



October 8, 2002

Our Reference: Common Identification Number A-06-02-00027

Mr. Jeffrey Brownawell
Vice President of Managed Care and Governmental Reporting
Memorial Hermann Hospital System
9401 S.W. Freeway, Suite 308
Houston, Texas 77074

Dear Mr. Brownawell:

Attached are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Audit of Inpatient Bad Debts Claimed by Memorial Hermann Hospital in its Medicare Cost Report for the Fiscal Year Ended June 30, 2000." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. 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 an impact on the final determination.

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To facilitate identification, please refer to Common Identification number A: 06-02-00027 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink that reads "Gordon L. Sato".

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Page 2 – Mr. Jeffrey Brownawell

Direct Reply to HHS Action Official:

Dr. James R. Farris, MD
Regional Administrator
Centers for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, TX 75202

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**AUDIT OF INPATIENT
BAD DEBTS CLAIMED BY
MEMORIAL HERMANN HOSPITAL
IN ITS MEDICARE COST REPORT
FOR THE FISCAL YEAR
ENDED JUNE 30, 2000**



JANET REHNQUIST
Inspector General

OCTOBER 2002
A-06-02-00027

Office of Inspector General

<http://oig.hhs.gov/>

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EXECUTIVE SUMMARY

Background

The Medicare program requires that beneficiaries (patients) share in defraying the costs of inpatient care through various deductible and coinsurance amounts. Bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from patients can be reimbursed to hospitals if the bad debts meet Medicare reimbursement criteria. The Medicare program requires that: (1) a reasonable effort be made to collect from the patient, and (2) debts be uncollectible when claimed as worthless. A hospital may presume debts are uncollectible if reasonable efforts are made to collect and debts remain unpaid for over 120 days prior to accounts being written off and claimed as bad debts. Moreover, the hospital's own policy stated that: (1) a bill must be submitted to the beneficiary or guarantor after Medicare paid, and (2) collection effort of some type must take place on a consistent basis for 120 days from the date the patient was first billed before the debt could be considered uncollectible and claimed as worthless.

The Medicare program also requires that debts be uncollectible and that it be established there will be no likelihood of recovery at anytime in the future before patient balances are claimed as bad debts. When payments are received after bad debts have been claimed (recoveries), the program requires that claims be offset by the recoveries in the year payments are received. When a patient is determined to be indigent, the provider is not required to make a reasonable effort to collect from the patient. However, supporting documentation must be maintained for the indigence determination.

Objective

The objective of this audit was to determine whether Medicare inpatient bad debts claimed by Memorial Hermann Hospital (hospital) in its Medicare cost report for the fiscal year ended June 30, 2000 (FY 2000), totaling \$1,490,159, met program reimbursement requirements.

Summary of Findings

The hospital claimed bad debts that did not meet Medicare reimbursement requirements for 93 of 140 (66 percent) bad debt claims tested. For 89 claims, the hospital did not make a reasonable effort to collect from patients or settle claims with insurance prior to write off. Thus, the hospital could not presume that the debts were uncollectible. In addition, there were four claims that were either: (1) paid in full, (2) not offset by patient payments, or (3) not supported by indigence documentation.

Further, the hospital did not offset its claimed bad debts for all recoveries. More specifically, the hospital's bad debts were not offset for all of the recoveries made during FY 2000 that related to accounts written off in FY 2000 and prior years.

Based on these results, we estimated that the hospital's inpatient bad debts claimed were overstated by \$919,331. The program requirements were not met because the hospital did not have procedures and controls in place to ensure that:

- reasonable efforts were made to collect from patients;
- accounts were not written off as bad debts before the hospital had either billed patients or completely settled insurance claims;
- bad debts claimed were decreased by non-covered services, insurance and patient payments, and recoveries from patients;
- indigence determinations were documented; and
- all recoveries were identified and offset against bad debts claimed.

Recommendations

Accordingly, we are recommending that the hospital implement procedures to ensure that: (1) a reasonable effort is made to collect debts before they are deemed uncollectible and claimed as worthless; (2) all Medicare debts are billed to patients prior to write off; (3) bad debts claimed are properly offset for non-covered services, payments, or recoveries; and (4) indigence determinations are adequately documented. Furthermore, because the hospital and numerous other hospitals are administered by the Memorial Hermann Hospital System (MHHS), we recommend that MHHS implement procedures to ensure that the conditions existing at the hospital do not occur at the other hospitals within the system, Medicare requirements are fully complied with, and collection policies are consistent for Medicare and non-Medicare patient accounts.

Additionally, we are recommending that the hospital amend its FY 2000 Medicare cost report to reduce its claim by an estimated \$919,331 for claims that did not meet program requirements and recovery payments that were not offset. See APPENDIX A for the financial results of audit.

Auditee Response

In its response to our draft report, the hospital generally disagreed with our findings and recommendations. The hospital did not contest our treatment of 19 of 93 claims that were questioned. However, the hospital maintained that with only these few exceptions the remaining bad debts reviewed were allowable and supported by proper documentation. See Appendix E for the complete text of the hospital's response. Also see page 11 of this report for the OIG's comments to this response.

TABLE OF CONTENTS

INTRODUCTION	1
BACKGROUND	1
OBJECTIVE, SCOPE AND METHODOLOGY	3
FINDINGS AND RECOMMENDATIONS	4
REASONABLE COLLECTION EFFORT NOT MADE	4
OTHER CLAIMS NOT MEETING MEDICARE REQUIREMENTS	7
RECOVERIES NOT FULLY OFFSET AGAINST CLAIMS	7
CONCLUSION	7
RECOMMENDATIONS	8
AUDITEE RESPONSE	8
OIG COMMENTS	11
OTHER MATTERS	16
APPENDIX A FINANCIAL RESULTS OF AUDIT	
APPENDIX B SAMPLING METHODOLOGY	
APPENDIX C STRATIFIED VARIABLE PROJECTION	
APPENDIX D ESTIMATED BAD DEBT RECOVERIES NOT OFFSET AGAINST INPATIENT BAD DEBTS	
APPENDIX E HOSPITAL'S RESPONSE TO REPORT	

INTRODUCTION

BACKGROUND

The Medicare program requires that beneficiaries (patients) share in defraying the costs of inpatient care through various deductible and coinsurance amounts. However, in the past, hospitals have been unable to collect all Medicare deductible and coinsurance amounts from patients. Based on a policy started in 1966, costs attributable to Medicare patients are not to be shifted to non-Medicare patients. As a result, Medicare reimburses hospitals for these bad debts, which hospitals claim by submitting Medicare cost reports.

Bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from patients 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 a reasonable collection effort was made.
- The debt was actually uncollectible when claimed as worthless.
- Sound business judgment must have been established that there was no likelihood of recovery at any time in the future.

Additional policies and guidelines to implement Medicare regulations that set forth principles for determining the reasonable cost of provider services are published in the Medicare Provider Reimbursement Manual (PRM). Specifically, the PRM states the following.

- Provider's collection efforts should be documented in the patient's file. (Part I, Section 310.B).
- To be considered a reasonable 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 to the party responsible for the patient's obligations on or shortly after discharge or death of the patient. This includes other actions such as subsequent billings, collection letters and telephone or personal contacts that constitute a genuine rather than a token collection effort. (Part I, Section 310)

- Providers may make a presumption that debts are uncollectible after reasonable and customary attempts are made to collect a bill, and the debt remains unpaid for more than 120 days from the date the first bill was mailed to the patient, unless there is a reason to believe that the debt is collectible. As an example, this includes instances in which the patient is currently making payments on account, or has currently promised to pay the debt. (Part I, Section 310.2, and Part II, Section 1102.3)
- When a provider claims Medicare bad debts in 120 days or less from the first bill sent to the patient, the provider must be prepared to demonstrate that the debts were actually worthless, and in all cases must be able to support that it pursued a reasonable collection effort. (Part II, Section 1102.3)
- When a provider determines that a patient is indigent and there was no improvement in the patient's financial condition, the debt may be deemed uncollectible and written off without making a reasonable collection effort. However, the provider must determine the patient's indigence. The determination should take into account a patient's total resources, and show that no source other than the patient would be legally responsible for payment. The file should contain the method and all back up information to substantiate the determination. (Part I, Section 312)
- Patients may be deemed indigent when such individuals have been determined to be eligible for Medicaid and as such, the patient's debts may be written off without making a reasonable collection effort. (Part I, Section 312)
- Where the Medicare program reimbursed the provider for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts received. (Part I, Section 316)

We also noted that the hospital's policy on Medicare bad debts was similar to the program requirements above. It was more definitive about collection efforts and determining the collectibility and worthlessness of debts. The hospital's policy on Medicare Bad Debts, dated March 11, 1997, specified that,

“A bill must be submitted to the beneficiary or guarantor after Medicare has paid.... The debts must be uncollectible when claimed as worthless. Collection effort of some type must take place on a consistent basis for 120 days from the date the first bill is sent to the patient or guarantor. After 120 days, the debt is considered uncollectible.”

The hospital is part of the Memorial Hermann Hospital System (MHHS), a Texas not-for-profit corporation operating principally in the Houston, Texas metropolitan area. The system is a not-for-profit, community-owned health system that is directly affiliated with the Memorial Hermann Healthcare System. The MHHS operates numerous acute-care hospitals and other facilities including Memorial Hermann Hospital.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of the audit was to determine whether Medicare inpatient bad debts (claimed by the hospital in its FY 2000 Medicare cost report) totaling \$1,490,159, met program reimbursement requirements. The hospital was selected for audit based on various analytical ratios and the amount of bad debts claimed in comparison to other providers in Texas. To accomplish the objective, we:

- reviewed criteria related to Medicare bad debts and accounting requirements;
- interviewed an MHHS official to gain an understanding of the hospital's procedures to accumulate bad debts claimed in the Medicare cost report;
- reviewed the hospital's policies and procedures for billing Medicare, collecting on patient accounts, using collection agencies, and writing off accounts;
- reviewed contracts the MHHS had with collection agencies;
- used a stratified sample approach to select for testing 140 Medicare bad debts claimed (see APPENDIX B for sampling methodology);
- examined the hospital's accounts receivable records, Medicare and Medicaid remittance advices, and collection agency notes on efforts made to collect from patients for each of the 140 sampled Medicare bad debts claimed;
- used the RAT-STATS Stratified Variable Appraisal program to estimate the dollar impact of questioned bad debts in the total population (see APPENDIX C for the results of our projection);
- examined the hospital's financial records relating to bad debt recoveries and related general ledger accounts;
- estimated recoveries which were not fully offset against the bad debts claimed for FY 2000 (See APPENDIX D for estimate of recoveries not offset);
- judgmentally selected and reviewed 30 non-Medicare bad debts written off by the hospital in FY 2000; and
- discussed the results of our review with MHHS officials.

In determining whether a reasonable and genuine effort was made to collect on Medicare bad debts claimed, we examined and considered all efforts occurring from discharge until the date the accounts were written off as bad debts. In general, collection efforts were not considered to be reasonable and genuine, nor were claims allowable, if: (1) no effort was made to collect from

the patient prior to write off; (2) the hospital did not support that a debt was uncollectible at the time of write off in those instances where an account was written off in 120 days or less from the initial billing to the patient; or (3) efforts were not made to collect on accounts at least monthly for at least the first 120 days following the initial billing to the patient or after the patient's last payment, and efforts, if any from day 120 through write off, were infrequent to a point of appearing as though a token effort was made to collect shortly before write off.

In our opinion, normal and prudent business practices would dictate that genuine collection efforts should occur at least once a month on a consistent basis and include a mix of collection letters, calls, or contacts with the patient. A 5-day window was added to the typical 30-day business billing cycle to examine whether monthly billings had occurred. This 5-day margin was added to make up for any unforeseen delay in the billing process that may have been experienced by the hospital. We questioned claims where there was a 35-day or more period or periods of time when collection efforts were not made during the first 120 days following an initial billing to the patient, and efforts, if any from day 120 until write off, were infrequent to a point of appearing as though a token effort was made to collect shortly before write off. In general, our methodology for assessing whether efforts constituted a reasonable and genuine effort included assessing whether an on-going and consistent collection effort had been made.

