DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

June 4, 2010

Report Number: A-04-09-00056

Mr. Michael G. Snyder
Assistant Vice President Financial Services
Carolinas HealthCare System
P.O. Box 32861
Charlotte, NC 28232-2861

Dear Mr. Snyder:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Part B Bad Debts at Carolinas Medical Center for the Fiscal Year Ended December 31, 2005*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (404) 562-7800, or contact Eric Bowen, Audit Manager, at (404) 562-7789 or through email at Eric.Bowen@oig.hhs.gov. Please refer to report number A-04-09-00056 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations (CFMFFSO)
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PART B BAD DEBTS AT CAROLINAS MEDICAL CENTER FOR THE FISCAL YEAR ENDED DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

June 2010
A-04-09-00056

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency within the U.S. Department of Health & Human Services that administers the Medicare program and provides Federal oversight of State Medicaid programs for every State in the nation. CMS contracts with Medicare fiscal intermediaries and administrative contractors to, among other things, process and pay claims submitted by Medicare providers. Fiscal intermediaries and Medicare administrative contractor responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Fiscal intermediaries and Medicare administrative contractors use the Medicare cost report for final settlement of Medicare reimbursement due to or from providers.

Section 1813 of the Social Security Act (42 U.S.C. § 1395e) mandates that beneficiaries share in defraying the costs of outpatient care through various deductibles and coinsurance amounts. This policy was adopted in 1966 when Medicare reimbursed hospitals retrospectively under reasonable cost principles. Beginning in 2000, outpatient hospital care was reimbursed under a prospective payment system (PPS). Under Medicare's PPS, bad debts (defined below) are pass-through costs and continue to be reimbursed under reasonable cost principles. Hospitals claim reimbursement for these bad debts on their annual Medicare cost reports.

Medicare bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services for Medicare patients. The Medicare program reimburses hospitals for bad debts associated with uncollectible Medicare deductible and coinsurance amounts if the bad debts meet Medicare reimbursement criteria. Federal regulations (42 CFR § 413.89(e)) provide that, to be eligible for reimbursement, the hospital must show that: (1) the bad debts are related to Medicare covered services and derived from unpaid deductible and coinsurance amounts, (2) reasonable collection efforts were made, (3) the debts were actually uncollectible when claimed as worthless, and (4) sound business judgment established there was no likelihood of recovery at any time in the future. Furthermore, Federal regulations (42 CFR § 413.89(f)) require hospitals to reduce their bad debts by the amount that they recover from previously written off bad debts. Because Federal regulations (42 CFR § 413.89(h)) reduced reimbursement for Medicare bad debts by 30 percent in fiscal year (FY) 2005, Medicare reimbursed 70 percent of the bad debts claimed.

The Carolinas Medical Center (CMC) is an 874-bed acute care hospital located in Charlotte, North Carolina. CMC includes a Level I trauma center, a research institute and a large number of specialty treatment units. On its hospital cost report for January 1, 2005, through December 31, 2005, CMC claimed $1,274,355 ($892,049 reimbursement) for Medicare outpatient bad debts (bad debts).

OBJECTIVE

Our objective was to determine whether bad debts claimed on CMC's FY 2005 hospital cost report were allowable under Medicare regulations and were reduced by bad debt recoveries.

SUMMARY OF FINDINGS

CMC properly reported 33 out of 110 bad debts in our sample on its FY 2005 hospital cost report. However, the remaining 77 bad debts in our sample were not allowable under Medicare regulations, nor were CMC's bad debts always reduced by bad debt recoveries. Specifically, CMC claimed 77 unallowable bad debts totaling $16,216 as follows:

- 69 bad debts totaling $12,127 were for accounts that were still with a collection agency when written off and, therefore, did not meet the definition of uncollectible when claimed as worthless and

- 8 bad debts totaling $4,089 were not subjected to reasonable collection efforts.

