercy Fitzgerald and Mercy Hospital of Philadelphia, with 700 beds and 25,000 annual inpatient admissions. The MCMC was organized in 1969 with the merger of Mercy Fitzgerald Hospital and Mercy Hospital of Philadelphia (Mercy).

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our audit was to determine whether Medicare inpatient bad debts claimed by MCMC on its CY 1999 cost report met Medicare requirements. Our audit of inpatient bad debts was made in accordance with generally accepted government auditing standards. The audit was performed as part of a nationwide audit of Medicare inpatient bad debts.

The MCMC provided us with a disk containing computerized listings of patients to support bad debts claimed. We limited our review to inpatient claims. In CY 1999, MCMC claimed 693 inpatient bad debts totaling $543,285.

To accomplish our objective, we:

- Selected a statistical sample of inpatient bad debt claims with a claim value equal to or less than $768. The value of these claims was $490,574. The sample contained 200 inpatient bad debt claims totaling $149,015. We terminated our review after reviewing the first 50 sample items. The results reported are based on the 50 items reviewed and were not extrapolated to the universe of claims.

- Selected and reviewed all 25 inpatient bad debt claims with a value greater than $768. The value of these claims was $52,711.

- Examined the following documentation:

- Patient account history,
- Billing documentation,
- Medicare remittance information,
- Patient statement notices,
- Patient contact notes, and
- Medicaid remittance information (if applicable).

We compared the Mercy Fitzgerald and Mercy hospitals' bad debt listings to determine if any of the bad claims appeared on both listings.

In addition, we reviewed Medicare bad debt criteria and MCMC policies and procedures for establishing and writing off bad debts. We also reviewed the FI's prior audit work papers to identify prior audit findings. A detailed review of internal controls was not performed because the objective of our review was accomplished through substantive testing.

We conducted our fieldwork at MCMC between October and December 2001.

FINDINGS AND RECOMMENDATIONS

Our audit showed that, with minor exceptions, MCMC claimed inpatient bad debts on its CY 1999 cost report that met Medicare reimbursement requirements. We found that MCMC established policies and procedures for identifying and collecting bad debts. Specifically, we found that:

- Debt was valid and related to covered services and derived from deductible and coinsurance amounts;
- Collection efforts were reasonable;
- Debt was uncollectible when reported as a bad debt; and
- There was no likelihood of recovery at any time in the future.

However, our review identified two minor errors resulting in bad debts being overstated $1,848. We identified a data entry error that resulted in a $1,080 charge. The error occurred because MCMC incorrectly wrote off $1,844 on the bad debt log. Only $764 of the $1,844 was allowable bad debt expense resulting from an unpaid deductible. This was caused by an unexplained clerical error.

We also determined that one bad debt totaling $768 was listed on both the Mercy Fitzgerald and Mercy bad debt listing. This duplication was due to an unexplained clerical error. We discussed both of these errors with MCMC officials who agreed with our findings.

CONCLUSIONS AND RECOMMENDATIONS

Our audit showed that, with minor exceptions, MCMC's claim for inpatient bad debts on its CY 1999 cost report were in accordance with Medicare requirements. The MCMC established adequate policies and procedures for identifying and collecting bad debts. However, we noted two exceptions that resulted in bad debts being overstated $1,848.

We therefore recommend that MCMC:

1. Coordinate with the FI to adjust their CY 1999 cost report by $1,848 to correct the overstated bad debts identified in our review.

2. Use the results of our audit to stress to its employees the need to use correct data in generating Medicare claims.

MCMC Response

By letter dated May 29, 2002, MCMC responded to a draft of this report. The MCMC stated that it advised the FI that Medicare bad debts claimed on its CY 1999 cost report were overstated by $1,848. The MCMC stated it provided in-service training to employees responsible for preparing the Medicare bad debt log, specifically related to the minor clerical errors found within the scope of the audit. Also, MCMC indicated it alerted and provided in-service training to management as to the nature of the clerical errors.

OIG Comment

We believe that the actions reported by MCMC in its response to our draft report, if implemented, represent positive steps to correct the deficiencies noted.

Sincerely yours,

David M. Long

David M. Long
Regional Inspector General
for Audit Services

APPENDIX

Mercy
Health System

May 29, 2002

David M. Long
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
Office of Audit Services
150 S. Independence Mall West
Suite 316
Philadelphia, PA 19106-3499

CIN: A-03-02-00002
Mercy Catholic Medical Center [MCMC]
Provider Number 39-0156,
Fiscal Year End: December 31, 1999

Dear Mr. Long:

Pursuant to the April 2002 draft report entitled "Review of Medicare Inpatient Bad Debts at Mercy Catholic Medical Center, Conshohocken, Pennsylvania for Calendar Year 1999" the following actions have been taken in light of the findings/ recommendations:

1- As recommended, The Mercy Health System Reimbursement department has contacted our fiscal intermediary, Veritus Medicare Services, in order to disclose that the inpatient Medicare bad debts claimed on the MCMC Medicare filed cost report were overstated by $1,848.

2 – The Mercy employees who are involved in the preparation of the Medicare Bad Debt Logs have been in-serviced regarding the preparation of the logs, specially related to the minor clerical errors found within the scope of the audit. Management has also been alerted and in-serviced regarding the nature of the clerical errors found.

We believe that these actions fulfill our responsibility to respond to the finding of the above referenced matter.

Sincerely,

Christine M. Ferreira
Reimbursement Manager

Douglas C. Smith
Vice President, Patient Financial Services

cc: Mike Glitz, Vince Ewing, and Jim Seaman