A detailed review of internal controls was not performed because the objective of our review was accomplished through substantive testing, although we did gain an understanding of the hospital's collection process.

Planning and field work was conducted from November 2001 until April 2002. Work was performed at the MHHS administrative offices located in Houston, Texas during February 2002. Work was also conducted at the fiscal intermediary's offices located in Dallas and San Antonio, Texas, and at the Texas State Medicaid Agency located in Austin, Texas.

Our audit was performed in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The hospital claimed bad debts that did not meet Medicare reimbursement requirements for 93 of the 140 (66 percent) bad debt claims tested. For 89 claims, the hospital did not make a reasonable effort to collect from patients or settle claims with insurance prior to write off. In addition, there were four claims that were either: (1) paid in full, (2) not offset by patient payments, or (3) not supported by indigence documentation. Furthermore, the hospital did not offset its total bad debts claimed for all recoveries that were received in FY 2000.

REASONABLE COLLECTION EFFORT NOT MADE

The hospital did not make a reasonable effort to collect from patients or insurance prior to writing off amounts as bad debts for 89 claims. More specifically, there were:

- 65 claims that were written off although a token effort was made to collect from patients, of which 28 claims were written off within 120 days after patients were first billed and the hospital did not demonstrate that the debts were actually uncollectible when claimed as worthless;
- 10 claims that were written off although no effort was made to collect from patients;
- 9 claims that were written off although a token effort was made to collect from patients after the patient's last payment; and
- 5 claims that were not settled with Medicaid or insurance prior to write off.

These four topics are discussed below.

Token Collection Effort

The hospital claimed 65 bad debts, totaling \$116,911, which were supported by a token effort to collect from patients. The 65 claims included:

- 54 claims that had collection effort spanning less than 90 days after the first bill was sent to patients with no effort thereafter and up until the time of write off; and
- 11 claims that had a 35-day or more period of time (during the first 120 days after the patient's first billing) when no effort to collect from the patient was made, and for which there were infrequent and inconsistent collection efforts made from day 120 and up until write off.

Thus, efforts were not considered to be reasonable and genuine, nor were they made on a consistent basis. Twenty-eight of the 54 claims were written off as bad debts on or before the 120th day after the patient was first billed. As a result, due to the early write off, the program required the hospital to demonstrate that these claims were uncollectible when claimed as worthless. The hospital did not demonstrate this.

No Effort Made to Collect from Patients Prior to Write Off

The hospital claimed 10 bad debts, totaling \$8,648, although no effort was made to collect from the patients prior to write off. Although there were instances where the hospital billed a patient's insurance, patients were not billed for balances owed for deductibles and coinsurance prior to write off. The hospital had a practice of writing off accounts before billing patients when a patient's insurance did not pay in a timely manner (i.e. within 120 days from the date the insurance was first billed).

According to the PRM, the provider must issue a bill to the party responsible for the patient's obligations on or shortly after discharge of the patient. Therefore, these claims should not have been presumed uncollectible.

Token Effort Made to Collect After Patient's Last Payment

The hospital claimed nine bad debts totaling \$6,709, although a token effort was made to collect from patients after the patient's last payment. Collection effort was not considered to be reasonable and genuine in accordance with the methodology discussed in the scope section of this report.

The nine claims included:

- four claims that had no collection effort after the patient's last payment;
- two claims that had effort spanning less than 90 days after the patient's last payment;
- two claims that had a 35-day or more period of time during the first 120 days after the patient's last payment, when no effort was made to collect from patients, and efforts thereafter were infrequent up until the write off date; and
- one claim that had no collection effort in the first 120 days after the patient's last payment, and efforts thereafter were infrequent up until the write off date.

Insurance Not Settled Prior to Write Off

The hospital claimed five bad debts totaling \$5,745, which were not settled with Medicaid or insurance prior to write off. Thus, these claims should not have been presumed uncollectible. The program requires that: (1) a debt should be actually uncollectible when claimed as worthless, and (2) sound business judgment must have been established that there was no likelihood of recovery at any time in the future.

The five claims included:

- three claims with patient files that showed secondary insurance was not settled prior to write off; and
- two claims with patient files that showed Medicaid had not settled the claims prior to write off. Initially, Medicaid denied payment because the patient also had private insurance. However, the hospital did not re-bill Medicaid after the private insurance had been settled.

OTHER CLAIMS NOT MEETING MEDICARE REQUIREMENTS

The hospital claimed four bad debts totaling \$1,556 that were either: (1) paid in full, (2) not offset by patient payments, or (3) not supported by indigence documentation. The program requires that debts be unpaid, and claims be offset by recoveries in the year payments are received. In instances where patients are determined to be indigent the provider is not required to make a reasonable collection effort from the patient. However, supporting documentation must be maintained for the indigence determination.

The four claims included:

- two claims that were paid in full by Medicaid or insurance and thus were not bad debts;
- one claim that was not offset by \$60 for recoveries received prior to the end of FY 2000; and
- one claim that did not have required documentation supporting an indigence determination.

RECOVERIES NOT FULLY OFFSET AGAINST CLAIMS

The hospital did not offset inpatient bad debts claimed by the full amount of payments recovered from patients during FY 2000. The hospital's detailed listing of bad debts claimed showed that the claims had been offset by recoveries totaling \$7,240. However, these recovery offsets were incomplete. Claims were not offset for recoveries: (1) made by one of the hospital's collection agencies for accounts written off in FY 2000 (such as the \$60 recovery discussed previously), and (2) related to claims written off in years prior to FY 2000. When payments are recovered after bad debts are claimed, the program requires that claims be offset by the recoveries in the year payments are received.

CONCLUSION

The hospital claimed bad debts that: (1) did not meet Medicare reimbursement requirements for 94 claims of 140 bad debt claims, and (2) were not offset by all recoveries that were received in FY 2000. We estimated that the hospital's inpatient bad debts claimed on the FY 2000 Medicare cost report were overstated by \$919,331 for claims that did not meet Medicare reimbursement requirements and recovery payments that were not fully offset. (See Appendix A for financial results of audit) The program requirements were not met because the hospital did not have procedures and controls in place to ensure that:

- reasonable efforts were made to collect from patients throughout the 120 days following the patient's first billing or last payment, and accounts were not written off prior to the 120-day period;

- accounts were not written off as bad debts before the hospital had either billed the patient or completely settled insurance claims;
- bad debts claimed were decreased by non-covered services, insurance and patient payments, and recoveries from patients;
- indigence determinations were documented; and
- all recoveries were identified and offset against bad debts claimed.

RECOMMENDATIONS

We recommend that the hospital implement procedures to ensure that: (1) a reasonable effort is made to collect before debts are presumed to be uncollectible, (2) all Medicare debts are billed to patients prior to write off, (3) bad debts claimed are properly offset, and (4) indigence determinations are adequately documented. Furthermore, because the hospital and numerous other hospitals are administered by the Memorial Hermann Hospital System (MHHS), we recommend that MHHS implement procedures to ensure that the conditions existing at the hospital do not occur at the other hospitals within the system, Medicare requirements are fully complied with, and collection policies are consistent for Medicare and non-Medicare patient accounts.

Additionally, we recommend that the hospital amend its FY 2000 Medicare cost report to reduce its claim by an estimated \$919,331 for claims that did not meet program requirements and recovery payments that were not offset. See APPENDIX A for financial results of audit.

AUDITEE RESPONSE

In its response to our draft report, the hospital generally disagreed with our findings and recommendations. The hospital did not contest our treatment of 19¹ of 93 claims that were questioned. However, the hospital maintained that with only these few exceptions, the remaining bad debts reviewed were allowable and supported by proper documentation. The hospital stated our approaches were based upon erroneous legal suppositions or upon incomplete facts. It also indicated a substantive discussion was needed before the report was finalized. The hospital made the following arguments in its response regarding our findings and recommendations as discussed below.

¹ These 19 claims consisted of 10 claims with no effort made to collect from patients (page 5), 5 claims which were not settled with Medicaid or insurance prior to write off (page 6), and 4 claims not meeting other Medicare requirements (page 7).

Hospital's Response to Our Findings

120-Day Write Off Principle

Writing off accounts prior to 120 days after the first bill or last patient payment did not disqualify the amount from being properly claimed as a bad debt. The 120-day rule is a presumption that allows a debt to be considered uncollectible if it remains unpaid for more than 120 days.

Specific Number of Efforts Not Required

There was no specific number of contacts specified by the PRM for a collection effort to be considered reasonable, yet it appeared the auditors considered four contacts (counting the first billing), evenly spaced in time, within the first 120 days, to be a reasonable effort.

All Efforts Not Considered

Not all collection efforts were considered to determine whether (1) genuine (rather than token) collection effort had been made, and (2) accounts were uncollectible. Noncollectibility was the fundamental test for determining allowable bad debts. The hospital stated its personnel explained that accounts were referred to second and third collection agencies for which the OIG auditors refused to review the data. Efforts that occurred after 120 days from initial billing and after write off should have been considered to determine the allowability of bad debt claims because auditors considered recoveries in FY 2000, which were a result of collection efforts made after write off.

Virtually All "Token Effort" Claims Had Four or More Efforts

The hospital stated that virtually all claims questioned as token collection efforts had a genuine collection effort and could not be considered a token effort. Virtually all claims had subsequent billings and had four or more efforts, and often many more. The hospital stated that, for this group of claims, the median number of efforts per claim was 9 and the mean number of efforts was 10.5. There were 16 claims that had a dozen or more collection efforts.

Genuine Effort Made on Claims With Less Than Four Efforts

For eight² accounts with less than four efforts, the hospital indicated it had an explanation why further efforts would have been fruitless: mail was returned, or patient was deceased. Only two accounts had no documentation that the patient could not be contacted. In sum, except for two accounts, all of the accounts clearly had a genuine rather than a token collection effort.

Genuine Effort Made on 24 Claims With 4 or More Efforts

Even if efforts made only prior to the write off date could be counted, which was not the legal requirement, the draft report contained errors because 24 claims had 4 or more efforts documented prior to the write off date. These efforts constituted genuine collection efforts under PRM, Section 310.

² See identified sample numbers at APPENDIX E, page 6.

Effort Prior to 120 Days Cannot Be Solely Considered

There was no legal requirement that only collection efforts within the first 120 days are counted in determining whether the effort is genuine. According to case law, the totality of collection efforts must be looked at both in determining reasonable collection efforts, and in establishing whether the debt was actually uncollectible.

No Requirement for 35-day Period

There was no requirement in the Medicare statutes, regulations, manuals, administrative decisions, or judicial case law stating that bad debt was not allowable if a 35-day period was allowed to elapse without a collection effort.

Consistent Effort Not Required by Hospital's Policy

Auditors apparently based the 35-day requirement on an interpretation of what they believed to be the hospital's bad debt policy, but this was not the hospital's policy. The policy related to that of two smaller hospitals of MHHS.

New Requirements Prohibited by OBRA 1987

Public Law 100-203, Section 4008 (c) ("OBRA 1987") prohibits the Secretary from imposing new requirements to disallow bad debt. The "35-day" and "restarting the clock" on the 120-day write off period following the last patient payment requirements were new requirements prohibited by OBRA 1987.

Additional Documentation Shows Reasonable Effort Made on One Account

The hospital contested the treatment of one account that we had classified as having no collection effort because the account had fifteen collection efforts and it was a "mail return" account. Therefore it should be allowed.

Restarting Clock on 120-Day Period Not Medicare Rule

Governing Medicare rules did not provide for "restarting the clock" on the 120-day period following the last patient payment. The 120-day period should be measured from the first date a bill is sent to the patient.

Reasonable Effort Made After Patient's Last Payment

A reasonable collection effort was made for nine accounts that were questioned because of a token effort after last patient payment. The total number of collection efforts for seven of nine accounts ranged between three and twelve efforts. The mean number of efforts for these accounts was five.