CMC generally claimed unallowable bad debts because its policies and procedures required accounts to be written off at the time they were referred to a collection agency. Additionally, in some cases, CMC's in-house collection efforts were inadequate.

Based on our statistical sample results, we estimated that CMC claimed $692,491 for bad debts that were not reimbursable under Medicare regulations. Of this amount, $666,617 related to bad debts that were with a collection agency. A CMS memorandum dated May 2, 2008, entitled *Clarification of Medicare Bad Debt Policy/Bad Debt Policy Related to Accounts at a Collection Agency*, states that Medicare contractors are required to disallow Medicare bad debts for accounts at a collection agency. This same memorandum instructed Medicare contractors not to reopen cost reports to disallow such bad debts prior to May 2, 2008. Therefore, we are not recommending a $666,617 reduction to the bad debt total claimed by CMC on its cost report or a refund of the $466,632 in related reimbursement. The remaining balance of $25,874 was unallowable for other reasons specifically related to CMC's actions and should be adjusted on CMC's cost report.

Finally, CMC's bad debts were not always reduced by bad debt recoveries. We identified 25 accounts with $1,233 in bad debt recoveries that were not reported on the cost report. CMC did not have adequate procedures in place to accurately report all Medicare bad debt recoveries.

RECOMMENDATIONS

We recommend that CMC:

- request its fiscal intermediary reopen its 2005 hospital cost report to reduce Medicare bad debts by $25,874 and refund $18,112 in related overpayments,

- request its fiscal intermediary reopen its 2005 hospital cost report to reduce Medicare bad debts by $1,233 for unreported recoveries and refund $863 in related overpayments,

- review its previously submitted FY 2008 cost report and ensure compliance with CMS's bad debt policy,

- ensure that cost reports submitted in the future comply with CMS's bad debt policy, and

- improve its policies and procedures to ensure that it properly accounts for and reports all Medicare bad debt recoveries.

CAROLINAS MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMC agreed with most of our findings and recommendations but believed that some of the wording in our report was "inaccurate and/or misleading."

After reviewing CMC's comments, we maintain that our findings and recommendations are valid. We also maintain that the wording of our report is accurate and truthful.

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INTRODUCTION

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency within the U.S. Department of Health & Human Services that administers the Medicare program and provides Federal oversight of State Medicaid programs for every State in the nation.

Medicare Fiscal Intermediaries and Administrative Contractors

CMS contracts with Medicare fiscal intermediaries[1] and administrative contractors to, among other things, process and pay claims submitted by Medicare providers. Fiscal intermediaries and Medicare administrative contractor responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Fiscal intermediaries and Medicare administrative contractors use the Medicare cost report for final settlement of Medicare reimbursement due to or from providers.

Medicare Bad Debt Policy

Section 1813 of the Social Security Act (42 U.S.C. § 1395e) mandates that beneficiaries share in defraying the costs of outpatient care through various deductibles and coinsurance amounts. This policy was adopted in 1966 when Medicare reimbursed hospitals retrospectively under reasonable cost principles. Beginning in 2000, outpatient hospital care was reimbursed under a prospective payment system (PPS). Under Medicare's PPS, bad debts (defined below) are pass-through costs and continue to be reimbursed under reasonable cost principles. Hospitals claim reimbursement for these bad debts on their annual Medicare cost reports.

Medicare bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services for Medicare patients. The Medicare program reimburses hospitals for bad debts associated with uncollectible Medicare deductible and coinsurance amounts if the bad debts meet Medicare reimbursement criteria. Federal regulations (42 CFR § 413.89(e)) provide that, to be eligible for reimbursement, the hospital must show that: (1) the bad debts are related to Medicare covered services and derived from unpaid deductible and coinsurance amounts, (2) reasonable collection efforts were made, (3) the debts were actually uncollectible when claimed as worthless, and (4) sound business judgment established there was no likelihood of recovery at any time in the future. Furthermore, Federal regulations (42 CFR § 413.89(f)) require hospitals to reduce their bad debts by the amount that they recover from previously written off bad debts. Because Federal regulations (42 CFR § 413.89(h))

