



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Report Number: A-04-02-02016

JAN 24 2003

Mr. David S. Hughes
Vice President Financial Services
Pitt County Memorial Hospital - Greenville
2100 Stantonsburg Road
Greenville, North Carolina 27835-60288

Dear Mr. Hughes:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, "*Review of Reimbursable Medicare Bad Debts for Pitt County Memorial Hospital for the Fiscal Year Ended September 30, 1999*". A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act, 5 United States Code 552, as amended by the Public Law 104-231, OIG/OAS reports are made available to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 Code of Federal Regulations, Part 5). As such, within 10 business days after the final report is issued, it will be posted on the World Wide Web at <http://oig.hhs.gov>.

To facilitate identification, please refer to the Report Number (A-04-02-02016) in all correspondence relating to this report. If you have any questions, please contact me or have your staff contact Peter Barbera at (404) 562-7758.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Page 2 – Mr. David S. Hughes

Direct Reply To HHS Action Official:

Mr. Eugene A. Grasser
Associate Regional Administrator
Department of Health and Human Services, Region IV
Division of Medicaid and State Operations
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE BAD DEBTS AT PITT
COUNTY MEMORIAL HOSPITAL FOR THE
FISCAL YEAR ENDED SEPTEMBER 30, 1999**



**JANET REHNQUIST
Inspector General**

**January 2003
A-04-02-02016**

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

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





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JAN 24 2003

Report Number: A-04-02-02016

Mr. David S. Hughes, C.P.A.
Vice President Financial Services
Pitt County Memorial Hospital - Greenville
2100 Stantonsburg Road
Greenville, North Carolina 27835-6028

Dear Mr. Hughes:

This report provides you with the results of our review of Medicare bad debts at Pitt County Memorial Hospital. The objective of our review was to determine if Medicare bad debts claimed by the hospital were in compliance with the Medicare reimbursement criteria.

Our review focused primarily on inpatient Medicare bad debts claimed by the hospital totaling \$1,500,617 during the hospital's fiscal year (FY) ended September 30, 1999. On a limited basis we also included outpatient services during our initial analysis of the bad debt log.

EXECUTIVE SUMMARY

Our sample review of inpatient bad debt claims indicated that the hospital generally complied with the Medicare reimbursement criteria in claiming \$1,500,617 in inpatient Medicare bad debts on its FY 1999 cost report. However, separate from the sample review, we found that the hospital over claimed \$43,396 in Medicare inpatient and outpatient bad debt, which we attribute to the following:

- Errors in a spreadsheet formula, causing certain figures to be added twice and certain figures to be omitted (\$38,240);
- Duplicate claims (\$5,156); and
- Submitting a bad debt log that did not contain all required information.

In other matters, we found that the hospital improperly claimed reimbursement of \$6,300 for End Stage Renal Disease (ESRD) outpatient bad debts. Medicare reimbursement criteria provide that ESRD bad debts may not exceed the Medicare cost for ESRD services. The hospital did not report any FY 1999 ESRD outpatient program cost, therefore the hospital should not receive reimbursement for these bad debts.

We recommend that the hospital amend its FY 1999 Medicare cost report to reduce allowable Medicare bad debts by \$49,696 (\$43,396 hospital + \$6,300 ESRD).

We also recommend that the hospital implement automated bad debt log procedures to reduce the likelihood of clerical errors and to ensure that all required fields are included on the bad debt log.

In written comments to our draft report, the hospital generally agreed with our findings and recommendations addressing the errors, duplicate claims, and incomplete bad debt logs, and have already implemented some procedural changes. Regarding other matters, the hospital acknowledges that they gave up the hospital beds for the outpatient ESRD program, but still believes that the ESRD bad debts should be allowed. Finally, the hospital noted that the draft report did not mention errors found during the audit that resulted in an understatement of bad debts. The hospital's complete response is included as Appendix B of the report.