Recovery Offset

The OIG's approach is flawed because recovery amounts were offset for which the hospital had not been paid due to audits not yet completed on prior years. In addition, because many prior year claims were disallowed (not paid) and are now being appealed or will be appealed, the amounts that may ultimately be reimbursed are unknown at this time. Rather than using an estimate, a more accurate method of offsetting recoveries would be to perform a claim-by-claim

comparison of recoveries for FY 2000 to actual claims that were reimbursed as bad debts in prior years.

Hospital's Response to Recommendations

The hospital, while not contesting the treatment of 19 claims questioned, generally disagreed with our recommendations. Some aspects of the manner in which the hospital manages and accounts for bad debts have been changed as a result of consolidation of the hospital with MHHS. The hospital (1) made reasonable collection efforts, (2) extended the time until write off to ensure that the 120 day presumption was met, (3) generally billed Medicare debts to patients prior to write off, (4) offset bad debt recoveries, and (5) updated indigence policies to match federal poverty guidelines when changed.

A monetary adjustment will not be made until the fiscal intermediary performs a field audit of the FY 2000 cost report. At that time, the questioned claims would be removed from the Medicare listing and provided to the fiscal intermediary. If this arrangement is not acceptable to the fiscal intermediary, an amended cost report will be filed and an additional tentative settlement would be expected.

See APPENDIX E for the complete text of the hospital's response.

OIG COMMENTS

We gave careful consideration to the hospital's positions about our audit approach and its views on the application of criteria used to determine the allowability of bad debts claimed. We met with a hospital representative and the hospital's attorney on September 13, 2002, to ensure that the hospital's position was fully understood. The hospital disagreed with the findings and recommendations in our report. However, we continue to believe that (1) the conditions noted in our report are valid, (2) the hospital has not fulfilled program requirements needed to claim allowable bad debts for 93 of the 140 claims reviewed, and (3) controls should be implemented to ensure compliance with program requirements as recommended. The following sections contain our comments on the hospital's response to our findings and recommendations.

Our Comments on Hospital's Response to Findings

120-Day Write Off Principle

We agreed with the hospital's comment that writing off accounts prior to 120 days after the initial billing or patient's last payment did not disqualify amounts from being properly claimed as bad debts. However, we did not question any claims solely because the accounts were written off in 120 days or less after the initial billing or a patient's last payment. Writing off accounts in 120 days or less made it necessary for the hospital to demonstrate that the debts were actually uncollectible when claimed as worthless, and in all cases that it had pursued reasonable collection efforts.

Specific Number of Efforts Not Required

We agreed with the hospital's statement that the PRM did not specify the total number of contacts that would be considered a reasonable collection effort. The PRM also did not specify the number of efforts to be made in the form of letters, calls, or contacts with the patient; the number of efforts to be made by type; or the frequency of efforts to be made for a collection effort to be reasonable. However, the PRM, Section 310 required that collection efforts subsequent to the initial billing be made and "constitute a genuine rather than a token effort" to collect from patients. As such, we were required to make decisions about what "constituted a genuine rather than a token" effort to collect from patients. In attempting to be fair and consistent, and to determine whether reasonable and genuine efforts were made to collect on the patient accounts, we chose to examine whether the hospital was consistently billing patients using a common billing timeframe: the monthly billing statement. Exercising this judgment did not constitute rule making.

All Efforts Not Considered

We disagreed with the hospital's contention that collection efforts made after write off should have been considered to determine the reasonableness of collection efforts or the allowability of bad debts. We also disagreed with the hospital's contention that efforts made after write off should have been considered because we examined recoveries in FY 2000 that were a result of collection efforts after write off. Once an account was written off and the bad debts were claimed for Medicare payment, there were no further program requirements.

We disagreed with the hospital's contention that we refused to review data for second and third collection agencies. We examined all data provided by hospital officials including collection effort by second and third collection agencies provided to us after the issuance of our draft report. As a result of this effort, one previously disallowed claim was allowed, and several other claims were reclassified from one unallowable category to another. These changes are reflected in this final report.

We also disagreed with the hospital's position that noncollectibility was "the fundamental test for determining allowable bad debts". While we agreed that noncollectibility was one of several tests for determining allowability, we noted there were numerous requirements in the CFR and PRM that had to be met for bad debts to be considered allowable, not just one as contended by the hospital.

Virtually All "Token Effort" Claims Had Four or More Efforts

We disagreed with the hospital's contention that "virtually all" claims questioned as having a token effort had four or more efforts. The hospital's statistics on the number of efforts made included efforts that occurred after accounts had been written off as bad debts. As discussed in the "All Efforts Not Considered" section above, efforts made after write off were not considered because they were not applicable in determining reasonableness of collection effort and allowability of bad debts. If efforts made after write off were excluded, the hospital's statistics would decrease significantly as shown below.

For example, using the collection efforts shown in the hospital's spreadsheet (at APPENDIX E, Attachment 1) and deleting all dates of effort that occurred after the write off date, we calculated: (1) 3 median efforts, not 9 as stated by the hospital; and (2) 3.9 mean efforts, not 10.5 as stated by the hospital. We noted that virtually all of the second and third collection agency efforts occurred after the date of write off.

We also disagreed with the hospital's implication that its statistics, or solely counting the number of efforts made, represented a valid method of demonstrating the reasonableness of its collection efforts and the allowability of the bad debts claimed. The hospital's use of statistics gave consideration to only one aspect of the collection effort for all claims taken as a whole. This did not give consideration to the on-going nature of the effort, or the consistency of effort, which we believe impacted the genuineness of collection effort.

Genuine Effort Made on Claims With Less Than Four Efforts

We disagreed with the hospital's contention that accounts were not collectible because mail was returned or patients were deceased. We continue to believe it would be prudent and reasonable for the hospital to exhaust reasonable avenues of collecting on the accounts. This would include contacting the next of kin or attempting to locate the patient at a relative's home, or medical facility to which the patient may have been discharged. This information would have been indicated in the hospital's records. The hospital's records did not indicate that these types of attempts had been made for the eight claims we questioned.

In addition, the hospital did not apply a consistent policy for collecting on deceased patient's accounts. The hospital's written policy was to not file liens on Medicare accounts. Hospital and MHHS officials stated that liens were not pursued or placed on the estates of deceased Medicare patients, although such efforts were pursued for non-Medicare accounts.

Genuine Effort Made on 24 Claims With 4 or More Efforts

We disagreed with the hospital's contention that a reasonable collection effort was made on the 24 claims identified by the hospital as having 4 or more efforts prior to write off. As previously noted, we examined whether the hospital made on-going efforts that occurred on a consistent monthly basis. Of the 24 claims,

- 2 claims had only an initial single billing before write off;
- 5 claims had efforts spread intermittently from 1 to 60 days after the initial billing; and
- 17 claims had efforts spread intermittently from 1 to 86 days from the initial billing.

In addition, 14 of the 24 claims were written off as bad debts in the hospital's accounting system in 120 days or less from the initial billing to the patient. This required that the hospital demonstrate the debts were actually worthless and uncollectible, as no presumption of noncollectibility could be made due to the early write off. The hospital did not demonstrate that

a reasonable effort was made or that the accounts were actually uncollectible at the time of write off, or when claimed as worthless.

Effort Prior to 120 Days Cannot Be Solely Considered

We agreed with the hospital's position that it was not a requirement that only efforts within the first 120 days after a patient was billed should have been considered in determining the reasonableness of the collection effort. However, we considered all efforts from discharge until write off and have clarified our position in this report.

No Requirement for 35-Day Period

We agreed with the hospital's position that the Medicare regulations and PRM were not specific, and did not specify a 35-day requirement. However, as previously noted, we continue to believe that normal and prudent business practices would dictate that patients should be billed on a monthly basis. We also allowed for a 5-day margin for unforeseen delays in the billing cycle. This judgment was one of the determining factors in assessing whether a reasonable and genuine collection effort was made.

Consistent Effort Not Required by Hospital's Policy

We disagreed with the hospital's contention that our use of the 35-day period, as part of our assessment of reasonable collection effort, was based solely upon the hospital's policies. We cited the hospital's policy, in this report, because it supported our contention that efforts should be made on a consistent basis. We believe that even without this policy, the hospital was still required to make reasonable and genuine collection efforts that would be indicated by making consistent collection efforts.

We noted that the policy in question was provided to us by MHHS at the start of the audit and was represented as being the hospital's collection policy. Additionally, MHHS officials reiterated this position during the audit.

New Requirements Prohibited by OBRA 1987

We agreed with the hospital's position that OBRA 1987 prohibits the Secretary from imposing new requirements to disallow bad debts, although we understand that this relates to changes in policy from those that were in effect on August 1, 1987. The OBRA states that the Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with rules in effect as of August 1, 1987, has accepted such policy before that date.

However, we did not agree that the rules in effect prevented us from making decisions about the reasonableness of collection efforts. The PRM did not specify what constituted a genuine rather than token collection effort. We continue to believe that our methodology for assessing what "constituted a genuine rather than a token effort" should not be viewed as new requirements prohibited by OBRA.

Additional Documentation Shows Reasonable Effort Made on One Account

We disagreed with the hospital's contention that the claim in question was allowable. The hospital records, provided subsequent to the issuance of our draft report, showed that one effort had been made prior to write off, not fifteen as indicated by the hospital in its response. The hospital's effort included fourteen efforts made after the account had been written off as a bad debt. As previously stated, we disagreed with the hospital's contention that efforts after should be considered to determine the reasonableness of collection efforts.

In addition, the hospital stated that a mail return occurred on this account. As previously stated, we disagreed with the hospital's contention that because mail was returned accounts were not collectible. The hospital's records did not indicate that any efforts were made to locate the patient, such as contacting a relative.

Restarting Clock on 120-Day Period Not Medicare Rule

We agreed with the hospital's position that the PRM did not require a restart of the 120-day clock for a presumption of noncollectibility after the patient's last payment. However, for a debt to be allowable, (1) a reasonable effort must be made to collect, (2) debts must be uncollectible when claimed as worthless, and (3) there could be no likelihood of recovery at anytime in the future. We believe that patient payments indicated that there was a likelihood of recovery, thus the hospital should have made reasonable efforts to demonstrate the account was uncollectible before write off.

Reasonable Effort Made After Patient's Last Payment

We disagreed with the hospital's position that a reasonable effort was made to collect after a patient's last payment. The hospital's statistics included efforts that occurred before the patient's last payment and after accounts were written off as bad debts. If these efforts were excluded (using the hospital's spreadsheet at APPENDIX E, Attachment 1), the mean number of efforts was one, not five as stated by the hospital. Furthermore, five accounts had no effort between the patient's last payment and write off, and the other four accounts had between two and three efforts. With regard to these four accounts, we noted efforts were inconsistent and infrequent to a point of appearing to be token efforts.

Recovery Offset

We disagreed with the hospital's contention that our approach for estimating recoveries not offset by the hospital was flawed. It was the hospital's responsibility to offset its current year claims for recoveries received as required by PRM Part I, Section 316. Therefore, the hospital was expected to keep records of its bad debt recoveries to be offset against current year claims. We agreed that a claim-by-claim analysis of recoveries received on claims previously paid would be more accurate and should have been provided by the hospital at the time of our audit. However, this listing was not provided. In accordance with the requirements of the fiscal intermediary, an estimate must be made of recoveries that were not offset.

Our Comments on Hospital's Response to Our Recommendations

The hospital did not agree to implement any of our recommendations. There were 19 claims that the hospital did not contest even though the conditions noted for these claims indicated there were problems with the hospital's bad debt system. This included claim(s) for which (1) no effort had been made to collect from patients, (2) insurance was not settled prior to write off, (3) payment had already been made by Medicaid or insurance, (4) a sampled claim was not offset by a recovery occurring in FY 2000, and (5) the required documentation was not provided to support the hospital's indigence determination. Nonetheless, the hospital did not agree to examine any of its policies and procedures to ensure that any of the conditions noted in this report were not repeated at the hospital or within MHHS in the future.

We continue to believe that the hospital should implement procedures to ensure that bad debts claimed are allowable as recommended in our report. We also continue to believe that the recommended adjustment of \$919,331 should be made.