[1] Effective October 1, 2005, Congress amended the Social Security Act to require that CMS contract with Medicare administrative contractors instead of fiscal intermediaries (Part A) and carriers (Part B) by October 2011. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 § 911, Social Security Act, §§ 1816 and 1842, 42 U.S.C. §§ 1395h, 1395u and 1395kk-1.

reduced reimbursement for Medicare bad debts by 30 percent in fiscal year (FY) 2005, Medicare reimbursed 70 percent of the bad debts claimed.

Carolinas Medical Center

The Carolinas Medical Center (CMC) is an 874-bed acute care hospital located in Charlotte, North Carolina. CMC includes a Level I trauma center, a research institute and a large number of specialty treatment units. On its hospital cost report for January 1, 2005, through December 31, 2005, CMC claimed $1,274,355 ($892,049 reimbursement) for Medicare outpatient bad debts (bad debts).[2]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether bad debts claimed on CMC's FY 2005 hospital cost report were allowable under Medicare regulations and were reduced by bad debt recoveries.

Scope

Our review was limited to $1,050,890 in bad debts reported on the bad debt listing supporting CMC's FY 2005 hospital cost report.[3] We reviewed a sample of 100 bad debts ranging between $50 and $1,999 totaling $18,213 and separately reviewed all 10 bad debts valued at $2,000 or more and totaling $28,877. We also reviewed the accuracy and completeness of bad debt recoveries reported by CMC during FY 2005.

We limited our review of CMC's internal controls to those controls applicable to CMC's managing and reporting of its bad debts.

We conducted our fieldwork from November 2008 through August 2009 at CMC in Charlotte, North Carolina.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;

[2] On its hospital cost report, CMC claimed $1,274,355 in Medicare bad debts, which equaled the $1,337,467 per its bad debt listing reduced by $63,112 debts in bad debt recoveries.

[3] As explained in Appendix A, our sampling frame of $1,050,890 equaled $1,337,467 minus 17,214 bad debts totaling $286,577 that were less than $50.

- held discussions with CMS officials regarding Medicare bad debt program guidance;

- evaluated CMC policies and procedures regarding the collection of deductibles and coinsurance amounts;

- obtained a list of bad debts claimed in FYs 2004 and 2005;

- verified that CMC claimed no duplicate bad debts on its FY 2005 cost report;

- conducted a stratified sample of bad debts as noted in Appendix A;

- validated the population of FY 2005 bad debt write offs;

- reviewed the patient accounting financial records, Medicare remittance documents, Medicaid remittance documents, and collection activity records for the 110 bad debts selected in the sample;

- used the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software to estimate the number and dollar value of unallowable bad debts for accounts that were with a collection agency when claimed as worthless (Appendix B);

- used the OIG/OAS statistical software to estimate the number and dollar value of unallowable bad debts related to CMC's actions (Appendix C);

- reviewed the collection agencies' contracts and bad debt invoices for FY 2005; and

- reviewed financial records for bad debt recoveries to determine the accuracy and completeness of bad debt recovery amounts used to reduce bad debts.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

CMC properly reported 33 out of 110 bad debts in our sample on its FY 2005 hospital cost report. However, the remaining 77 bad debts in our sample were not allowable under Medicare regulations, nor were CMC's bad debts always reduced by bad debt recoveries. Specifically, CMC claimed 77 unallowable bad debts totaling $16,216 as follows:

- 69 bad debts totaling $12,127 were for accounts that were still with a collection agency when written off and, therefore, did not meet the definition of uncollectible when claimed as worthless and

- 8 bad debts totaling $4,089 were not subjected to reasonable collection efforts.

CMC generally claimed unallowable bad debts because its policies and procedures required accounts to be written off at the time they were referred to a collection agency. Additionally, in some cases, CMC's in-house collection efforts were inadequate.