BACKGROUND

Medicare has long had a policy that beneficiaries should share in defraying the costs of inpatient care through various deductibles and coinsurance amounts. For example, during calendar year 2002, the Medicare patient is liable for an \$812 deductible for each benefit period in which the patient 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 been unable to collect a certain percentage of Medicare coinsurance and deductible amounts from program beneficiaries. Under a policy that costs attributable to Medicare beneficiaries are not to be shifted to non-Medicare patients, Medicare reimburses hospitals for these bad debts. 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 annual Medicare cost reports.

Under Section 1861(v)(1)(T) of the Social Security Act, the amount of allowable bad debt for cost reporting periods beginning during 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 the 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 debts meet Medicare reimbursement criteria. Generally, bad debts must meet the following criteria, as set forth in 42 Code of Federal Regulations (CFR) 413.80:

- 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.

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 1102.3, 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 specificity required for a bad debt claim is reiterated in the PRM Part II. The Center for Medicare & Medicaid Services manual requires that certain beneficiary-specific information [such as names and Medicare health insurance number (HIC)] be sent in by providers claiming reimbursement of bad debts.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine if Medicare bad debts claimed by the hospital were in compliance with the Medicare reimbursement criteria. Our audit primarily covered hospital inpatient Medicare bad debts claimed on the cost report for the cost report year October 1, 1998 through September 30, 1999. On a limited basis, we also reviewed Medicare outpatient and ESRD bad debt claims.

To accomplish our objectives, we met with staff at the Medicare Fiscal Intermediary (FI), Cahaba Benefit Administrators (Cahaba) in Raleigh, North Carolina, and discussed their role and reviewed their audit work papers and permanent files pertaining to Pitt County Memorial Hospital. We also discussed with Cahaba the state's policy regarding Medicaid reimbursement of Medicare deductibles and coinsurance for Medicare patients who also are eligible for Medicaid.

During our review at the hospital we reviewed written policies and procedures for collection of patient balances. We also sampled a population of 1,000 Medicare inpatient bad debt entries totaling \$625,653 (see Appendix A for a tie-in to the cost report). This included 991 entries totaling \$607,233 that were under \$1,000, and nine entries totaling \$18,420 that were \$1,000 and over. We reviewed all 9 bad debt entries greater than or equal to \$1,000 and randomly selected 100 entries, totaling \$58,420 from the remaining population. For the sample items, we performed detailed audit testing on the patient account financial records, Medicare remittance documents, Medicaid remittance documents, and collection activity records for the selected

entries. We used the RAT-STATS Variable Appraisal Program to estimate the dollar impact of improper bad debts in the total population. Finally, we obtained the Medicare cost report work papers for Medicare bad debt recoveries of previously written off bad debts to verify correctness.

Prior to conducting our sample, we reviewed the accuracy and completeness of the hospital's bad debt log, which included Medicare inpatient and outpatient bad debts. This log supported the amounts claimed on the cost report.

Our review of the outpatient and ESRD bad debt claims was limited to identifying summation and duplicate errors on the bad debt log and tracing the bad debts to the cost report. We did not perform a review of the hospital's collection efforts relative to outpatient or ESRD bad debt.

Our review was conducted in accordance with government auditing standards. The review was conducted from April 2002 through June 2002. We performed fieldwork at Pitt County Memorial Hospital and at the Raleigh, North Carolina office of Cahaba. At the hospital we relied primarily on substantive testing and as such, an understanding of internal controls of the hospital was not required.

RESULTS

Our sample review of inpatient bad debt claims indicated that the hospital generally complied with the Medicare reimbursement criteria in claiming \$1,500,617 in inpatient Medicare bad debts on its FY 1999 cost report. However, separate from our sample, we found that the hospital over claimed \$43,396 in Medicare inpatient and outpatient bad debt, which we attribute to the following clerical errors:

- Errors in a spreadsheet, causing certain figures to be added twice and certain figures to be omitted (\$38,240);
- Duplicate claims (\$5,156); and
- Submitting a bad debt log that did not include all the required information.

