PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2014-D5

PROVIDER –
Ashton Hall Nursing & Rehabilitation Center
Philadelphia, PA

Provider No.: 39-5110

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ Novitas Solutions, Inc.

DATE OF HEARING -
September 26, 2012

Cost Reporting Period Ended -
June 30, 2005

CASE NO.: 07-2069

INDEX

ISSUE:

Whether the Intermediary's adjustment to disallow Medicare Bad Debts on the Medicare Cost Report was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act ("Act"), as amended, to provide health insurance to the aged and disabled. The Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"), is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MAC"). FIs and MACs[1] determine payment amounts due providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[3] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[4]

A provider dissatisfied with the intermediary's final determination of total reimbursement (*i.e.*, the NPR) may file an appeal with the Provider Reimbursement Review Board ("Board") if it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[5]

BAD DEBT POLICY

In order to claim a bad debt, the regulation at 42 C.F.R. § 413.89(e) specifies that the following criteria must be met:

> (e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:
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> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.

> (2) The provider must be able to establish that reasonable collection efforts were made.
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> (3) The debt was actually uncollectible when claimed as worthless.
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> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

CMS issued additional guidance in the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1") on the second criterion requiring "reasonable collection efforts." In particular, PRM 15-1 § 312 addresses "indigent or medically indigent patients" and states in pertinent part:

> In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. *Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals*. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:
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> A. The patient's indigence must be determined by the provider . . .;
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> B. The provider should take into account the patient's total resources . . .;
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> C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX [i.e., the State Medicaid plan], local welfare agency and guardian; and
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> D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.
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> Once indigence is determined and the provider concludes that there has been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures. (*See §322 for bad debts under State Welfare Programs.*)[6]

[6] (Emphasis added.)

Thus, if a patient is eligible for Medicare and Medicaid ("dual eligible"), a presumption of uncollectibility may apply and the provider may claim the related debt without first pursuing collection efforts against the patient.

As noted by the cross-reference in § 312 to § 322, CMS provides guidance in § 322 on Medicare bad debts under State welfare programs:

> Where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of §310 are met.
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> In some instances, the State has an obligation to pay, but either does not pay anything or pays only part of the deductible or coinsurance because of a State payment "ceiling." For example, assume that a State pays a maximum of $42.50 per day for SNF services and the provider's cost is $60.00 a day. The coinsurance is $32.50 a day so that Medicare pays $27.50 ($60.00 less $32.50). In this case, the State limits its payment towards the coinsurance to $15.00 ($42.50 less $27.50). In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 are met.

"Crossover" claims are claims for services in which both the Medicare and Medicaid programs are involved because the individual to whom the services were furnished is covered by both programs. Federal statute, 42 U.S.C. § 1902(n)(2), requires the State to pay Medicare copayments, coinsurance and deductibles on behalf of qualified Medicare beneficiaries but may limit such payment to the State Medicaid program's "payment ceiling" which is generally the maximum amount that the State Medicaid program would pay for the service.[7] Similarly, with respect to payment of Medicare copayments, coinsurance and deductibles for dual eligibles, Medicare program guidance allows States to limit payment to the State Medicaid program's "payment ceiling."[8] Any portion of the Medicare copayments, deductibles or co-insurance that the State does not pay can be included as allowable bad debts and reimbursed by Medicare.[9]

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[7] Intermediary Exhibits I-5. Section 4714 of the Balanced Budget Act of 1997 (P.L. 105-33) added 42 U.S.C. § 1902(n)(2) to allow state Medicaid programs to limit payment of cost sharing for dual eligibles to the state Medicaid payment rate (*i.e.*, "the payment ceiling"). Prior to this change in 1997, Pennsylvania was under a court order to pay full Medicare cost sharing. *See Pennsylvania Medical Society v. Snider*, 29 F3d 886, (3rd Cir. 1994).

[8] *See* Enclosure 1 of the CMS State Medicaid Director Letter dated November 24, 1997 (*available at*: http://www.medicaid.gov/Federal-Policy-guidance/federal-policy-guidance.html).

[9] PRM 15-1 § 322.