Finally, CMC did not always reduce its bad debts by bad debt recoveries. We identified 25 accounts with $1,233 in bad debt recoveries that were not reported on the cost report. CMC did not have adequate procedures in place to accurately report all Medicare bad debt recoveries.

BAD DEBTS NOT UNCOLLECTIBLE WHEN CLAIMED AS WORTHLESS

Federal regulations (42 CFR § 413.89(e)(3)) require that a bad debt be "actually uncollectible when claimed as worthless." Moreover, Federal regulations (42 CFR § 413.89(e)(4)) require that there be "no likelihood of recovery at any time in the future." Accordingly, a May 2, 2008, CMS Joint Signature Memorandum (JSM), entitled *Clarification of Medicare Bad Debt Policy/Bad Debt Policy Related to Accounts at a Collection Agency*, states that Medicare contractors are required to disallow Medicare bad debts for accounts at a collection agency.

The memorandum states that it has been CMS's longstanding policy that when an account is in collection, a provider cannot have determined the debt to be uncollectible and cannot have established that there is no likelihood of recovery under the regulations. That is, until a provider's reasonable collection effort has been completed, a Medicare bad debt may not be deemed as uncollectible. According to CMS, the collection policy supporting the regulation applies to a provider's entire collection effort, both in-house and by use of a collection agency.

Contrary to these regulations, we identified 69 unallowable bad debts totaling $12,127 for accounts that were still with a collection agency when written off. These bad debts did not meet the definition of "uncollectible" when claimed as worthless because they could still have been recovered in the future.

REASONABLE COLLECTION EFFORTS NOT MADE

Federal regulations (42 CFR § 413.89(e)(2)) state that, for a bad debt to be allowable, "[t]he provider must be able to establish that reasonable collection efforts were made." Furthermore, Federal regulations (42 CFR §§ 413.89(e)(3) and (4)) require that a bad debt actually be uncollectible when claimed as worthless and that sound business judgment established no likelihood of recovery at any time in the future. In addition, the Provider Reimbursement Manual (CMS, *Provider Reimbursement Manual* (PRM), Pub. No. 15-1,

chapter 3, § 310.2) states that "[i]f after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."

Seven bad debts totaling $3,734[4] pertained to patients who were making payments to CMC when CMC wrote off the accounts and abandoned all efforts to collect the remaining balances simply because 120 days had passed since the date of the first bill was mailed to the beneficiary. Writing off accounts on which patients are making payments does not constitute reasonable collection efforts. Moreover, CMC wrote off these accounts without establishing that the bad debt was uncollectible when claimed as worthless and had no likelihood of recovery at any time in the future.

The PRM (Pub. No. 15-1, chapter 3, § 312) provides that a hospital may deem a bad debt to be uncollectable and forego the collection efforts required by § 310 if the patient is determined by the hospital to be indigent. The patient's file should "contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination."

One bad debt totaling $355[5] was considered uncollectable by CMC on the basis of patient indigency. Consequently, CMC made no collection efforts on this bad debt. However, CMC did not document the basis for considering this patient indigent. For example, CMC did not document a determination that there was no source other than the patient that would be legally responsible for the patient's medical bill, such as title XIX or a local welfare agency.

MEDICARE BAD DEBT RECOVERIES NOT ALWAYS REPORTED

According to Federal regulations (42 CFR § 413.89(f)), the amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases, an amount previously written off as a bad debt and allocated to the Medicare program may be recovered in a subsequent accounting period; in such cases, the income from the Medicare recoveries must be used to reduce the cost of beneficiary services for the period in which the collection is made.

Contrary to these guidelines, CMC's records and records of its collection agency showed that 25 accounts with $1,233 in bad debt recoveries were not reported on the cost report as a reduction to bad debts. CMC did not have adequate procedures in place to accurately report all Medicare bad debt recoveries.

[4] This amount includes six bad debts totaling $1,509 from stratum 1 and one $2,225 bad debt from stratum 2.

