PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
Hearing on the Record
2020-D20

PROVIDER-
UHS 2006-2009 Medicare Bad Debts Still At Agency CIRP Group

Provider Nos.: Various

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

HEARING DATE –
February 20, 2018

Cost Reporting Period Ended –
2006-2009

CASE NOs. 08-2236GC,
09-1414GC, 10-1019GC, 11-0106GC,

INDEX

ISSUE:

Whether the Providers' Medicare bad debts pending at outside collection agencies are allowable.[1]

DECISION:

After considering the Medicare law, regulations and program instructions, arguments presented, and evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor properly disallowed the Medicare bad debts protested by the subsidiary hospital providers of Universal Health Services, Inc. ("UHS") listed in Appendix A ("UHS Providers") for the fiscal years ("FYs") 2006 through 2009, because the bad debts remained at outside collection agencies ("OCAs") and that these disallowances did not violate the Bad Debt Moratorium. Accordingly, the Board affirms the Medicare Contractor's adjustments in these appeals.

INTRODUCTION:

The UHS Providers in these common issue related party ("CIRP") groups appealed cost reports from FYs 2006, 2007, 2008 and 2009.[2] The UHS Providers are challenging the disallowances made by Novitas Solutions, Inc. ("Medicare Contractor[3]") of Medicare bad debts solely on the ground that the accounts related to such bad debts were still pending at OCAs.[4] The UHS Providers had self-disallowed the bad debts pending at the OCAs and protested the self-disallowance on the as-filed cost reports.[5]

The UHS Providers timely requested a hearing before the Board and met the jurisdictional requirements on the collection agency bad debt issue. Accordingly, the Board held a hearing on the record on February 20, 2018. The UHS Providers were represented by John R. Hellow, Esq. of Hooper, Lundy & Bookman, P.C. The Medicare Contractor was represented by Joseph J Bauers, Esq. of Federal Specialized Services.

STATEMENT OF FACTS:

The regulations governing bad debt are located at 42 C.F.R. § 413.89.[6] Subsection (a) states the general rule that bad debts are deductions from revenue and are not to be included in allowable Medicare costs. However, subsection (d) allows reimbursement for bad debts attributable to

---

[1] Statement of Stipulated Facts ("Stipulations") at ¶ 1.
[2] *See* Appendix A for a list of the UHS Providers by CIRP group. *See also* Exhibit P-4. The Parties submitted separate Final Position Papers for the four cases in this appeal. Unless otherwise notes, citations in this decision will be to the briefs submitted in Case No. 08-2236GC.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[4] Stipulations at ¶ 2.
[5] *Id.* at ¶ 3.
[6] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

Medicare deductibles and coinsurance in order to ensure that costs associated with care furnished to Medicare beneficiaries are not borne by non-Medicare patients.

Pursuant to 42 C.F.R. § 413.89(e), bad debts must meet the following criteria to be allowable:

> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (3) The debt was actually uncollectible when claimed as worthless.
>
> (4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

Additional guidance on the Medicare bad debt requirements is located in Chapter 3 of the Provider Reimbursement Manual, CMS Pub. 15, Part 1 ("PRM 15-1"). PRM 15-1 § 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four criteria that must be satisfied in order for bad debts to be eligible for reimbursement by Medicare. PRM 15-1 § 310 provides guidance as to what constitutes reasonable collection efforts. PRM 15-1 § 310.2 sets forth the "Presumption of Noncollectability," providing that, "[i]f after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."

In § 4008(c) of the Omnibus Budget Reconciliation Act of 1987, Congress enacted a non-codified statutory provision that became known as the "Bad Debt Moratorium."[7] In § 8402 of the Technical and Miscellaneous Revenue Act of 1988, Congress retroactively amended the Bad Debt Moratorium.[8] Finally, in § 6023 of the Omnibus Budget Reconciliation Act of 1989, Congress again retroactively amended the Bad Debt Moratorium.[9] As a result of these serial amendments, the Bad Debt Moratorium reads:

> CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.— 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 service for reasonable costs relating to 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). The Secretary may not require a hospital to change its bad debt collection policy if a fiscal

[7] Pub. L. No. 100-203, 101 Stat. 1330, 1330-55 (1987) (copy at Exhibit P-8).
[8] Pub. L. No. 100-647, 102 Stat. 3342, 3798 (1988) (copy at Exhibit P-9).
[9] Pub. L. No. 101-239, 103 Stat. 2106, 2167 (1989) (copy at Exhibit P-10).

> intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.[10]

In these CIRP group cases, it is undisputed that the bad debts at issue derive from Medicare deductible and coinsurance amounts for covered services provided to Medicare-eligible patients. After 120 days had passed from the transmittal of the first bill, the UHS Providers forwarded all such accounts (with three exceptions) to OCAs.[11] When the accounts were referred to the OCAs, the UHS Providers maintain that they wrote off the accounts as bad debts based on their "sound business judgment that, after such [collection] efforts, and in light of a low chance of success collecting at the [OCAs], the accounts are uncollectible."[12]

Notably, during previous years' audits,[13] the Medicare Contractor removed similar bad debts as allowable costs from the UHS Providers' as-filed cost reports. Therefore, in the years under appeal in these CIRP groups, the UHS Providers included the cost related to bad debts sent to OCAs as protested amounts on the as-filed cost reports. The Medicare Contractor removed the protested amounts from the UHS Providers' final settled cost reports because these amounts were still pending at OCAs and were presumed to be collectible.[14]

DISCUSSION, FINDINGS OF FACT, CONCLUSIONS OF LAW:

The issue agreed to by the parties to these appeals is whether UHS Providers' FY 2006-2009 claimed Medicare bad debts pending at OCAs are allowable.

The UHS Providers contend that patient accounts pending at OCAs are entitled to the Presumption of Noncollectibility – provided that the reasonable collection efforts required by PRM 15-1 § 310 were satisfied ***prior to*** sending the accounts to the OCAs. The UHS Providers further contend that the CMS and Medicare Contractor policy denying reimbursement for accounts pending at OCAs violates the first and second prongs of the Bad Debt Moratorium because, with respect to the first prong, it represents a prohibited change to CMS' bad debt policy as it existed on August 1, 1987 and because, with respect to the second prong, it improperly required the UHS Providers to change their bad debt practice that was established

---

[10] Reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services." Though not relevant to the instant appeal, in 2012, the language was amended to include the following: "Effective for cost reporting periods beginning on or after October 1, 2012, the provisions of the previous two sentences shall not apply." Pub. L. No. 112-96, § 3201, 126 Stat. 156, 192-193 (2012).

[11] Providers' Final Position Paper at 3. The three exceptions where the accounts that were not forwarded to a collection agency were ones that: (1) the UHS Providers were legally prohibited from collecting; (2) the UHS Providers believed future payment was probable; or (3) had an outstanding balance below a certain dollar amount. *See also* Exhibit P-2.

[12] Providers' Final Position Paper at 3.

[13] *Id*. at 4 indicates that similar adjustments were made in 2004 and 2005. *See also* Stipulations at ¶ 11.

[14] *See* Providers' Final Position Paper at 3-4.

prior August 1, 1987.[15] Finally, the UHS Providers assert that this issue has been finally decided in the following federal district court case between the same parties and/or parties in privity with the parties to these appeals: *District Hosp. Partners, L.P. v. Sebelius*, 932 F. Supp. 2d 194 (D.D.C. 2013) ("*District Hospital*").[16]

Thus, the Board's findings in these appeals address the Bad Debt Moratorium, the criteria necessary to be met before a provider's bad debt collection efforts comply with relevant rules and regulations for claiming Medicare bad debt, and the effect, if any, of the UHS Providers' prior litigation in *District Hospital Partners*.

A. THE BAD DEBT MORATORIUM

At the outset, it is important to address the applicability and scope of the Bad Debt Moratorium. There are two separate and independent prongs to the Bad Debt Moratorium: (1) CMS is prohibited from changing its bad debt policy in effect on August 1, 1987; and (2) CMS is prohibited from requiring a provider to change its bad debt collection policy when the Medicare Contractor had accepted that policy prior to August 1, 1987.[17] The UHS Providers have alleged that CMS violated each prong and, as a result, the Board will address each prong separately.[18]

1. First Prong of the Bad Debt Moratorium – CMS's Bad Debt Policy

The first prong of the Bad Debt Moratorium prohibits changes to CMS' bad debt policy in effect on August 1, 1987. Accordingly, the Board must determine whether CMS' bad debt policy that was applied to the UHS Providers' Medicare bad debt pending with OCAs is consistent with the policy that was in effect on August 1, 1987.

As stated above, Chapter 3 of PRM 15-1 provides additional guidance for the requirements of 42 C.F.R. § 413.89(e). Section 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four main criteria that must be satisfied in order for bad debts to be reimbursable by Medicare. PRM 15-1 § 310 provides additional guidance on how a provider can satisfy the second criterion that requires provider to "establish that reasonable collection efforts were made." The § 310 guidance in effect during the time period at issue was revised in 1983 and, thus, was established prior to the Bad Debt Moratorium.[19]

The UHS Providers' appeal centers on the meaning and application of § 310 and, in particular, the second subsection of § 310.2 addressing the "Presumption of Noncollectibility." In reading the § 310 guidance in its entirety, it is important to understand that the guidance recognizes and

---

[15] *Id.* at 4, 21-25.
[16] *Id.* at 11-18. On December 20, 2016, the Board denied the UHS Providers' Motion for Summary Judgment in these appeals. In the UHS Providers' Motion for Summary Judgment, they argued that the preclusion facet of *res judicata* applied and the Medicare Contractor should not be able to relitigate this issue based on the *District Hospital Partners* decision related to this case. The Board further ruled that it issue a decision on the merits in these appeals, including a decision of whether the *res judicata* applied.
[17] *See District Hospital*, 932 F. Supp. 2d at 198.
[18] Providers' Final Position Paper at 18-25.
[19] *See* PRM 15-1, Transmittal 278 (Jan. 1983) (revising § 310). Subsequent to the time at issue, CMS revised PRM 15-1 Chapter 3 "to reflect updated references from HCFA to CMS, correction of typos, and replace Fiscal Intermediary with Contractor"). *See* PRM 15-1, Transmittal 435 (Mar. 2008).