OTHER MATTERS

During the audit, it came to our attention that the hospital implemented a collection procedure that was not consistent in the collections made on Medicare and non-Medicare accounts primarily affecting the year following the period of our review (FY 2001). Hospital and collection agency officials stated that the hospital had a verbal agreement with a collection agency to collect on Medicare accounts for 120 days while non-Medicare accounts were collected on for only 90 days before being returned to the hospital for write off if payment arrangements had not been made. A collection agency official stated that once the agreement was implemented, the Medicare accounts: (1) were held for an extra 30 days beyond the 90-day cycle for non-Medicare accounts; and (2) did not receive additional collection letters, but would have been included with all accounts that were subject to possible random calls. After an account's 120 or 90-day collection cycle ended, the accounts were referred back to the hospital and written off before being placed indefinitely with a long-term (hard) collection agency.

According to hospital officials, the verbal agreement was implemented in about April or May 2000, although we noted these terms were not disclosed in the written contracts the hospital had with the collection agency for FY 2001. Thus, reading the terms of contracts would not have identified the collection practices that were in place. Program requirements state that 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. While the financial impact of this procedural difference was not evaluated, we believe it warrants closer audit attention in the future.

APPENDIX A

**FINANCIAL RESULTS OF AUDIT
BAD DEBTS FOR YEAR
ENDED JUNE 30, 2000**

	<u>Amount</u>	<u>Notes</u>
Bad Debts Claimed by Memorial Herman Hospital (hospital)	\$1,490,159	(a)
Unallowable Bad Debts Projected Per OIG Review of Sampled Claims	\$ <841,611>	(b)
Recoveries Not Fully Offset Against Claims	\$ <77,720>	(c)
Total Disallowance Recommended by OIG	<u>\$ 919,331</u>	
Allowable FY 2000 Bad Debts	<u>\$ 570,828</u>	

NOTES:

- (a) This amount was for inpatient bad debts claimed on the hospital's FY 2000 Medicare cost report dated December 14, 2000.
- (b) This amount represents our projection of the stratified sample results. (See APPENDIX C for details.)
- (c) This amount represents our estimate of Medicare recoveries that were not previously offset against the bad debts claimed for FY 2000 Medicare cost report. (See APPENDIX D for details.)

SAMPLING METHODOLOGY

OBJECTIVE

The objective of the audit was to determine whether Medicare inpatient bad debts that the hospital claimed on its FY 2000 cost report met program reimbursement requirements.

POPULATION

The hospital claimed \$1,490,159 in bad debts on its FY 2000 Medicare cost report. The \$1,490,159 consisted of 1,825 bad debts. Each line item on the hospital's bad debts list represented a bad debt. There were 40 items that were above \$2,000 and 1,785 that were \$2,000 or less.

The population is shown below:

<u>Strata</u>	<u>Number of Bad Debts</u>	<u>Dollar Amount of Bad Debts</u>
Above \$2,000	40	\$173,188
\$2,000 or Less	<u>1,785</u>	<u>\$1,316,971</u>
Total	<u>1,825</u>	<u>\$1,490,159</u>

SAMPLE UNIT

The sample unit was a bad debt resulting from unpaid deductible and coinsurance amounts.

SAMPLE DESIGN

The sample design was stratified. All items above \$2,000 were included in a separate stratum for 100 percent review. We then select an unrestricted random sample of items with values of \$2,000 or less.

SAMPLE SIZE

We reviewed all 40 bad debts that were above \$2,000 and randomly selected 100 bad debts that were \$2,000 or less.

ESTIMATION METHODOLOGY

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Stratified Variable Appraisal program for samples, we projected the amount of bad debts that were:

- supported by a token collection effort, or written off within 120 days after the patient was first billed, or both;
- written off although no efforts were made to collect from the patient;
- not settled with Medicaid or insurance prior to write off;
- paid in full by Medicaid or insurance and thus were not bad debts;
- not supported by documentation for an indigence determination; and
- not offset by recoveries from the patient after write off but prior to the fiscal year end.

APPENDIX C

STRATIFIED VARIABLE PROJECTION

SAMPLE RESULTS

The results of our review are as follows:

<u>Strata</u>	<u>Number of Bad Debts</u>	<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Errors</u>	<u>Value of Errors</u>
Above \$2,000	40	40	\$173,188	26	\$ 90,064
\$2000 and Less	<u>1,785</u>	<u>100</u>	<u>73,727</u>	<u>67</u>	<u>49,505</u>
Totals	<u>1,825</u>	<u>140</u>	<u>\$246,915</u>	<u>93</u>	<u>\$139,569</u>

STRATIFIED VARIABLE PROJECTION

Point Estimate \$973,726

90 Percent Confidence Interval

Lower Limit \$841,611

Upper Limit \$1,105,841

APPENDIX D

ESTIMATED BAD DEBT RECOVERIES NOT OFFSET AGAINST INPATIENT BAD DEBTS CLAIMED FOR FY 2000

COMPUTATION OF RECOVERY ADJUSTMENT

Total Medicare Bad Debts Recovered in FY 2000	\$ 454,065
Total Medicare Bad Debt Write Offs for FY 2000	<u>\$3,466,142</u>
Ratio of Medicare Recoveries to Write Offs	13.10%
Medicare Inpatient Bad Debt Claims Net of Unallowable Bad Debts Per OIG Review of Claims ³	<u>\$ 648,548</u>
Estimated Recoveries ⁴ Received in FY 2000	\$ 84,960
Less: Adjustment for Recoveries Partially Offset by Hospital Against Inpatient Bad Debts Claimed	<u>\$ 7,240</u>
Estimated Recoveries Received in FY 2000 Not Offset Against Bad Debts Claimed	<u>\$ 77,720</u>

³ This amount was computed by taking the \$1,490,159 in total Medicare inpatient bad debts claimed by the hospital for FY 2000 minus \$841,611 for estimated unallowable Medicare bad debts per our sample projection at Appendix C.

⁴ The recovery estimation was based on a methodology prescribed by the hospital's fiscal intermediary.

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August 8, 2002

BY FACSIMILE AND FEDERAL EXPRESS

Gordon L. Sato
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services
1100 Commerce, Room 6B6
Dallas, TX 75242

**Re: Memorial Hermann Hospital Bad Debt Audit
FYE 6/30/2000
Common Identification No. A-06-02-00027**

Dear Mr. Sato:

Our client Memorial Hermann Hospital ("MHH") is in receipt of the draft report and letter from you dated June 5, 2002, regarding the OIG audit of inpatient bad debt for FYE June 30, 2000. The following constitutes the written comments and formal response of MHH to the draft report. We understand that this response will be summarized in the OIG's final report, and will be included in its entirety as an appendix to that report when it is made public and posted on the OIG website.

As you may be aware, in accordance with your June 5 letter MHH contacted Mr. William Shrigley and Ms. Sonia Feist of the Office of Inspector General following receipt of that letter. The purpose was to bring to their attention informally some additional facts and information which MHH believed should be considered by your office, and which would modify substantially the proposed conclusions in the draft report. Pursuant to discussions with Mr. Shrigley, additional time was given to submit that information, and MHH submitted detailed spreadsheet data and other supporting documents to Ms. Feist and Mr. Shrigley. MHH also requested the opportunity to discuss this information with Ms. Feist or Mr. Shrigley.

* See OIG auditor's note on page 19 of this appendix.

* See auditor's note.

Following submission of that information, however, I received a call on August 1 from Ms. Feist, who informed me that only a single additional account would now be allowed out of the 94 disallowed sample accounts. In attempting to discuss our other arguments with Ms. Feist, I was simply informed several times by her that the recommendation on that one account was

20039770.2

Gordon L. Sato
August 8, 2002
Page 2

being changed. I was unable to have a more substantive discussion with her regarding the merits of the other information presented by MHH. She also stated (as clarified in a subsequent call) that MHH's final response must be submitted by Friday, August 9.

Accordingly, MHH requests that this response be reviewed independently within your office before a final report is issued. Although there were some accounts in the sample that MHH agrees not to contest, the additional facts and legal principles presented in this response demonstrate that the approaches taken by the auditors in the draft report for certain major categories of data are based upon erroneous legal suppositions or upon incomplete facts. We continue to believe that it would be useful to have a substantive discussion regarding these issues before the report is finalized. For the reasons that follow, MHH maintains that with only a few exceptions the bad debts reviewed by the OIG were both allowable and supported by proper documentation.

MHH was provided with a draft schedule of sampled Medicare bad debts by Ms. Feist in May of 2002. Each sample account was given an identifying number, and categorized as either "strata 1" (above \$2000) or "strata 2" (\$2000 or less). In that schedule, and in the draft report, the disallowed bad debt claims were categorized as follows:

- "65 claims that were (1) written off although a token effort was made to collect from patients, or (2) written off within 120 days after patients were first billed, or (3) both." This category is further broken down on the schedule as "token collection effort and accounts written off prior to 120 days" (57 claims) and "claims with 35 or more day period with no collection effort" (8 claims).

* See auditor's note.

- "11 claims that were written off although no effort was made to collect from patients."

- "9 claims that were written off although a token effort was made to collect from patients during the first 120 days after the patient's last payment."

- "5 claims that were not settled with Medicaid or insurance prior to writeoff."

In addition, the draft report stated that there were four accounts that were either paid in full, not offset by patient payments, or not supported by indigence documentation. It also asserted that there was a \$60 recovery that was not offset, and that bad debt recoveries related to claims written off in years prior to FY 2000 had not been properly offset. Several recommendations were also made in the draft report.

MHH does not contest the treatment in the draft report of the five accounts that were categorized as not settled with insurance prior to writeoff. It also does not contest the four accounts that were categorized as paid, not fully offset, or not supported by indigence documentation. An additional 10 out of 11 accounts for which there was allegedly no effort to collect are not contested (see Part II, below). Thus, there are 19 accounts out of the sample of 140 which are not contested. The other categories, comprising the largest groups of accounts, 20039770.2

Gordon L. Sato
August 8, 2002
Page 3

will be addressed in the order in which they are presented in the draft report. The recommendations are discussed in the final section of this letter.

I. Alleged token collection efforts/120 day period

A. Claims for which collection effort was allegedly “token,” claims written off in less than 120 days, or both

For 57 of the 65 claims, the draft report states that the collection effort was only token, that the claims were written off in less than 120 days, or that both of these conditions were true. (See Part I.B, below, for discussion of the additional eight claims to which a “35 day” rule was applied).

The spreadsheet attached as Attachment 1 provides a listing of the 57 accounts that were included in this category in the draft schedule provided by Ms. Feist, and sets forth additional information regarding those accounts. They are in the same order as the accounts on the draft schedule, and are listed by the same sample identifier number as on the draft schedule. (Attachment 1 also contains similar information for the other categories of accounts that are being disputed by MHH in this letter.)

* See auditor's note.

1. 120 day principle

Of the 57 claims, the first (30) listed on the draft schedule (beginning with sample no. 4, and ending with sample no. 40) are identified with a code of 6a, 6b, 6c, or 6d as the “primary condition code.” All of these codes mean that the debt was written off internally on MHH’s books in fewer than 120 days. However, contrary to what the auditors apparently presumed, writing off a deductible or coinsurance amount prior to 120 days after the first bill does not disqualify that amount from being properly claimed as a bad debt on the Medicare cost report.

The bad debt regulation (42 C.F.R. § 413.80) and the Medicare manual provision defining bad debts (PRM-I, § 308) specify the same four criteria for when a debt is an allowable bad debt. First, the debt must be related to covered services and be derived from deductible and coinsurance amounts. Second, reasonable collection efforts must have been made. Third, the debt was actually uncollectible when claimed as worthless. Fourth, sound business judgment established that there was no likelihood of recovery in the future.

The 120 day rule is simply a presumption that allows a debt to be considered uncollectible if it remains unpaid for more than 120 days. PRM § 310.2 states:

Presumption of Noncollectibility. If 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.