[5] This amount includes one $355 bad debt from stratum 1.

CONCLUSION

Our sample review identified 69 unallowable bad debts totaling $12,127 for accounts that were still with a collection agency when written off. Based on our sample results, we estimated that CMC claimed 3,793 such bad debts on its FY 2005 cost report, representing $666,617 in bad debts, and received $466,632 in related reimbursement. The May 2, 2008 JSM, however, stated that Medicare contractors whose practice had been since August 1, 1987, to allow hospitals to claim as bad debts accounts at a collection agency should not reopen cost reports to disallow bad debts that were improperly paid for this reason prior to May 2, 2008.[6] Therefore, we are not recommending a $666,617 reduction to the bad debt total claimed by CMC on its FY 2005 cost report or a refund of the $466,632 in related reimbursement. (See Appendix B for details on our sample results and estimates.)

Our sample review also identified 8 bad debts totaling $4,089 that were unallowable for other reasons specifically related to CMC's actions. Based on these results, we estimated that CMC claimed 186 such bad debts on its FY 2005 cost report, representing $25,874 in bad debts, and received $18,112 in related reimbursement. (See Appendix C for details on our sample results and estimates.)

Additionally, CMC's improper reporting of its bad debt recoveries resulted in a $1,233 overstatement of bad debts claimed and excess reimbursement of $863.

RECOMMENDATIONS

We recommend that CMC:

- request its fiscal intermediary reopen its 2005 hospital cost report to reduce Medicare bad debts by $25,874 and refund $18,112 in related overpayments,

- request its fiscal intermediary reopen its 2005 hospital cost report to reduce Medicare bad debts by $1,233 for unreported recoveries and refund $863 in related overpayments,

- review its previously submitted FY 2008 cost report and ensure compliance with CMS's bad debt policy,

- ensure that cost reports submitted in the future comply with CMS's bad debt policy, and

- improve its policies and procedures to ensure that it properly accounts for and reports all Medicare bad debt recoveries.

[6] In 1987, the FI for North Carolina allowed bad debt write-offs at the time patient accounts were sent to a collection agency. This practice was continued by subsequent Medicare contractors in North Carolina until May 2, 2008.

CAROLINAS MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMC agreed with most of our findings and recommendations but believed that some of the wording in our report was "inaccurate and/or misleading."

After reviewing CMC's comments, we maintain that our findings and recommendations are valid. We also maintain that the wording of our report is accurate and truthful.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicare Part B bad debts that were claimed on Carolinas Medical Center's FY 2005 hospital cost report.

SAMPLING FRAME

Carolinas Medical Center provided a single Excel file supporting Part A and Part B Medicare bad debts claimed on its 2005 cost report. This file included four worksheets, two each for Part A and Part B. One Medicare Part B bad debt worksheet represented crossover bad debts, and the other Medicare Part B bad debt worksheet represented non-crossover bad debts. We combined these two Medicare Part B bad debt worksheets to create a single Medicare Part B bad debt worksheet comprised of 22,721 bad debts totaling $1,337,467. We sorted the Part B bad debts from highest to lowest dollars claimed, and separated the 22,721 Medicare Part B bad debts (bad debts) as follows:

- 10 bad debts totaling $28,877 that were $2,000 or greater,
- 5,497 bad debts totaling $1,022,013 that were $50 or greater but less than $2,000, and
- 17,214 bad debts totaling $286,577 that were less than $50.

To avoid extreme variations in bad debts within our frame, we excluded the 17,214 bad debts totaling $286,577 that were less than $50. We then created a new excel file containing 5,507 bad debts $50 or greater totaling $1,050,890. This file was our sampling frame.

SAMPLE UNIT

The sample unit was a Medicare Part B bad debt.

SAMPLE DESIGN

We used a stratified sample. The sampling frame was divided into two strata based on dollar value. Stratum 1 consisted of bad debts $50 or greater but less than $2,000. Stratum 2 consisted of all bad debts $2,000 or greater.