In other matters, we found that the hospital improperly claimed reimbursement for \$6,300 in ESRD outpatient bad debts. Medicare reimbursement criteria provide that ESRD Medicare bad debts may not exceed the Medicare cost (net of deductibles and co-insurance) for ESRD services. Since the hospital's FY 1999 ESRD outpatient program did not have any costs, the hospital should not receive reimbursement for these bad debts on its FY 1999 cost report.

We recommend that the hospital amend its FY 1999 Medicare cost report to reduce allowable Medicare bad debts by \$49,696 (\$43,396 hospital + \$6,300 ESRD).

We also recommend that the hospital implement automated bad debt log procedures to reduce the likelihood of clerical errors and to ensure that all required fields are included on the bad debt log.

The following sections provide more details on the results of our review.

SAMPLE RESULTS INDICATE GENERAL COMPLIANCE

Our sample of inpatient bad debt claims found that the hospital generally complied with the Medicare reimbursement criteria. The hospital demonstrated that reasonable collection efforts were made and the hospital used similar collection efforts for both Medicare and non-Medicare patients.

All of the errors in our sample were immaterial. The primary error we found was that the hospital incorporated deductibles and co-insurance relating to physicians' services on the Medicare bad debt log. Since physicians' services are covered under Part B of the Medicare program, deductibles and coinsurance related to such services may not be claimed on the cost report. Because the total error in our sample was only \$202, and this error projected out to only \$695¹, we have not recommended any adjustment to the cost report relative to our sample testing.

CLERICAL ERRORS

The hospital made clerical errors in preparing its Medicare bad debt log. As a result, the bad debts (inpatient and outpatient) were overstated by \$43,396. On the spreadsheet used by the hospital to record bad debts, certain subtotals were incorrectly included twice and certain subtotals were omitted causing bad debts to be overstated by \$38,240. The other clerical errors represented duplicate claims on the bad debt log totaling \$5,156. The hospital's log process was not automated which helped to create an environment in which such clerical errors could be made.

Spreadsheet Errors

The FY 1999 Medicare/Medicaid crossover log contained calculation errors, resulting in the log being overstated by \$38,240. The hospital recorded the Medicare bad debts for patients who also qualified for Medicaid on an electronic spreadsheet. Each month the spreadsheet was updated with additional Medicare/Medicaid crossover patients. The spreadsheet contained a summation function, allowing various cells to be added to compute a total. The hospital inadvertently included some cells in a subtotal and also added them a second time in the grand total. In addition, the hospital inadvertently omitted one subtotal from the grand total. These errors resulted in the summary totals being overstated.

¹ The point estimate of our sample projection was \$1,921 with a precision of +/- \$1,226 at the 90 percent confidence level.

Duplicate Claims

Prior to selecting our sample, we reviewed the bad debt log for duplicate claims and noted there were a total of 18 duplicate entries on the log totaling \$5,156. Seven of these entries were inpatient claims totaling \$3,546 and 11 were for outpatient claims totaling \$1,610. The \$3,546 for inpatient claims was not a part of our sample testing and accordingly there is no projection of this amount to the population.

Incomplete Logs

The Medicare bad debt log filed by the hospital does not contain all of the required fields. The hospital's bad debt logs are missing the following fields:

- 1) HIC #;
- 2) service dates (admit date, discharge date); and
- 3) date of first bill sent to the patient.

The missing fields hinder a proper review of Medicare bad debts. A log with complete information helps to substantiate that the amount reported for Medicare bad debt is proper and allowable.

OTHER MATTERS

The hospital claimed reimbursement for \$6,300 in outpatient ESRD Medicare bad debts. During the FY under audit, the hospital did not have outpatient ESRD costs included on its cost report. Thus, this claim is unallowable.

According to 42 CFR, Section 413.178, the reimbursement for a facility's ESRD Medicare bad debts is to be capped by ESRD Medicare cost. In other words, ESRD Medicare bad debts may not exceed the Medicare cost, net of deductibles and co-insurance for ESRD services. Since the hospital did not report any costs for its FY 1999 ESRD outpatient program, the hospital is not entitled to reimbursement of the ESRD Medicare bad debts included on its FY 1999 Medicare cost report.