Two things should be noted about this provision. First, it is not mandatory. It is a “one-way” presumption that allows a provider to claim as bad debts those amounts remaining unpaid

Gordon L. Sato
August 8, 2002
Page 4

for more than 120 days after the first bill is sent, provided that reasonable collection efforts have been made. There is no requirement that a debt be more than 120 days old before it is written off on the provider's books, or before it is claimed as a bad debt on the Medicare cost report. The 120 day presumption is simply a convenience that permits debts older than that 120 day "bright line" to automatically be considered uncollectible. Second, this provision says nothing about the hospital's internal write-off policies or practices for turning active accounts receivable to bad debt. It does not state that the hospital must or must not write off certain accounts before or after 120 days, or what the effect would be if it does or does not do so. Only two things are important under § 310.2: First, has the debt remained unpaid for more than 120 days? Second, have there been reasonable collection efforts? If so, when the time comes to prepare the Medicare cost report, the debt may be considered uncollectible.

The Provider Reimbursement Review Board, in a decision affirmed by the Administrator of HCFA (now CMS), specifically addressed whether the 120 day rule acts as a bar to claiming bad debts written off prior to 120 days. The Board and HCFA Administrator concluded that the rule does not have that effect. Lourdes Hospital v. Blue Cross and Blue Shield Association/AdminiStar of Kentucky, PRRB Dec. 95-D58 (Aug. 31, 1995), *aff'd* by Adm'r Dec. 95-D58, 95-D59, 95-D60 (Oct. 25, 1995). The Intermediary argued before the PRRB that the Intermediary "has consistently followed a policy of disallowing bad debts held less than 120 days from the date of the first billing." The PRRB held that "the Intermediary's application of HCFA Pub. 15-1 § 310.2 [the 120 day provision] as the sole basis to disallow the Provider's bad debts was improper." The Board found that "section 310.2 is merely a guideline for establishing reasonable collection efforts and non-collectibility." It held that "other factors delineated in [the bad debt regulation and manual provision] also must be considered." The bad debts in that case, though written off prior to 120 days, were considered worthless based upon the historical experience of the provider. Among other things, the Board noted that for the provider in that appeal Medicare accounts generated only a 13-15% rate of recovery, thereby showing the worthlessness of the debts. For MHH in FY 2000, the Medicare recovery rate was 13%, as noted in Appendix D to the draft report.

The Administrator in the Lourdes Hospital appeal agreed that "for debts claimed in 120 days or less from the first billing, no presumption of noncollectibility exists but, rather, the provider must establish that the debts are actually uncollectible." On the facts above, the Administrator agreed that "the debts were uncollectible."

Similarly, in King's Daughters' Hospital v. Blue Cross and Blue Shield/Blue Cross and Blue Shield of Kentucky, Inc., PRRB Dec. No. 91-D5 (Nov. 14, 1990), the provider contended that the bad debts at issue had not been recovered after the cost year in question. Therefore, it contended that "subsequent events demonstrate that the claimed bad debts were actually uncollectible when claimed as worthless." The Board held for the provider, noting that "the Provider's bad debts which it wrote off in less than 120 days from the date of its initial billing to patients should be allowed." It held that "the Intermediary's application of PRM section 310.2 (Presumption of Noncollectibility) to disallow the under-120 day bad debt write offs is incorrect." That section, the Board opined, is "merely a guideline." The Provider "has met all of the...criteria except the 120 day requirement." Because it made reasonable collection efforts,

Gordon L. Sato
August 8, 2002
Page 5

“the Provider has met all of the regulatory requirements of [the regulation] even though the bad debts were written off in less than 120 days,” and therefore the Intermediary’s disallowance of the bad debt was reversed. The HCFA Administrator reached a similar result in the Administrator’s review of Scotland Memorial Hospital v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of North Carolina, PRRB Dec. No. 84-D174 (Sep. 12, 1984), aff’d by Adm’r Dec. 84-D174 (Nov. 8, 1984). In that case, the Administrator affirmed the Board’s allowance of bad debts that were turned over to a collection agency when they “were 107 to 120 days delinquent.”

Accordingly, the 120 day principle enunciated in PRM-I, § 310.2 cannot be used to disallow bad debt. If the debt is uncollectible, and reasonable efforts to collect it were made, it is allowable as bad debt. The critical fact here is that none of these debts were collected by the hospital. As shown on Attachment 1, extensive efforts (including collection agency efforts) were made to collect these accounts, and those efforts were unsuccessful. The efforts are summarized in detail in Part I.A.2., below. Therefore, the accounts should be treated as allowable bad debts for Medicare purposes.

2. Genuine rather than “token” collection effort

The draft report purports to disallow many of the 57 claims in this category on grounds that the collection effort was only “token,” and not a genuine effort at collection. Condition codes 7e, 7f, 7g, and 7h were applied to accounts where, according to the draft report, the efforts to collect were “spread intermittently” over varying periods less than 120 days from the first bill date. These were “additional” codes for the first 30 of the 57 accounts, and “primary” codes for the final 27 accounts. (That is, there was no 120 day issue identified for the final 27 accounts.) However, reasonable collection efforts were made for almost all of these claims, and those efforts cannot be considered to be merely “token” by any legitimate construction of that word.

The applicable Medicare manual provision, PRM-I, § 310, first states the fundamental criterion:

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.

This provision is met. There was no contention in the draft report that MHH employed a different level of effort to collect Medicare amounts than was used for comparable amounts for non-Medicare patients.¹ The manual then continues:

¹ The draft report states that there was a slight difference, implemented at the very end of fiscal year 2000, in how long Medicare accounts were held by the first agency before being returned to the hospital. However, there was no allegation that the actual collection efforts themselves were different, and this system implementation issue had no effect on the draft report’s treatment of bad debts for FY 2000.

* See auditor’s note.

Gordon L. Sato
August 8, 2002
Page 6

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.

This provision is also met with respect to the 57 claims, and the draft report does not contend that bills were not sent as described. Finally, the manual states:

It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort.

For virtually all of the 57 claims, there were subsequent billings, letters, calls, or other contacts. No specific number of contacts is specified by the manual for a collection effort to be considered reasonable. However, we note that the draft report apparently considered four contacts (counting the first bill), evenly spaced in time, within the first 120 days, to be a reasonable effort.

The fundamental problem with the disallowance of the 57 claims (apart from the 120 day issue discussed above) is that the auditors simply did not consider all of the collection efforts in which MHH engaged. The original bills were sent to the patient or other responsible party by an outside agency known as ACS on behalf of MHH, and the first follow up contacts were made by ACS. (This was true for both Medicare and non-Medicare patients). If the account was returned without being collected, it was then generally sent to a second agency. Three agencies, known as FMA, Triad, and RMA were employed by MHH for this purpose. Some accounts were referred to a third agency, either NCO or Equifax.

The auditors did not consider efforts by the second and third agencies in determining whether a genuine (rather than token) collection effort had been made. They also did not consider these efforts in determining whether the account was uncollectible—the fundamental test for determining allowable bad debt. As shown on the attached spreadsheet, for the 57 accounts disallowed, only five accounts had two or fewer collection efforts documented. Three accounts had three efforts documented. Of the eight accounts with fewer than four efforts, we note that for five accounts (sample nos. 18, 85, 36, 78 and 100) mail sent to the patient's billing address was returned (indicated by "MR" in the "Notes" column on Attachment 1). For another one of those eight accounts, the patient was noted to be deceased. See note to sample no. 89 on Attachment 1. It was certainly reasonable to have somewhat fewer efforts where the results of those efforts were that the patient could not be contacted. For only two accounts (sample nos. 29 and 56) out of the 57 disallowed were there fewer than four efforts and no documentation that the patient could not be contacted.

Virtually all of the accounts—49 out of 57—had four or more efforts, and often many more. The median number of collection efforts for the first and second agencies combined for the 57 disallowed claims was seven, and for all three agencies the median

Gordon L. Sato
August 8, 2002
Page 7

number was nine efforts. The mean number of efforts for the first two agencies was 7.5, and the mean number for all three agencies was 10.5. Sixteen of the 57 claims had a dozen or more collection efforts.

Thus, for these 57 disallowed accounts, 55 had either four or more efforts or an explanation why further efforts would have been fruitless (patient deceased or could not be located because mail returned). Furthermore, for these 57 accounts as a whole, the average number of collection efforts was nine (median) or 10.5 (mean). For each specific account, and for the group of 57 as a whole, this cannot be considered a “token” effort at collection. This was a genuine effort by MHH to collect the deductibles and coinsurance. The auditors simply failed to count the efforts by the second and third agencies, apparently on the erroneous assumption that only efforts prior to 120 days were relevant. Although MHH personnel explained quite clearly to the auditors that accounts were referred to collection agencies after the “early out” agency (ACS), and offered to provide data on those efforts by the second and third agencies, the auditors refused to look at that data.

It is not the law, however, that only collection efforts within the first 120 days are counted in determining whether the collection effort is genuine rather than “token.” As the case law discussed above makes clear, the totality of collection efforts must be looked at, both in determining reasonable collection efforts, and in establishing whether the debt was actually uncollectible. Furthermore, the auditors considered recoveries in FY 2000, all of which (by definition) are the result of collection efforts after the writeoff. If MHH did not engage in collection efforts after the writeoff, there would be no recoveries. Those later collection efforts must therefore be considered as part of the overall effort made by the hospital to collect the bad debts. They cannot be ignored simply because those efforts went on beyond 120 days. See Methodist Hospital of Dyersburg v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Tennessee, PRRB Dec. No. 2000-D56 (May 30, 2000) (in upholding provider’s bad debt claims, “the Board also notes evidence presented by the Provider that indicates that bad debt recovery efforts continued beyond the 120 day time line, as documented by the recoveries made by Consolidated Recoveries”).

Even if only efforts prior to the writeoff date could be counted (which, again, is not the law), the draft report still contains substantial errors. For nearly half of the 57 claims (24 of 57), four or more efforts were documented prior to the writeoff date. These claims are identified in the “1st Agency Efforts No.” column in Attachment 1. It is unclear why the auditors did not count all of these efforts, or considered them to be “token.” These contacts all consisted of bills or telephone calls, which are expressly considered to be the kinds of efforts that constitute genuine collection efforts under PRM § 310.

In sum, except for two accounts, all of the 57 accounts clearly had a genuine collection effort, not a “token” effort. The accounts were uncollectible, and the 120 day rule cannot be applied to disallow them. In response to MHH’s earlier submission, Ms. Feist agreed to reverse the disallowance of one account (strata 2, no. 43) falling into this category. For the reasons stated, MHH believes that the other 54 accounts should be allowed as well.

Gordon L. Sato
August 8, 2002
Page 8

B. "35 day" period with no collection effort

An additional 8 claims (which, when added to the 57 claims discussed above, total to the 65 claims for which collection effort was allegedly insufficient) were disallowed by the draft report on grounds that there was "a 35-day or more period of time (during the first 120 days after the patient's first billing) when no effort to collect from the patient was made." Draft report, p. 6. There are three principal problems with the disallowance of these 8 claims.

First, there is no requirement in the Medicare statutes, regulations, manuals, administrative decisions, or judicial case law stating that bad debt is not allowable if a 35 day period is allowed to elapse without a collection effort. We have reviewed the Medicare legal authorities on this point, and find no such requirement. Consequently, these accounts should not be disallowed retrospectively on grounds that are not contained in the applicable law.

Second, the auditors apparently based this requirement on an interpretation of what they believed to be MHH's bad debt policy. The draft report states that the hospital's policy required that "collection effort of some type must take place on a consistent basis for 120 days from the date the patient was first billed" before the debt could be considered uncollectible. From this policy, the auditors apparently devised their own rule that collection effort was not "consistent" if more than 35 days were allowed to elapse between efforts prior to writeoff.

However, the policy on which the auditors based this requirement was not MHH's policy, but instead was a policy that related only to two smaller hospitals (Katy and Fort Bend) that Memorial Hermann Hospital System had acquired from Columbia/HCA a few years ago. When the auditors first came on site, they requested copies of bad debt policies. Hospital personnel provided a number of policies, some of which related to other hospitals within the system. The policy on which the auditors based the 35 day requirement does not state that it was applicable to MHH, and hospital personnel never stated that it was. The auditors did not inquire as to which policy was in effect at MHH. The policy specifically applicable to MHH was included in what was provided to the auditors, and it clearly is identified as the Hermann policy. To document this fact, both of these policies were provided to Ms. Feist and Mr. Shrigley in our prior informal submission.