SAMPLE SIZE

We randomly selected 100 bad debts $50 or greater but less than $2,000. We reviewed all 10 bad debts that were $2,000 or greater. The total sample size was 110.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG/OAS statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We selected all bad debts that were $2,000 or greater for review. We consecutively numbered the bad debts that were $50 or greater but less than $2,000 from 1 through 5,497. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the number and dollar value of unallowable bad debts claimed during fiscal year 2005.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES FOR BAD DEBTS THAT WERE NOT UNCOLLECTIBLE WHEN CLAIMED AS WORTHLESS

SAMPLE RESULTS

Stratum	Sample Size	Value of Sample	No. of Unallowable Bad Debts	Value of Unallowable Bad Debts
1 – $50 - $1,999	100	$18,213	69	$12,127
2 – ≥ $2,000	10	28,877	0	0
TOTAL	**110**	**$47,090**	**69**	**$12,127**

ESTIMATES

Estimated Unallowable Bad Debts
Limits Calculated for a 90-Percent Confidence Interval

	Estimated Value of Unallowable Bad Debts	Estimated No. of Unallowable Bad Debts
Point Estimate	$666,617	3,793
Lower limit	$501,600	3,332
Upper limit	$831,634	4,207

APPENDIX C: SAMPLE RESULTS AND ESTIMATES FOR UNALLOWABLE BAD DEBTS RELATED TO CAROLINAS MEDICAL CENTER'S ACTIONS

SAMPLE RESULTS

Stratum	Sample Size	Value of Sample	No. of Unallowable Bad Debts	Value of Unallowable Bad Debts
1 - $50 - $1,999	100	$18,213	7	$1,864
2 – ≥ $2,000	10	28,877	1	2,225
TOTAL	**110**	**$47,090**	**8**	**$4,089**

ESTIMATES

Estimated Unallowable Bad Debts
Limits Calculated for a 90-Percent Confidence Interval

	Estimated Value of Unallowable Bad Debts	Estimated No. of Unallowable Bad Debts
Point Estimate		
Stratum 1	$102,449	7
Stratum 2	2,225	1
Total	**$104,674**	**8**
Lower Limit	$23,649	185
Upper Limit	$181,249	697

APPENDIX D: CAROLINAS MEDICAL CENTER COMMENTS

Carolinas HealthCare System

April 15. 2010

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Inspector General
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

RE: Hospital: Carolinas Medical Center
Year: FYE 12/31/2005
Report: A-04-09-0056 Part B Bad Debts

Dear Mr. Barbera:

We recently received the U.S. Department of Health & Human Services, Office of Inspector General (OIG), draft report entitled *Review of Medicare Part B Bad Debts at Carolinas Medical Center for the Fiscal Year Ended December 31, 2005*. We have reviewed this report and agree with most of the findings and recommendations. However, we believe some of the wording is inaccurate and/or misleading. Our comments are included below.

Pg. 3 and Summary: The report includes the following:

"CMC properly reported 33 out of 110 bad debts in our sample on its FY 2005 hospital cost report. However, the remaining 77 bad debts in our sample were not allowable under Medicare regulations, nor were CMC's bad debts always reduced by bad debt recoveries. Specifically, CMC claimed 77 bad debts totaling $16,216 as follows:

- *8 bad debts totaling $12,127 were for accounts that were still with a collection agency when written off and, therefore, did not meet the definition of uncollectible when claimed as worthless."*

As noted in footnote 6 on page 7, "the North Carolina FI allowed bad debt write-offs at the time patient accounts were sent to a collection agency. This practice was continued by subsequent Medicare contractors in North Carolina until May 2, 2008". We believe this footnote needs to be prevalently included as part of this discussion and the summary. CMC policies and procedures were consistent with

interpretations provided by the NC Medicare contractor that allowed bad debts sent to a collection agency and therefore, met their definition of uncollectible when claimed as worthless.