In November 1995, CMS promulgated the following guidance on billing the State Medicaid programs, Provider Reimbursement Manual, CMS Pub. No. 15-2 ("PRM 15-2"), § 1102.3(L):

> Evidence of a debt arising from Medicare/Medicaid crossovers may include a copy of the Medicaid remittance showing the crossover claim and resulting Medicaid payment or non-payment. However, it may *not* be necessary for a provider to actually bill the Medicaid program to establish a Medicare crossover bad debt where the provider can establish that Medicaid is not responsible for payment. *In lieu of billing the Medicaid program, the provider must furnish documentation of*:
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> - Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number, and
> - Nonpayment would have occurred if the crossover claim had actually been filed with Medicaid.[10]

In 2003, the U.S Court of Appeals for the Ninth Circuit ("9th Circuit") reviewed this then-existing guidance in *Community Hosp. of the Monterey Peninsula v. Thompson* ("*Monterey*").[11] In that case, the Secretary asserted that, in order to fulfill the requirement in 42 C.F.R. § 413.80(e) a provider make "reasonable collection efforts," a provider "must bill" State Medicaid programs with respect to any deductibles and coinsurance amounts owed by dual-eligible patients and obtain a remittance advice ("RA") from the State Medicaid program detailing the amount of payment, if any. This is known as CMS' "must bill" policy.[12] The 9th Circuit found that, based on the record before it, the § 1102.3(L) guidance was in conflict with the Secretary's "must bill" policy and that the Secretary has consistently applied that "must bill" policy notwithstanding the § 1102.3(L) guidance.[13] The 9th Circuit further found that the provider's documentation, which purported to comply with that then-existing § 1102.3(L) guidance, failed to satisfy the regulation, 42 C.F.R. § 413.20(a) because "in this case, the [p]roviders did not maintain contemporaneous documentation in the ordinary course of business to support their claim."[14] Accordingly, the 9th Circuit declined to enforce § 1102.3(L) "to the extent [it] authorized reimbursement to the [p]roviders in this case" and deferred to the Secretary's "must bill" policy.[15]

As a result of the *Monterey* decision, on September 12, 2003, CMS issued Transmittal 5 to revise PRM 15-2 § 1102.3(L) to deleted the above-quoted guidance.[16] In addition, on August 10, 2004,

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[10] PRM 15-2, Ch. 11, Transmittal No. 4 (Nov. 1995) (emphasis added) (revising PRM 15-2 § 1102.3(L)).
[11] 323 F.3d 782 (9th Cir. 2003)
[12] *Id.* at 785, 798.
[13] *Id.* at 798.
[14] *Id.* at 799 (quoting *California Hosp. 90-91 Outpatient Crossover Bad Debts Grp. v. Blue Cross of Cal.*, Administrator Dec. at (Oct. 31, 2000), *rev'g*, PRRB Dec. No. 2000-D80 (Sept. 6, 2000)).
[15] *Id.*
[16] *See* PRM 15-2, Ch. 11, Transmittal 5 (Sept. 12, 2003) (revising § 1102.3(L) "to properly state the instructions to complete Exhibit 5, Column 4 of the 339").

CMS issued a directive, Joint Signature Memorandum 370 ("JSM 370"), to intermediaries.[17] The JSM specifies that: "[T]he provider must make certain that 'no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency . . .' prior to claiming the bad debt from Medicare."[18] The JSM also directs intermediaries to "hold harmless providers that can demonstrate that they followed the instructions previously laid out in [the pre-2003 version of] PRM 15-2 § 1102.3L, for open cost reporting periods beginning prior to January 1, 2004." Intermediaries conveyed the contents of the JSM to providers through Medicare newsletters sent to providers.[19]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Ashton Hall Nursing & Rehab Center ("Provider") is a skilled nursing facility ("SNF") located in Philadelphia, Pennsylvania. Novitas Solutions, Inc. has assumed the responsibility for this provider, which was previously serviced by Mutual of Omaha (each referred to as the "Intermediary").

On November 27, 2006, in connection with the Provider's cost report for the fiscal year ending June 30, 2005 ("FY 2005"), the Intermediary issued an NPR which disallowed a portion of the bad debts associated with deductible and coinsurance amounts for dual eligibles. The Provider filed a timely request for hearing with the Board on May 15, 2007.

The Provider disputes two portions of the adjustment. The first disputed amount was an adjustment for $342, due to lack of documentation (missing RA); however, the Provider later withdrew this issue from the appeal.

The other and sole remaining disputed amount in this appeal involves CMS' "must bill" policy. The amount in controversy for this issue is $37,671.17 in Medicare bad debt reimbursement. The specific issue presented in this case is whether the Provider's documentation could establish that the State Medicaid program would not pay a crossover claim which the Provider could then report as a Medicare bad debt on its FY 2005 cost report. CMS maintains that its long standing "must bill" policy requires that providers submit crossover claims to state Medicaid programs and obtain RAs from those programs detailing the amount of payment, if any.