Accordingly, the 35 day "rule" was derived from a policy for a different hospital than the one that was audited. The MHH policy contains no such requirement, and no "consistency" requirement.

Third, the Secretary is prohibited from imposing new requirements to disallow bad debt. In 1987, Congress passed § 4008(c) of Pub. L. 100-203 ("OBRA 1987"), which (as amended) provided that:

In making payments to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of services for reasonable costs relating to

Gordon L. Sato
August 8, 2002
Page 9

unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort), including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency.

That statute also prohibited the Secretary from requiring certain changes in a hospital's bad debt collection policy if the FI had accepted the policy on August 1, 1987, and prohibited the Secretary from collecting from a hospital on the basis of an expectation of a change in the hospital's bad debt collection policy.

In short, the Secretary, cannot add new requirements for bad debt to be considered allowable after 1987. Unlike certain other jurisdictions, this statute has been specifically upheld and enforced in the United States Court of Appeals for the Fifth Circuit, which has jurisdiction over Texas. Harris County Hospital District v. Shalala, 64 F.3d 220 (5th Cir. 1995). The PRRB and Administrator have applied the provisions of OBRA 1987 and the Harris County case to bad debt appeals arising in Texas, and reversed the Intermediary's disallowance of bad debt on that basis. Baptist Memorial Hospital System v. Blue Cross and Blue Shield of Texas, PRRB Dec. No. 97-D11 (Dec. 2, 1996); aff'd by Adm'r Dec. No. 97-D11 (Jan. 28, 1997). Copies of the Harris County case and other cases cited in this response were provided to Ms. Feist and Mr. Shrigley.

Accordingly, the draft report is in error in purporting to apply a 35 day rule that is nowhere contained in the governing Medicare law, is not founded on the hospital's policy, and is contrary to the specific prohibitions of OBRA 1987, § 4008(c) as passed by Congress.

II. No effort to collect from patients

The draft report disallowed 11 accounts on grounds that there was no effort to collect from the patients. MHH does not contest 10 of the 11 disallowances, but notes that there were fifteen collection efforts on one of these accounts (sample no. 84). See Attachment 1. It is also listed as a "mail return" account. This account should therefore be allowed.

III. Accounts written off within less than 120 days after last payment from patient

The draft report also disallowed nine claims in which only a "token" effort was allegedly made to collect from the patient "during the first 120 days after the patient's last payment."

For these accounts, the auditors took the position that the 120 day period begins anew after the last payment from the patient, and that there must be reasonable collection efforts extending over that "restarted" time period. The draft report states that "collection effort was considered to be reasonable and genuine, rather than token, using the 120-day and 35-day criteria discussed previously, except measuring the effort after the last patient payment rather than the first billing." Draft report, p. 7.

Gordon L. Sato
August 8, 2002
Page 10

Once again, the disallowance of these accounts is in error for several reasons.

First, the governing Medicare rules do not provide for “restarting the clock” on the 120 period following the last payment. The 120 day period is measured from the date the first bill is sent to the patient. PRM-I, § 310.2. Applying a different rule is not in accordance with law.

Second, as discussed above, the 120 day period only provides a presumption of uncollectibility. It is not a basis for disallowing bad debts and, as demonstrated above, the determination as to whether the hospital engaged in reasonable collection efforts is not limited to efforts conducted within the 120 day period, if the debt is in fact uncollectible.

Third, the hospital engaged in reasonable collection efforts for these nine accounts. As shown on Attachment 1, the total number of collection efforts for seven out of nine of these accounts ranged between three and twelve efforts. The mean number of efforts for all nine accounts was five efforts. This was not a token effort, and these accounts were uncollectible.

Fourth, as with the “35 day” principle discussed above, any new rule that the clock must be “restarted” after the last patient payment is prohibited by § 4008(c) of Pub. L. 100-203. The Secretary is prevented by that statute from changing the rules on reasonable collection efforts for bad debt to differ from what those rules provided in 1987. There was no “restart” rule in 1987, there is no such rule now, and the Secretary cannot add such a rule because of the legal prohibitions imposed by § 4008(c).

IV. Offset of recoveries

The draft report proposes to offset an additional \$75,860, which represents estimated recoveries received in FY 2000 that had allegedly not been offset by MHH. This figure was arrived at by first calculating a ratio of “total Medicare bad debts recovered in FY 2000” (\$454,065) to “total Medicare bad debt writeoffs for FY 2000” (\$3,466,142), which computes to be 13.10%. See Appendix D of draft report. This 13.10% figure is then applied to the allowable inpatient bad debt claims per OIG review (\$634,354) to arrive at a figure of \$83,100, representing “estimated recoveries received in FY 2000.” The offset of \$7,240 by the hospital is then subtracted, to arrive at the additional offset of \$75,860.

* See
auditor’s
note.

MHH believes this approach is flawed, because the draft report proposes to offset “recovery” amounts for which MHH has not been paid. All but a few hundred dollars of the \$454,065 in alleged “recoveries” resulted from patient services rendered in FY 1994 or thereafter. For fiscal years 1999 and 1998, no audit has yet been performed by the fiscal intermediary, so it is unknown for how many of these “bad debts” MHH may ultimately be reimbursed. As noted below, MHH became part of the Memorial system only at the end of calendar year 1997. The 1997 fiscal year has been field audited, but no Notice of Program Reimbursement has been issued. For 1994, 1995, and 1996, only modest amounts of Medicare bad debt were paid compared to the total Medicare bad debts written off on the hospital’s books. (MHH disagrees with the treatment of bad debt in many of these years, and has appealed or will

Gordon L. Sato
August 8, 2002
Page 11

appeal that issue administratively). Accordingly, the draft report proposes to offset "recoveries" of amounts that were never reimbursed by Medicare.

MHH posts recoveries to individual patient accounts. Rather than using an estimate based upon recoveries of bad debts that may have never been reimbursed, the more accurate methodology is to do a claim by claim comparison of the recoveries for FY 2000 to actual claims that were reimbursed as bad debt in prior years, after those prior years are audited and settled. The additional offset of \$75,860 should therefore be removed from the draft report.

V. Conclusion and response to recommendations

In summary, with the exception of two out of the 65 accounts which were disallowed on grounds of the 120 day rule and/or "token" collection efforts, the debt was uncollectible and reasonable collection efforts were made. Therefore, 63 of those 65 bad debt accounts should be allowed. One account of the 11 disallowed for no collection efforts should be permitted as bad debt. Similarly, the 9 accounts that were disallowed on grounds of the "restart" of the 120 day period should be allowed for the reasons stated. The offset of recoveries also should be modified as described above.

In the draft report, it is recommended that MHH amend the 6/30/00 cost report to reflect the findings contained in that report. In this regard, MHH notes that it disagrees, as described above, with many of those findings, and requests in this response that those findings be modified. Accordingly, the final course of action by MHH in this regard cannot be determined until the report is finalized. As confirmed to me by Mr. Shrigley, the allowable bad debt for this cost year will ultimately be adjudicated by the Medicare fiscal intermediary, Trailblazer Health Enterprises, with appeal rights thereafter.

The draft report recommends that inpatient bad debt be allowed in an amount in excess of the amount that the Medicare fiscal intermediary has allowed in the tentative settlement of the FY 2000 cost report. The OIG has calculated that a net amount of ~~(\$558,494)~~ should be allowed for Medicare inpatient bad debt. Based on the tentative settlement workpapers provided by Trailblazer, MHH calculates that TrailBlazer allowed and paid just over \$67,000 related to Medicare inpatient bad debt in the tentative settlement.

* See
auditor's
note.

As noted above, MHH does not contest the OIG's conclusion for 19 accounts out of the 94 accounts that the draft report recommended be disallowed. At the time the FY 2000 cost year is field audited by the fiscal intermediary, MHH will remove these accounts from the bad debt listing to be provided to Trailblazer. Removal of these accounts will result in a very small reimbursement impact. Accordingly, MHH will send a letter to Trailblazer proposing that when the FY 2000 cost report is audited, these accounts will not be included in the MHH inpatient bad debt listing, but that no amendment to the cost report should be necessary at this time. If this arrangement or an alternative arrangement is not acceptable to TrailBlazer, then MHH will file an amended cost report, and would also expect to receive an additional tentative settlement from

Gordon L. Sato
August 8, 2002
Page 12

TrailBlazer of at least \$491,000. This amount is based on the \$558,494 regarded as allowable by the draft report, less the \$67,000 paid on the tentative settlement.

The draft report also recommends that MHH implement procedures to ensure that (1) a reasonable collection effort is made to collect before debts are presumed to be uncollectible, (2) all Medicare debts are billed to patients prior to write off, (3) bad debt claims are properly offset, and (4) indigence determinations are adequately documented.

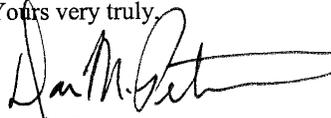
In this regard, please note that Hermann Hospital became part of the Memorial system less than two years prior to the beginning of the FY 2000 cost year. Accordingly, Hermann utilized different software and a different revenue system than did other MHHS hospitals. MHH also had a separate business office at that time. Consolidation under one business office was accomplished near the very end of FY 2000. Accordingly, changes have been made in some aspects of the manner in which MHH manages and accounts for bad debts, including Medicare bad debts.

As noted above, MHH believes that it does make reasonable collection efforts (averaging 9 or 10 efforts even on the sample of disallowed accounts). The time until writeoff has also been extended to help ensure that the 120 day presumption is met. Generally, Medicare debts are billed to patients prior to writeoff. Bad debt recoveries are offset. Indigence determinations were at issue in only one of the sampled claims, but MHH notes that its indigence policies are updated to match federal poverty guidelines when those are changed.

In summary, MHH would urge the OIG to take the information in this response into account, and to modify the draft report accordingly. If you are willing to discuss this response, or if there is any other information that you may need, please let me know. My direct line number is (202) 662-4610.

We appreciate your taking the time to review this matter.

Yours very truly,



Dan M. Peterson

Attachment

cc: H. Jeffrey Brownawell (MHHS)
William Shrigley (OIG)
Sonia Feist (OIG)

20039770.2

ATTACHMENT 1

Note 1: Dates are incorrect. Hospital accounts receivable records indicate NCO collection agency was not used until May 2001.