CONCLUSION AND RECOMMENDATIONS

Our sample review found that the hospital generally complied with the Medicare reimbursement criteria in claiming \$1,500,617 in inpatient Medicare bad debts on its FY 1999 cost report. However, because of clerical errors, we found that the hospital's bad debts (inpatient and outpatient) were overstated by \$43,396. In addition, we found that the ESRD outpatient bad debts were overstated by \$6,300.

We recommend that the hospital file an amended cost report for FY 1999 to reduce allowable bad debts by a total of \$49,696 (\$43,396 + \$6,300). We also recommend that the hospital implement automated bad debt log procedures to reduce the likelihood of clerical errors and to ensure that all required fields are included on the bad debt log.

Auditee's Comments

The hospital generally agreed with our findings and recommendations addressing the errors, duplicate claims, and incomplete bad debt logs, and have already implemented some procedural changes to ensure they are following Medicare guidelines for bad debts. These changes include:

- 1) Revising the spreadsheet used to record bad debts;
- 2) Instituting a procedural step whereby the various databases that make up the Medicare bad debt total are combined, sorted, and reviewed for duplicate entries;
- 3) Adding the additional fields to the bad debt log; and
- 4) Implementing an automated Medicare bad debt log.

In addition, the hospital contends that the Medicare ESRD bad debt amount of \$6,300 addressed at "Other Matters" should be allowable. The hospital states that the Medicare ESRD bad debt relates to patients at the hospital and that the Medicare ESRD bad debt should be included as general outpatient if not allowed as ESRD.

The hospital also noted that additional errors were discovered during the audit, but not mentioned in the report, that indicated the actual bad debts claimed by the hospital might be understated.

OIG's Response

While our review showed the hospital was in compliance with the Medicare reimbursement criteria, the hospital has indicated it will make changes to make a good program better. We are pleased the hospital is taking some corrective action in response to our review.

Regarding Medicare ESRD bad debt, we note that Medicare ESRD is distinct and separate from other Medicare bad debt and there are specific regulations for Medicare ESRD bad debt. As such, Medicare ESRD bad debt should be maintained separate from other Medicare bad debt and should not be included as "general outpatient" bad debt. According to CFR 413.178, the Medicare program will reimburse ESRD bad debts only up to the point of the provider's actual ESRD costs, net of deductibles and coinsurance. Again, since the FY 1999 cost report did not include any ESRD costs, there is no basis to allow the ESRD bad debt claimed in FY 1999. According to the hospital, the Medicare ESRD bad debt in question relates to FY 1998. If anything, the hospital should attempt to obtain reimbursement through its FY 1998 cost report.

If the hospital wants to pursue this issue, it should submit documentation illustrating its 1998 ESRD cost along with the related ESRD bad debt to the fiscal intermediary for their consideration.

The hospital also refers to additional errors that indicate actual bad debts may be understated. We believe the hospital is referring to Medicare bad debt recoveries that were used to net down the Medicare bad debt logs. The hospital believes that they used the wrong figures from their records when reporting the total for Medicare bad debt recoveries, and as a result the reported total for recoveries was overstated. Thus, they believe the net total reported for Medicare bad debt is understated.

Our review of bad debt recoveries was limited when our initial tests indicated the amount reported was reasonable. Further, the hospital's documentation for recoveries is based on a general ledger account rather than a recovery log similar to the bad debt log. To verify the hospital's contention would have required an audit of this general ledger account and this step was beyond the scope of our review. Had the hospital maintained a more appropriate record of recoveries, (i.e., a patient listing of recoveries) we may have been able to verify the actual amount of recoveries. We recommend the hospital resolve this issue with the fiscal intermediary upon final settlement of the hospital's cost report.