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[17] JSM-370 from Director of Chronic Care Policy Group and Acting Director of Medicare Contractor Management Group to All Fiscal Intermediaries (Aug. 10, 2004). CMS instructions on the use of JSMs and Technical Direction Letters ("TDLs") specify that JSMs/TDLs are used by CMS to communicate internally with its contractors and, thus, are not issued to the general public. "JSMs/TDLs are typically used to communicate information to . . . [CMS contractors] that does not warrant a contractor manual instruction." A JSM/TDL is appropriate for a contract award announcement, an emergency alert, and/or a one-time request for information. CMS "cannot use a JSM/TDL . . . [to c]onvey new instructions; or [p]rovide clarification of existing requirements that impact contractor operations" but rather "[i]n these situations, submit a manual instruction through the formal Change Management/Change Request (CR) process." *See* CMS Division of Change & Operations Management of CMS/CMM/Medicare Contractor Management Group, *About Joint Signature Memorandums (JSMs) and Technical Direction Letters (TDLs)*, §§ 1 – 2.2 (May 2010) (available only on the CMS Intranet).

[18] (Quoting PRM 15-1 § 312.)

[19] *See, e.g.,* Mutual of Omaha, Medicare Newsletter at 3-4 (October 1, 2004) (describing to providers the "must bill" policy and the hold harmless provisions relating to PRM 15-2 § 1102.3(L) that are described in JSM 370) (copy included as Intermediary Exhibit I-10).

The Provider was represented by Robert M. Rickabaugh, C.P.A., of Knaup & Associates, LTD. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it relied on PRM 15-2 § 1102.3(L) as it existed prior to the September 2003 revisions and the subsequent JSM 370 instructions. More specifically, the Provider contends that the pre-2003 PRM provisions allowed it to be reimbursed for bad debts for dual eligibles even though it did not bill the State Medicaid program. Accordingly, reasonable collection efforts may be waived for dual eligible patients because they may be deemed indigent, and bad debts for an indigent patient may be written off and claimed upon discharge or upon the determination of indigency, whichever is later.[20]

The Provider further argues that the Intermediary's insistence on applying the "must bill" policy to crossover claims for services provided before January 1, 2004 and reported as bad debts for cost reporting periods beginning on or after January 1, 2004 is "patently incorrect." The Provider argues that the hold harmless directive in JSM 370 pertains to any bad debt with a date of service prior to January 1, 2004 regardless of the cost reporting period in which it was reported and claimed as a bad debt.[21]

Further, the Provider argues that the Intermediary's Newsletter dated October 1, 2004 announcing the "must bill" policy based on the *Monterey* decision places the Provider in an "impossible situation." First, Pennsylvania State Medicaid policy required providers to bill the program within 180 days from the patient's date of service.[22] Since the Intermediary's Newsletter announcing the new "must bill" policy was not issued until October of 2004, had the Provider attempted to bill the Pennsylvania Medicaid program for any claims for services furnished prior to May 1, 2004, the Pennsylvania Medicaid program would have denied those claims as untimely because the 180-day filing deadline for those claims had already tolled when the Newsletter was issued.[23]

The Provider also asserts that it faced a third problem preventing the facility from obtaining RAs from the Pennsylvania Medicaid program. The Pennsylvania Medicaid program could not accept any bills for Medicare coinsurance prior to July 1, 2004. Pennsylvania had set up a new billing system called the Promise Billing System on March 1, 2004. However, because providers had never had to bill the Pennsylvania Medicaid program in the past, it was not set up to handle the coinsurance bills. Accordingly, it was impossible for the Provider to obtain RAs for any claims filed prior to this date as required by CMS.[24]

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[20] *See* Provider's Final Position Paper at 4.
[21] *See id.*
[22] *See* Exhibit P-5 (excerpt from "Billing and Claims Status Frequently Asked Questions" *available at:* http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/frequentlyaskedquestions/billingandclaimsstatusfrequentlyaskedquestions/index.htm).
[23] *See* Provider's Final Position Paper at 4.
[24] *See id.*

The Provider submitted evidence that Pennsylvania's Promise Billing System was unable to handle coinsurance bills. Specifically, the Provider points to the following statement that the Director of Provider Relations at Pennsylvania's Department of Public Welfare made at the April 14, 2004 meeting of Long Term Care Subcommittee, an advisory committee for the Pennsylvania Medicaid program:

> Mr. Newett asked if the Department could respond to a zero bill and generate a denial that nursing facility providers can then use for claiming the Medicare bad debt. [The Director] stated that the system does have the capability to handle a zero bill and the Department would probably need to develop procedures for that process.[25]

Pennsylvania did not begin generating denials for Medicare coinsurance until July 1, 2004. In this regard, the Provider provided a copy of a notice, Provider Notice 04-116, issued on July 19, 2004 by another intermediary, Veritus Medicare which the Provider contends was the intermediary for the majority of SNFs in Pennsylvania.[26] This notice required all Pennsylvania SNFs for which it was the designated intermediary to begin sending claims to the State for dates of service after July 1, 2004 stating:

> All provider types must bill the State of Pennsylvania for Medicaid recipients in order to be able to claim the un-reimbursed amount as a bad debt on the Medicare cost report. A rejection notice must be received and maintained for intermediary verification at time of desk review or field audit. . . . *If you are a Skilled Nursing Facility and are not currently billing the state, you should change your billing practices effective July 1, 2004 to comply with this notice.* (*Emphasis* added)

The Provider contends that this intermediary certainly received permission from CMS to use the July 1, 2004 date because it was impossible for facilities to bill the Pennsylvania Medicaid program for Medicare deductible and coinsurance prior to that date. The Provider argues that this inconsistency between the policy as applied by two intermediaries in the same state is unfair because it allows a waiver of the application of the "must bill" policy for one facility serviced by one intermediary, while holding another facility to the policy because it is serviced by a different intermediary.[27]

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[25] *See* Provider Exhibit P-6 at 4 (copy of the minutes from the Pennsylvania Medicaid advisory board meeting of the Long Term Care Subcommittee (April 14, 2004) (*available at* http://listserv.dpw.state.pa.us/Scripts/wa.exe?A1=ind10&L=ltc-meeting-minutes)).

[26] *See* Provider Exhibit P-4 (copy of Provider Notice 04-116 issued by Veritus Medicare on July 19, 2004 and entitled "Clarification of Medicare Bad Debt Payments"). Veritus Medicare was the Part A contractor for Pennsylvania that later became Highmark Medicare Services (HMS). HMS then later became Novitas Solutions, Inc .

[27] *See* Provider's Final Position Paper at 4-5.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider's method for writing off dual eligible bad debts without billing the State Medicaid program does not constitute a reasonable collection effort as contemplated by the regulations or the manual provisions.[28] These provisions clearly state that the Provider must prove that a bad debt is uncollectible when claimed and that reasonable collection efforts using sound business judgment were employed. The Provider's policy to not bill the State of Pennsylvania fails to demonstrate that the Provider determined that "no source other than the patient would be legally responsible for the patient's medical bills" as required by the regulation and program guidance.[29]

The Intermediary maintains that CMS' "must bill" policy requirement is a reasonable reading of the regulations and has been upheld by the CMS Administrator[30] and the courts, such as the Ninth Circuit in *Monterey*. Accordingly, the Provider's policy of not billing the State does not constitute a reasonable collection effort as required by the regulations.[31]

The Intermediary further contends the Provider was notified of the "must-bill" policy before October 1, 2004. First, it points to the PRM 15-2 transmittal that CMS issued on September 12, 2003 in response to the decision in *Monterey*.[32] The Intermediary asserts that this transmittal changed the language in PRM 15-2 § 1102.3(L) to revert back to pre-1995 language which the Intermediary asserts required providers to bill the individual states for dual eligible beneficiary co-payments before claiming a Medicare bad debt.[33] The Intermediary communicated this "must bill" requirement to all providers in a Medicare Newsletter dated October 15, 2003. In particular, this Newsletter stated:

> A provider must demonstrate that a debt was uncollectible when claimed as worthless. With respect to a dual-eligible, this can only be done by billing the welfare agency for each deductible and coinsurance amount and receiving a partial or total denial of the claim. The denial must be documented and made available to the auditor upon request. We cannot accept other forms of documentation such as a provider's calculations of the agency's liability for the debt or an affidavit from the provider's employee that they were instructed not to bill by the agency. Moreover, we will not accept a letter from the welfare agency informing providers that it will no longer pay Medicare deductible and coinsurance amounts because of a State payment ceiling or budget shortfall.[34]

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[28] *See* 42 CFR § 413.89(e); PRM 15-1 § 308.
[29] *See* Intermediary's Final Position Paper at 6 (quoting PRM Pub 15-I § 312).
[30] *See, e.g., California Hosps. Bad Debts Group v. Blue Cross/Blue Shield of Cal,* Administrator Dec. (Oct. 31, 2000), *rev'g*, PRRB Dec. No. 2000-D80 (Sept. 6, 2000).
[31] *See* Intermediary's Final Position Paper at 6-7.
[32] *See* PRM 15-2, Ch. 11, Transmittal 5 (Sept. 12, 2003) (revising § 1102.3(L) "to properly state the instructions to complete Exhibit 5, Column 4 of the 339").
[33] *See* Intermediary Final Position Paper at 11.
[34] *See* Intermediary Exhibit I-9 (excerpts from the October 15, 2003 Medicare Newsletter).