MEMORIAL HERMANN HOSPITAL - AUDIT OF OIG RESULTS OF INPATIENT BAD DEBTS CLAIMED FOR FISCAL YEAR JUNE 30, 2000

Strata #1 #2	Amount Reviewed	1st Addtl Code	Last Pat. Pay Date	NOTE	1st Agency	1st Agency Date (init letter)	1st Agency Flup Date	1st Agency Efforts No.	W/O Date	Days from Init. Letter to W/O Date	NOTE	2nd Agency	2nd Agency Flup Date	1st and 2nd agency efforts no.	NOTE	3rd Agency	3rd Agency Flup Date	All agency efforts no.		
						letter	phone					letter	phone			letter	phone			
Token Collection Effort and Accounts Written Off Prior to 120 Days																				
4	768.00 6d 7f				ACS	05/23/1999	05/23/1999	4	09/14/1999	114		RMA		4				0	4	
						06/23/1999														
						07/18/1999														
2	6528.00 6d 7g				ACS	01/01/2000	02/11/2000	6	04/25/2000	115		RMA	05/04/2000	9		NCO	07/09/2001	2	11	
						03/01/2000							06/05/2000							
						02/24/2000	03/18/2000													
3	2888.00 6d 7g				ACS	05/09/1999	05/09/1999	3	08/31/1999	114		RMA	09/14/1999	9		NCO	07/09/2001	4	13	
						06/08/1999							02/21/2001							
						07/12/1999							10/23/1999							
													11/18/1999							
13	1920.00 6d 7g				ACS	01/30/2000	02/25/2000	8	05/23/2000	114		RMA	05/31/2000	18		NCO	07/09/2001	6	24	
							03/01/2000						06/30/2000							
						02/27/2000							09/26/2000							
						04/02/2000	04/07/2000						07/31/2000							
						04/20/2000	04/10/2000						02/16/2001							
													02/21/2001							
													10/23/2000							
15	768.00 6d 7f				ACS	02/23/2000	04/10/2000	7	08/13/2000	111		RMA	06/20/2000	19		NCO	07/09/2001	3	22	
						03/23/2000	04/10/2000						08/01/2000							
						04/20/2000	04/13/2000						08/03/2000							
							04/13/2000						10/03/2000							
													02/21/2001							
													09/11/2000							
													09/25/2000							
24	758.00 6d 7e				ACS	07/21/1999	07/23/1999	3	10/27/1999	98		NCO	10/05/2000	9		FMA	11/02/1999	2	11	
						08/10/1999	08/03/1999						10/22/2000							
													03/07/2001							
													11/22/2000							
27	768.00 6d 7g				ACS	02/09/2000	03/01/2000	8	06/06/2000	118		RMA	06/13/2000	19		NCO	10/12/2001	1	20	
						03/09/2000	03/10/2000						07/14/2000							
						04/08/2000	03/27/2000						08/14/2000							
							04/10/2000						02/21/2001							
							04/13/2000						02/23/2001							
													07/06/2000							
29	373.66 6b 7e				ACS	10/03/1999	10/03/1999	1	11/01/1999	29		RMA	10/28/1998	2		Agcy Z		0	2	
37	768.00 6d 7f				ACS	01/01/2000	01/01/2000	3	04/25/2000	115		FMA		3		NCO	02/09/2001	1	4	
							02/24/2000													
							02/24/2000													
11	5376.00 6d 7f				ACS	01/01/2000	01/01/2000	3	04/25/2000	115		FMA	05/02/2000	6					6	
							02/01/2000						08/17/2000							
							02/24/2000													
13	2688.00 6d 7f				ACS	03/01/2000	03/01/2000	2	06/20/2000	111		RMA	06/27/2000	5		NCO	02/09/2001	6	11	
							04/28/2000						07/12/2000							
18	2016.00 6d 7g-11				ACS	02/09/2000	03/01/2000	3	06/06/2000	118		FMA		3					0	3
							02/24/2000													

6. W/O to BD from bill date. 6a. 0-30, 6b. 31-60, 6c. 61-90, 6d. 91-120
7. token effort. Effort to collect. 7e. Spread intermittently 0-30 days from 1st bill date. 7f. 31-60 days. 7g. 61-90 days

MEMORIAL HERMANN HOSPITAL - AUDIT OF OIG RESULTS OF INPATIENT BAD DEBITS CLAIMED
FOR FISCAL YEAR JUNE 30, 2000

Strata #1 #2	Amount Reviewed	1st Code	Addtl Code	Last Pat. Pay Date	NOTE	1st Agency Date (init letter)	1st Agency Flup Date letter phone	1st Agency Efforts No.	W/O Date	Days from Init. Letter to W/O Date	NOTE	2nd Agency letter	2nd Agency Flup Date letter phone	1st and 2nd agency efforts no.	NOTE	3rd Agency letter	3rd Agency Flup Date letter phone	3rd agency efforts no.	All agency efforts no.
59	765.00	6d	7g			ACS 01/13/2000	02/11/2000 02/11/2000	6	05/09/2000	117		FMA		6				0	6
							02/14/2000 03/01/2000												
							03/13/2000 04/07/2000												
61	764.00	6a	7e			ACS 10/14/1999	11/03/1999 11/03/1999	6	11/02/1999	19		FMA	10/15/1998 02/17/2001	10				0	10
							09/13/2000 09/13/2000						01/02/2001 02/26/2001						
							12/04/2000 10/02/2000						12/18/2000 01/16/2001						
63	764.00	6a	7e			ACS 10/14/1999	11/03/1999 11/03/1999	2	11/02/1999	19		FMA	02/28/2001 02/28/2001	9				0	9
													07/17/2001 07/17/2001						
													02/28/2001 02/28/2001						
20	3056.00	6d	7e		MR	ACS 11/07/1999	11/07/1999 11/07/1999	1	02/08/2000	93	MR	FMA	02/17/2000 03/23/2000	3	NCO	09/25/2001	07/10/2001	1	4
21	2888.00	6d	7g		MR	ACS 04/07/1999	04/07/1999 04/07/1999	3	08/04/1999	119		FMA	08/20/1999 09/17/1999	8			07/11/2001	0	8
							05/20/1999						09/20/1999 09/21/1999				07/16/2001		
							06/01/1999						10/21/1999				07/18/2001		
24	2015.40	6c	7g			ACS 05/09/1999	05/09/1999 05/09/1999	3	07/27/1999	79		RMA	08/17/1999 11/03/1999	6	NCO	07/09/2001	07/10/2001	5	11
							06/08/1999						04/17/2000				07/11/2001		
							07/12/1999										07/16/2001		
28	14975.00	6d	7g			ACS 05/27/1999	05/27/1999 08/03/1999	5	09/21/1999	117		FMA	09/28/1999	6				0	6
							06/28/1999 06/19/1999												
							07/29/1999												
83	153.60	6d	7g			ACS 07/18/1999	10/12/1999 10/12/1999	4	10/19/1999	93		FMA	10/26/1999 02/18/2000	6	NCO	09/25/2000 03/13/2001	03/12/2001	25	31
							08/17/1999										10/04/2000		
							09/09/1999											03/16/2001	
																		03/19/2001	
																		03/20/2001	
																		x18 addtl	
85	765.00	6b	7e		MR	ACS 06/20/1999	06/20/1999 06/20/1999	1	08/10/1999	51	MR	FMA	08/24/1999	2			10/04/2000	0	2
86	765.00	6d	7g			ACS 07/01/1999	07/23/1999 07/23/1999	4	10/26/1999	117		FMA	11/02/1999 11/15/1999	8	NCO	10/04/2000	08/10/2001	1	9
							08/01/1999						12/02/1999						
89	765.00	6c	7f		DECEA	ACS 08/12/1999	09/01/1999 09/01/1999	3	10/29/1999	78	MR	RMA		3				0	3
							09/13/1999												
30	3648.00	6d	7g			ACS 01/09/2000	02/11/2000 02/11/2000	7	05/02/2000	114		FMA	05/09/2000 05/25/2000	11				0	11
							02/06/2000 02/25/2000						03/05/2001						
							03/06/2000 03/01/2000												
							03/10/2000												
97	765.00	6d	7g			ACS 02/03/2000	02/03/2000 02/03/2000	3	05/23/2000	110	MR	RMA	05/31/2000 07/31/2000	5	MR	02/09/2001 07/09/2001	08/10/2001	3	8
							04/18/2000												
							03/05/2000												
98	1392.50	6d	7g			ACS 07/27/1999	08/10/1999 08/10/1999	13	11/23/1999	119		RMA	12/02/1999 02/25/2000	21				0	21
							08/24/1999 08/14/1999						02/16/2000 03/23/2000						
							09/16/1999 09/18/1999						03/09/2000 03/29/2000						
							09/22/1999						03/21/2000 03/30/2000						
							09/29/1999												
							10/02/1999												
							10/07/1999												
							10/11/1999												
36	2065.50	6a	7e & 10		MR	ACS 07/18/1999	08/10/1999 08/10/1999	2	08/10/1999	23				2				0	2
38	2034.70	6d	7g			ACS 11/14/1999	11/14/1999 11/14/1999	8	03/07/2000	114		RMA	03/14/2000 03/14/2000	14				0	14

6. W/O to BD from bill date. 6a. 0-30. 6b. 31-60. 6c. 61-90. 6d. 91-120
7. taken effort. Effort to collect. 7e. Spread intermittently 0-30 days from 1st bill date. 7f. 31-60 days. 7g. 61-90 days

Note 2: We identified write off date as 10/29/1999 per hospital's records.

MEMORIAL HERMANN HOSPITAL - AUDIT OF OIG RESULTS OF INPATIENT BAD DEBTS CLAIMED FOR FISCAL YEAR JUNE 30, 2000

Strata #1 #2	Amount Reviewed	1st Addtl Code	Last Pat. Pay Date	NOTE	1st Agency	1st Agency Date (init letter)	1st Agency Flup Date letter	1st Agency Flup Date phone	1st Agency Efforts No.	W/O Date	W/O Date	Days from Init. Letter to W/O Date	NOTE	2nd Agency	2nd Agency letter	2nd Agency Flup Date letter	2nd Agency Flup Date phone	1st and 2nd agency efforts no.	NOTE	3rd Agency	3rd Agency letter	3rd Agency Flup Date letter	3rd Agency Flup Date phone	3rd agency efforts no.	All agency efforts no.	
																										7f
39	2228.45	6c	7g		ACS	11/28/1999	11/28/1999	01/13/2000	6	02/22/2000	86			FMA	03/01/2000	06/13/2000	05/03/2000	7		NCO	10/04/2000	03/03/2001	03/19/2001	15	22	
								01/11/2000								05/23/2000	06/12/2000									
								01/31/2000																		
40	2171.95	6c	7f		ACS	08/19/1999	08/19/1999	09/22/1999	4	11/23/1999	102	MR		RMA	11/18/1999	02/18/2000	11/23/1999	03/21/2000	8		Equifax	07/09/2001	07/11/2001	07/18/2001	3	11
								09/20/1999																		
								10/18/1999																		
8	768.00	7f			ACS	03/19/1999	03/19/1999	02/15/1999	3	07/20/1999	123			FMA	07/27/1999	08/16/1999	07/31/1999	08/25/1999	9		NCO	09/25/2000	03/13/2001	03/14/2001	11	20
								04/18/1999																		
								05/10/1999																		
14	152.80	7e		MR	ACS	03/19/1999	03/19/1999		1	07/20/1999	123	MR		FMA	07/12/1999	11/30/1999	11/30/1999	10/12/1999	3		NCO	10/04/2000	03/05/2001	03/05/2001	5	8
16	764.00	7g			ACS	12/29/1998	12/29/1998	02/04/1999	7	07/07/1999	190	MR		RMA	08/13/1999	10/14/1999	10/14/1999	07/10/2000	10		NCO	07/09/2001	07/10/2001	07/10/2001	2	12
								02/15/1999																		
								02/24/1999																		
17	768.00	7f		MR	ACS	11/07/1999	11/07/1999	12/08/1999	2	03/07/2000	121	MR		RMA	03/14/2000	04/26/2000	04/26/2000	08/22/2000	6		NCO	07/09/2001	07/09/2001	07/09/2001	1	7
18	748.15	7g			ACS	03/21/1999	03/21/1999	04/27/1999	7	07/20/1999	121			FMA	07/26/1999	08/05/1999	08/05/1999	08/22/2000	10							
								04/18/1999																		
								05/10/1999																		
36	768.00	7f			ACS	04/15/1999	04/15/1999	06/02/1999	3	10/13/1999	187	MR		RMA	10/28/1999	10/28/1999	10/28/1999	10/28/1999	10		NCO	07/09/2001	07/13/2001	07/13/2001	6	16
								05/16/1999																		
								08/11/1999																		
42	4224.00	7e			ACS	01/01/2000	01/01/2000	02/11/2000	4	04/25/2000	115			FMA	05/03/2000	08/17/2000	08/17/2000	04/04/2000	6							
								02/01/2000																		
								02/24/2000																		
41	191.00	7f		MR	ACS	01/24/1999	01/24/1999		1	08/04/1999	192	MR		RMA	07/19/2000	06/12/2000	06/12/2000	06/14/2000	4							
43	764.00	7e			ACS	01/24/1999	01/24/1999	02/23/1999	2	07/07/1999	164			FMA	03/16/1999	03/20/1999	03/20/1999	03/29/1999	8							
47	768.00	7f			ACS	04/22/1999	04/22/1999	05/20/1999	4	08/24/1999	124			RMA	05/28/1999	03/31/1999	03/31/1999		4		NCO		03/03/2001	03/03/2001	1	5
								06/16/1999																		
								06/16/1999																		
48	768.00	7f			ACS	10/03/1999	10/03/1999		3	02/08/2000	120	MR		RMA	02/16/2000	02/25/2000	02/25/2000	03/17/2000	9		NCO	02/20/2001	03/05/2001	03/05/2001	12	21
								10/04/1999																		
								10/26/1999																		
45	4541.40	7g			ACS	09/02/1999	09/02/1999		3	01/04/2000	124	MR		RMA	02/16/2000	03/01/2000	03/01/2000	05/03/2000	9							
								10/03/1999																		