Sincerely,



Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

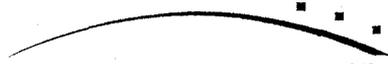
2 Enclosures

APPENDIX A

Tie-in To Medicare Cost Report

Medicare only bad debts (audited)	\$ 632,839 (see note below)
Medicare/Medicaid crossover bad debts (not audited)	<u>953,856</u>
Total bad debts	\$1,586,695
Less recoveries of previously written off bad debts	<u>(86,078)</u>
Total claimed on cost report	<u>\$1,500,617</u>

Note: Auditors removed \$7,186 of potentially duplicate entries from the Medicare only bad debts prior to selecting a sample. Thus, the total population from which samples were selected was \$625,653 (\$632,839 - \$7,186).



PITT COUNTY MEMORIAL HOSPITAL

University Health Systems of Eastern Carolina

November 18, 2002

APPENDIX B

Peter Barbera
Regional Inspector General for Audit Services, Region IV
Department of Health and Human Services
Room 3T41
61 Forsyth Street, S.W.
Atlanta Georgia 30303-8909

RE: Pitt County Memorial Hospital
CIN: A-04-02-02016

Dear Mr. Barbera:

This letter is in response to the Office of Inspector General, Office of Audit Services' draft report entitled *Review of Reimbursable Medicare Bad Debts for Pitt County Memorial Hospital for the Fiscal Year Ended September 30, 1999*. We appreciate the opportunity to provide comments prior to the final report being issued.

We have reviewed the recommendations drafted in the report and have the following responses:

Under the title Spreadsheet Errors, it was noted there was a summation function error in the spreadsheet that included some subtotals in the grand total twice. Pitt County Memorial Hospital has performed a check on all formulas for future years to make sure this was not a problem that carried forward and has made this a required check prior to filing of the cost report.

Under the title Duplicate Claims, it was noted there were claims that were included twice on the bad debt listing. Separate staff within Pitt County Memorial Hospital had the actual bad debt and the Medicaid deductible portion of the official bad debts for the cost report. Pitt County Memorial Hospital now performs its own audit of the two files by combining and sorting them by EDP# to see that there are not any duplicates.

Under the Incomplete Logs, it was noted that Pitt County Memorial's Medicare Bad Debt Logs did not contain all the required fields. Pitt County Memorial for bad debts for the Cost Report for Fiscal Year 2002 started completing the expanded profile as used in the official exhibits to include the data such as the HIC#, service dates and date of the first bill sent to the patient.

Under Other Matters regarding the claiming reimbursement for outpatient ESRD Medicare bad debts, without having any outpatient ESRD costs included on the cost report. Pitt County Memorial gave up the outpatient beds for this program. This occurred prior to the accounts being eligible for bad debt recovery. Pitt County Memorial agrees that there were no treatments or cost associated with the outpatient ESRD program for that year. However, Pitt County Memorial did provide services to these patients and believe that these amounts should be allowed if not on the ESRD schedules then as a general outpatient.

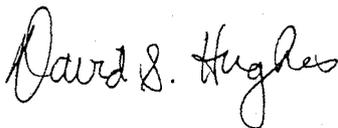
Under the Conclusions and Recommendations it was recommended that the fiscal year 2000 information be reviewed for the same type errors and an amended cost report be filed. Pitt County Memorial had not yet filed the fiscal year 2000 cost report when the review was conducted. All the above items were reviewed prior to the final cost report being submitted.

Also under the Conclusions and Recommendations it was recommended that the hospital implement an automated bad debt log procedure to reduce the likelihood of clerical errors and to ensure that all required fields are included on the bad debt log. Pitt County Memorial is in the process of developing an automated process as recommended with an expected completion date of January 2003.

Pitt County Memorial Hospital has responded to all recommendations made in the report and changed the practices by which the Medicare bad debts are being accumulated and reported. We would also like to note in addition to the errors identified in the report, there were additional errors discovered during the audit. These additional errors indicated the actual bad debts claimed by Pitt County Memorial Hospital were understated; however, this was not noted in the report.

If you have any questions concerning the comments above, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "David S. Hughes".

David S. Hughes
Vice President Financial Services