The Intermediary points to another Medicare Newsletter dated October l, 2004 which further clarified the "must bill" policy and described a "hold harmless" policy for cost reports beginning before January l, 2004. In particular, the Newsletter stated:

> In order to fulfill the requirement that a provider make a "reasonable" collection effort with respect to deductibles and coinsurance amounts owed by dual-eligible patients, CMS bad debt policy requires the provider to bill the patient or entity legally responsible for the patient's bill before the provider can be reimbursed for uncollectible amounts. . . .
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> . . . . [I]n those instances where the state owes none or only a portion of the dual- eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State Remittance Advice). . . .
>
> On August 10, 2004, CMS issued a directive to fiscal intermediaries to hold harmless providers that can demonstrate that they followed the instructions previously laid out at 1102.3L, for open cost reporting periods beginning prior to January 1, 2004. Intermediaries who followed the now-obsolete Section 1102.3L instructions for cost reporting periods prior to January 1, 2004 may reimburse providers they service for dual-eligible bad debts with respect to unsettled cost reports that were deemed allowable using other documentation in lieu of billing the state.[35]

The Intermediary maintains that the hold harmless provision is only applicable to bad debts requested in cost reports open as of August 10, 2004 and filed before January 1, 2004 rather than to claims with dates of service prior to January 1, 2004 as requested by the Provider.[36]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions and the evidence presented on the record. Set forth below are the Board's findings and conclusions.

The Board finds that the Provider was fully notified of the Medicare Program's "must bill" policy through the Intermediary's publication of its Newsletter dated October 1, 2003.[37] The

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[35] *See* Intermediary Exhibit I-10 (excerpts from the October 1, 2004 Medicare Newsletter).

[36] *See* Intermediary's Final Position Paper at 11-12.

[37] The Board notes that, because the Provider is a SNF, rather than a hospital, the moratorium which prohibits the Secretary from making changes to the bad-debt policy in effect as of August 1, 1987 (the "Bad Debt Moratorium") is not applicable to the Provider. *See* OBRA 1987, Pub. L. No. 100-203, § 4008(c), 101 Stat. 1330, 1355 (1987), *as amended by* Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8402,102 Stat. 3342, 3798 (1988), *as amended by* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6023, 103 Stat. 2106, 2167 (1989) (reprinted in 42 U.S.C. § 1395f note).

Board is not persuaded by the Intermediary's argument that the transmittal issued on September 12, 2003 to revise PRM 15-2 § 1102.3(L) provided any notification on the "must bill" policy because no such policy statement was added to that section.[38]

However, notwithstanding this October 2003 notification, the records establish that the Provider could not bill the Pennsylvania Medicaid program for denial at that time. Specifically, the Board finds the Pennsylvania Medicaid program was not properly set up to process denials and zero bills until July 1, 2004. This is confirmed by: 1) the minutes from the April 14, 2004 meeting of Long Term Care Subcommittee, an advisory committee for the Pennsylvania Medicaid program; and 2) newsletters from the other intermediary servicing SNFs in Pennsylvania.[39]

The Board further finds that the claim submission rules for the Pennsylvania Medicaid program would only have permitted the Provider's required claims to be filed within 180 days of the date of service. As a result of the time limits for submitting Pennsylvania Medicaid claims and the capability limitations of the Pennsylvania Medicaid billing system, the Board concludes that it was not possible for the Provider to bill the Pennsylvania Medicaid program for the coinsurance claims on the bad debt list with dates of service prior to January 3, 2004 (*i.e.*, 180 days prior to July 1, 2004) and receive a denial from the State.

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[38] The Board notes that CMS simply cross-references other previously-existing sections of PRM 15-1 without making any policy statements: "See the criteria in Provider Reimbursement Manual – 1 §§312 and 322 and 42 C.F.R. 413.80 for guidance on billing requirements for indigent and welfare recipients." PRM 15-2, Ch. 11, Transmittal 5 at 11-12 (Sept. 12, 2003).