6. W/O to BD from bill date, 6a. 0-30, 6b. 31-60, 6c. 61-90, 6d. 91-120
7. taken effort. Effort to collect: 7e. Spread intermittently 0-30 days from 1st bill date, 7f. 31-60 days, 7g. 61-90 days

MEMORIAL HERMANN HOSPITAL - AUDIT OF OIG RESULTS OF INPATIENT BAD DEBTS CLAIMED
FOR FISCAL YEAR JUNE 30, 2000

Strata #1 #2	Amount Reviewed	1st Agency Code	1st Agency	Last Pat. Pay Date	NOTE	1st Agency Date (init letter)	1st Agency Flup Date letter	1st Agency Flup Date phone	1st Agency Efforts No.	W/O Date	Days from Init. Letter to W/O Date	NOTE	2nd Agency	2nd Agency Flup Date letter	2nd Agency Flup Date phone	1st and 2nd agency efforts no.	NOTE	3rd Agency	3rd Agency Flup Date letter	3rd Agency Flup Date phone	3rd agency efforts no.	All agency efforts no.	
							10/21/1999								03/17/2000								
53	768.00	7f	ACS			09/19/1999	09/19/1999		3	01/25/2000	128		RMA		04/12/2000	4		NCO				0	4
56	764.00	7e	ACS			10/14/1999	10/14/1999		1	05/04/2000	203		Agnv Z		11/03/1999	1						0	1
70	764.00	7g	ACS			02/04/1999	02/04/1999		3	07/07/1999	153	MR	RMA	08/13/1999	10/19/1999	7		NCO	10/11/2001			1	8
						03/05/1999	03/05/1999								04/12/2000								
						04/08/1999	04/08/1999																
72	764.00	7f	ACS			02/14/1999	02/14/1999		3	07/07/1999	143	MR	RMA	08/13/1999	10/13/1999	7						0	7
						03/17/1999	03/17/1999								05/10/2000								
						04/08/1999	04/08/1999																
19	7640.00	7g	ACS	MR		01/08/1999	01/08/1999	02/04/1999	4	07/07/1999	180	MR	RMA	08/13/1999	08/09/1999	9						0	9
						02/07/1999	02/07/1999	03/24/1999							05/31/2000								
						07/08/1999	07/08/1999		1	07/07/1999	180	MR	RMA	08/13/1999	10/15/1999	4		NCO	07/09/2001	07/10/2001	x12 addtl	14	18
74	764.00	7b	ACS			01/25/1999	01/25/1999	03/03/1999	5	07/07/1999	163	MR	RMA	08/13/1999	10/22/1999	7		NCO	07/09/2001	07/10/2001		2	9
76	764.00	7f	ACS			01/25/1999	01/25/1999	03/10/1999	5	07/07/1999	163	MR	RMA	08/13/1999	10/22/1999	7		NCO	07/09/2001	07/10/2001		2	9
						02/25/1999	02/25/1999	03/10/1999							05/31/2000								
						03/22/1999	03/22/1999								08/05/2000								
78	1257.05	7e	ACS	MR		02/14/1999	02/14/1999	02/04/1999	1	05/03/2000	444		Agnv Z			1						0	1
27	2066.25	7g	ACS			01/14/1999	01/14/1999	03/01/1999	6	07/07/1999	174		FMA			6						0	6
						02/14/1999	02/14/1999	03/01/1999							08/23/1999							0	6
						03/18/1999	03/18/1999	03/15/1999							09/23/1999							0	6
81	768.00	7f	ACS			03/19/1999	03/19/1999	04/18/1999	3	07/20/1999	123	MR	RMA	08/11/1999	08/09/1999	12		NCO	08/18/2000	08/22/2000		26	38
						04/18/1999	04/18/1999								09/23/1999							0	38
						05/10/1999	05/10/1999								09/23/1999							0	38
82	768.00	7g	ACS			03/14/1999	03/14/1999	05/03/1999	6	07/20/1999	128		FMA	08/30/1999	08/23/1999	10						0	10
						03/19/1999	03/19/1999	05/17/1999							09/23/1999							0	10
						04/12/1999	04/12/1999								09/23/1999							0	10
						05/04/1999	05/04/1999								09/23/1999							0	10
91	768.00	7e	ACS	MR		10/27/1999	10/27/1999	11/18/1999	2	03/07/2000	132		FMA	03/14/2000	03/25/2000	6						0	6
						03/19/1999	03/19/1999	05/10/1999							05/02/2000							0	6
						04/12/1999	04/12/1999								05/02/1999							0	6
32	2017.30	7f	ACS	10partial		03/19/1999	03/19/1999	05/10/1999	2	07/20/1999	123		FMA	07/27/1999	07/31/1999	7		NCO				15	22
						05/10/1999	05/10/1999								08/16/1999							0	22
						03/19/1999	03/19/1999	05/10/1999							08/16/1999							0	22
34	2035.75	7g	ACS	10partial		03/14/1999	03/14/1999	05/03/1999	5	07/20/1999	128	MR	RMA	08/11/1999	08/04/1999	12						0	12
						04/29/1999	04/29/1999	05/06/1999							08/16/1999							0	12
						05/18/1999	05/18/1999								10/13/1999							0	12
						12/05/1999	12/05/1999	01/04/2000							11/10/1999							0	12
100	1669.40	7b	ACS	MR		12/05/1999	12/05/1999	01/04/2000	2	04/04/2000	121		FMA	04/10/2000		3						0	3
						01/04/2000	01/04/2000															0	3
						02/21/1999	02/21/1999	03/19/1999	4	10/28/1999	247	MR	RMA	11/18/1999	05/24/2000	11		NCO	02/20/2001	03/05/2001		8	19
23	768.00	7f	ACS			02/21/1999	02/21/1999	03/19/1999	4	10/28/1999	247	MR	RMA	11/18/1999	05/24/2000	11		NCO	02/20/2001	03/05/2001		8	19
						03/19/1999	03/19/1999	07/20/1999							07/13/2000							0	19
						07/20/1999	07/20/1999								07/13/2000							0	19

6. W/O to BD from bill date. 6a. 0-30. 6b. 31-60. 6c. 61-90. 6d. 91-120
7. token effort. Effort to collect. 7e. Spread intermittently 0-30 days from 1st bill date. 7f. 31-60 days. 7g. 61-90 days

MEMORIAL HERMANN HOSPITAL - AUDIT OF OIG RESULTS OF INPATIENT BAD DEBITS CLAIMED
FOR FISCAL YEAR JUNE 30, 2000

Strata #1 #2	Amount Reviewed	1st Agency Code	Addtl Code	Last Pat. Pay Date	NOTE	1st Agency	1st Agency Date (init letter)	1st Agency Flup Date letter	1st Agency Flup Date phone	1st Agency Efforts No.	WIO Date	Days from Init. Letter to WIO Date	NOTE	2nd Agency	2nd Agency Flup Date letter	2nd Agency Flup Date phone	1st and 2nd agency efforts no.	NOTE	3rd Agency	3rd Agency Flup Date letter	3rd Agency Flup Date phone	3rd agency efforts no.	All agency efforts no.	
30	768.00	7i	6d			ACS	03/28/1999	08/31/1999	08/22/2000	3	07/20/1999	114	MR	RMA	08/04/1999	08/22/2000	5				x4 addtl	0	5	
14	2218.56	7i				ACS	10/03/1999	10/03/1999	11/12/1999	6	04/11/2000	191		RMA			6						0	6
66	1241.00	7i				ACS	11/04/1998	11/04/1998	04/09/1999	4	05/04/2000	547		Agny Z			4						0	4
75	1916.00	7i				ACS	05/23/1999	05/23/1999	06/03/1999	5	05/30/2000	373	DECEA	RMA	06/05/2000	06/07/2000	5						0	5
25	2235.75	7i				ACS	02/04/1999	02/04/1999		1	07/07/1999	153	MR	RMA	08/13/1999	10/18/1999	5		NCO	02/09/2001	03/05/2001	19	24	
88	768.00	7i				ACS	07/11/1999	07/11/1999	08/10/1999	6	11/09/1999	121	MR	RMA	11/20/1999	05/22/2000	13						0	13
92	768.00	7i				ACS	10/17/1999	10/17/1999	11/12/1999	4	02/22/2000	128	MR	RMA	02/25/2000	08/10/2000	10						0	10
No Effort Made to Collect from the Patient Prior to Write Off																								
84	768.00		4			MIR	ACS			0	02/22/2000		MR	FMA	01/31/2000	03/10/2000	4		NCO	09/25/2001	03/05/2001	11	15	
Token Effort Made to Collect After Last Patient Payment																								
46	364.00	9n		02/12/1999		ACS	12/15/1998	12/15/1998	12/18/1998	3	05/03/2000	505		Agny Z			3						0	3
68	514.00	9n		04/12/1999		ACS		02/04/1999		0	05/04/2000			Agny Z			0						0	0
79	851.40	9n		02/17/1999		ACS	11/01/1998	11/01/1998		3	05/04/2000	550		Agny Z			3						0	3
28	2107.95	9n		10/25/1999		ACS	05/24/1999	05/24/1999	10/12/1999	4	05/04/2000	346		Agny Z			4						0	4
87	708.00	9r		09/13/1999				10/05/1999		0	01/11/2000			FMA	01/18/2000	01/21/2000	5						0	5
96	688.00	9q	8m			ACS	02/06/2000	02/06/2000		3	05/30/2000	114		FMA	06/06/2000	08/11/2000	8						0	8
51	76.40	9s		01/15/1999		ACS	12/30/1998	12/30/1998	01/08/1999	6	04/29/2000	486		Agny Z			6						6	12

Note 3: We identified the patient's last payment as 2/22/2000 per hospital records.

6.WO to BD from bill date. 6a. 0-30, 6b. 31-60, 6c. 61-90, 6d. 91-120
7.token effort. Effort to collect: 7e. Spread intermittently 0-30 days from 1st bill date, 7f. 31-60 days, 7g. 61-90 days

MEMORIAL HERMANN HOSPITAL - AUDIT OF OIG RESULTS OF INFANT PATIENT BAD DEBTS CLAIMED
FOR FISCAL YEAR JUNE 30, 2000

Strata # 1 # 2	Amount Reviewed	1st Agency Code	Addtl Code	Last Pat. Pay Date	NOTE	1st Agency	1st Agency Date (init letter)	1st Agency Flup Date letter	1st Agency Flup Date phone	1st Agency Efforts No.	W/O Date	Days from Init. Letter to W/O Date	2nd Agency	2nd Agency Flup Date letter	2nd Agency Flup Date phone	1st and 2nd agency efforts no.	NOTE	3rd Agency	3rd Agency Flup Date letter	3rd Agency Flup Date phone	3rd agency efforts no.	All agency efforts no.	
								01/03/1999	05/05/1999														
								05/17/1999															
93	768.00	95	2 part	11/05/1999		ACS	10/20/1999	10/20/1999	02/03/2000	6	02/01/2000	104	IMA	04/06/2000	04/06/2000	8						0	8
								10/26/1999															
								11/12/1999															
								12/27/1999															
								02/10/2000															
8	751.50	90		03/10/1999		ACS	02/03/1999	02/03/1999	05/24/2000	2	05/05/2000	457	Agny Z			2						0	2

* **OIG Auditor's Note:** Due to the hospital providing additional documentation subsequent to the issuance of our draft report, we determined that one questioned claim was allowable, and three claims were reclassified from one unallowable category to another unallowable category. As a result of these changes, the numbers of claims and dollars cited in the hospital's response do not always agree to the figures in our final report. This note is used the first time an amount is cited in the hospital's response that was changed for our final report.