Pg 5: *"CMC generally claimed unallowable bad debts because its policies and procedures required accounts to be written off at the time they were referred to a collection agency."*

We request the following sentence be substituted. "CMC's policy required that accounts be written off at least 120 days after the first bill was sent to the patient indicating that a coinsurance or deductible was due. This policy is consistent with the interpretation and guidelines received from the Medicare contractor."

Pg 6 and summary: *"CMC's records and records of its collection agency showed that 25 accounts with $1,233 in bad debt recoveries were not reported on the cost report as a reduction to bad debts. CMC did not have adequate procedures in place to accurately report all Medicare bad debt recoveries. "*

The auditors performed a 100% review of recoveries which included about 19,000 inpatient and outpatient recoveries. The auditor found 25 errors out of 19,000 accounts. This represents a .13% error rate. We have reviewed our policies and procedures and believe they are sufficient to ensure recoveries are accurately stated. We do not agree with your assumption of inadequate procedures and request the statement be stricken from the final report. We request the following replacement. "CMC's records and records of its collection agency showed that 25 accounts out of 19,000 reviewed were not reported on the cost report as a reduction to bad debts."

Pg 6: *"Our sample review identified 69 unallowable bad debts totaling $12,127 for accounts that were still with a collection agency when written off. Based on our sample results, we estimated that CMC claimed 3,793 such bad debts on its FY2005 cost report, representing $666,617 in bad debts, and received $466,632 in related reimbursement."*

Again, we request that this statement include some qualification that CMC was following the Medicare contractor's guidance and audit instructions at that time. We recommend the following language replace the sentence above.

"Our sample review identified 69 bad debts totaling $12,127 for accounts that remained with a collection agency when written off. The local Medicare contractor interpretation permitted hospitals to claim, as bad debts, accounts subsequent to being placed with a collection agency. As a result, CMC's policies and procedures were consistent with the Medicare contractor's guidance and audit instructions. We estimate that CMC claimed 3,793 such bad debts representing $666,617 in bad debts, and received $466,632 in related reimbursement."

The OIG recommendations are included below:

- Request its fiscal intermediary reopen its 2005 cost report to reduce Medicare bad debts by $25,874 and refund $18,112 in related overpayments,
- Request its fiscal intermediary reopen its 2005 hospital cost report to reduce Medicare bad debts by $1,233 for unreported recoveries and refund $863 in related overpayments.
- Review its previously submitted FY2008 cost report and ensure compliance with CMS's bad debt policy,
- Ensure that cost reports submitted in the future comply with CMS's bad debt policy, and

- Improve its policies and procedures to ensure that it properly accounts for and reports all Medicare bad debt recoveries.

CMC's responses to these recommendations are enclosed:

- The fiscal intermediary has initiated the re-opening process related to the 2005 cost report.
- We have reviewed our previously submitted FY2008 cost report and confirmed that the bad debts claimed do not include any accounts still at a collection agency. This practice is compliant with CMS's bad debt policy.
- Current CHS policy prohibits claiming any account placed with a collection agency as a Medicare bad debt. We have included these accounts as a protested item.
- We have reviewed our policies and procedures related to Medicare bad debt recoveries. As noted above, the OIG auditors found 25 errors out of about 19,000 payments received from collection agencies. This represents a .13% error rate. As a result, we believe our policies and procedures are adequate to ensure bad debt recoveries are identified and offset against bad debts.

Carolinas HealthCare System is dedicated to maintaining accurate cost reports. Our Corporate Compliance Program has systems in place to monitor compliance with regulations. If errors are detected internally or identified by an external organization, we are committed to resolving the errors and refunding any associated overpayments. In each of the situations described above, steps have already been taken to completely resolve the issue and prevent future occurrences of these errors. Carolinas HealthCare System appreciates the opportunity to remediate these unintentional errors.

Thank you for the opportunity to respond. Please feel free to contact me if you have any further questions.

Sincerely,

James Ramsey
Vice President, Financial Services