[39] In addition to the "Clarification of Medicare Bad Debt Payments" issued on July 19, 2004 by Veritus Medicare (*see* Provider Exhibit P-4), the Board notes that Novitas Solutions Inc. which was previously Veritus Medicare has posted on its website the following guidance concerning bad debts:

> Skilled Nursing Facility (SNF) Providers that can demonstrate that they followed the instructions that were previously laid out at PRM 15-2 1102.3L* (*select chapter 11, open pr2_1100-_to_1102.3 doc, then scroll to section 1102.3L*) for open cost reporting periods beginning prior to January 1, 2004, will be held harmless for those periods. Section 1102.3L, which was added in November 1995, permitted SNF providers to show other documentation in lieu of billing the states. This language was in conflict with the billing requirements in Chapter 3 of the PRM 15-1, and due to a moratorium on changes in bad debt reimbursement policies imposed by Congress in August 1987, the Secretary lacked authority in November 1995 to effect a change in policy. CMS has reverted back to the pre 1995 language, which requires all providers to bill the individual states for dual-eligible co-pays and deductibles before claiming Medicare bad debts. SNF providers were instructed via Provider Notice 04-116 to begin billing the state effective for services rendered on or after July 1, 2004.
>
> Intermediaries who followed the now-obsolete Section 1102.3L instructions for cost reporting periods prior to January 1, 2004, may reimburse SNF providers for dual-eligible bad debts with respect to unsettled cost reports that were deemed allowable using other documentation in lieu of billing the state.
>
> Therefore, for cost reporting periods beginning January 1, 2004, and forward, we will require that all providers have a processed State Medicaid remittance advice before allowing dual eligible bad debts.

Novitas Solutions Inc. webpage entitled "Provider Audit & Reimbursement (Part A): Bad Debts" (italics in original and underline added) (*available at:* http://www.novitas-solutions.com/webcenter/content/conn/UCM_Repository/uuid/dDocName:00003685 (last accessed on Nov. 22, 2013)). The Board also notes that Novitas Solutions Inc. assumed the responsibility for the Provider, which was previously serviced by Mutual of Omaha.

Based on the above, the Board concludes that the Intermediary's adjustment for the claims on the bad debt list with a service date prior to January 3, 2004 was improper. In making this finding, the Board notes that, in general, it is not bound by the PRM manual guidance but must only give great weight to it[40] and that the Board is not bound by the bad debt provisions in the PRM *as they are applied to SNFs* (including the application to SNFs of the so called "must bill" policy to the extent, if any, that such policy conflicts with the Board's finding) because the Bad Debt Moratorium which prohibits the Secretary from making changes to the bad-debt policy in effect as of August 1, 1987 pertains *only* to hospitals and not to SNFs.[41]

Based on the above, as of July 1, 2004, the Pennsylvania Medicaid program had the capability to generate an RA for denial and zero bills. As a result, the Provider could have obtained the required RA documentation from the Pennsylvania State Medicaid program for any claim for a date of service for any claim on or after January 3, 2004.[42]

Accordingly, the Intermediary should review any dual eligible claims on the June 30, 2005 bad debt list[43] that have dates of service prior to January 3, 2004 in order to determine if the claims would qualify as bad debts, under the statutes and regulations without adhering to the "must bill" policy and adjust those bad debt claims accordingly in favor of the Provider. The Board affirms the Intermediary's adjustment to disallow bad debts with a date of service on or after January 3, 2004 because the Provider did not have on file a Medicaid RA denying payment for these dates of service.

DECISION AND ORDER:

The Intermediary's adjustments for the claims on the bad debt list with service dates prior to January 3, 2004 were improper while those adjustments to bad debts with dates of service on or after January 3, 2004 were proper. The issue is remanded to the Intermediary to recalculate the allowable bad debts for the dual eligible claims on the June 30, 2005 bad debt list.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

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[40] *See* 42 C.F.R. § 405.1867.
[41] *See supra* note 37.
[42] It is unclear whether the hold harmless provisions delineated in JSM 370 would have been applicable to dates of service prior to January 1, 2004 because the record does not establish whether the Provider followed the 339 instructions located in the pre-2003 version of PRM 15-2 § 1102.3(L). Rather, the record only establishes that it was impossible to bill the state in the first instance for dates of service covered by the hold harmless provisions of JSM 370.
[43] The bad debt list to which the Board refers is located at Provider Exhibit P-2.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: APR 09 2014