distinguishes between the provider's actual "collection effort" (*i.e.*, what steps and procedures a provider actually takes as part of its collection efforts) and what may be "considered a reasonable collection effort":

> 310. REASONABLE COLLECTION EFFORT
>
> ***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. *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. *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. *The provider's collection effort may include* using or threatening to use court action to obtain payment. (See § 312 for indigent or medically indigent patients.)
>
> A. Collection Agencies. —*A provider's collection effort may include* the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.
>
> B. Documentation Required. —*The provider's collection effort should be documented* in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.
>
> 310.1 Collection Fees.—*Where a provider utilizes the services of a collection agency and the reasonable collection effort described in § 310 is applied*, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.
>
> . . . .

> 310.2 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.[20]

Significantly, § 310 makes clear that, in order for a debt collection policy to be reasonable, the provider must, at a minimum, issue a bill, as well as subsequent or follow-up bills, and collection letters which may or may not threaten a lawsuit. Section 310 also requires the provider to make telephone calls or other personal contacts and *may* include the use of a collection agency (*i.e*., OCA) in lieu of any of the preceding efforts, or subsequent to its prior efforts to collect a bill. It is up to the provider to make a business decision as to how much and what types of actual "collection effort" it will expend to collect debts. The provider has numerous tools at its disposal as part of its actual "collection effort," including whether and when to engage OCAs to assist in its collection effort.

Regardless of the tools the provider selects for its actual "collection effort," § 310 specifies that, in order for a collection effort to be considered *reasonable*, the following two conditions must be met: (1) the provider's actual "collection effort" for Medicare accounts must be similar to that used for non-Medicare accounts; and (2) there is consistency in this treatment across Medicare and non-Medicare debts.[21]

Thus, it is the provider's business decisions on what process and tools it will adopt and use for its customary collection effort for Medicare deductibles and coinsurance and this is mediated by the Medicare requirement that those customary collection effort be "reasonable," namely that the collection effort on Medicare bad debt be similar to and consistent with its efforts to collect comparable amounts of non-Medicare bad debt.

These business decisions that the provider makes in establishing its debt collection process and procedures must be reflected in the provider's written debt collection policy. As part of the normal cost report audit process and procedure, Medicare contractors request a copy of the provider's written bad debt collection policy for the handling of Medicare and non-Medicare patient accounts.[22] This requirement is memorialized in the CMS Form 339 which is submitted with the as-filed cost report.[23]

---

[20] (Italics emphasis added and underline in original.) (copy at Exhibit P-6).

[21] Prior to the Bad Debt Moratorium, CMS gave the following example of the § 310 requirement for similar treatment in the context of collection fees:

> [T]he allowability of collection fees has been clarified. *When a collection agency is used by a provider*, the collection fees are allowable costs *only if all uncollected charges of like amount, without regard to class of patient (Medicare or non-Medicare), are referred to a collection agency*.

PRM 15-1, Transmittal 210 (Sept. 1978) (emphasis added) (revising provisions addressing collection agency fees and moving those provisions from § 318 to § 310.1). *See also infra* note 51 and accompanying text (discussing the relevance of § 310.1 in interpreting the rest of § 310).

[22] *See* PRM 15-2, Ch. 11, § 1102 and Exhibit 1.

[23] *Id.*

The hospital audit program in effect prior to the Bad Debt Moratorium confirms that the Medicare program expected hospitals to maintain and make available during audit a written bad debt collections policy at least since December 1985.[24] Specifically, as part of the audit of a hospital, the hospital audit program required the Medicare Contractor to review the hospital's bad debt policy to test the hospital's internal controls and adherence to Medicare bad debt policies:

> 15.01 The Auditor should review the provider's policies and procedures to obtain an understanding of the method used to determine bad debts, bad debt collection effort and the method used to record the recovery of bad debts previously written off. After reviewing bad debt policies and procedures, the auditor should determine that only uncollectible deductible and coinsurance amounts are included in the calculation of *reimbursable* bad debts.[25]

Further, the hospital audit program is derived from 42 C.F.R. §§ 413.20 and 413.24 for the purpose of testing hospital internal controls and adherence to Medicare policies.[26] In this regard, the Board notes that maintaining a written bad debt collection policy is consistent with 42 C.F.R. §§ 413.20(a) and (d) and 413.24(c) to ensure adequate and sufficient cost information is maintained. Specifically, 42 C.F.R. § 413.20(a) specifies in pertinent part:

---

[24] *See* Medicare Intermediary Manual, Part 4, CMS Pub. No. 13-4 ("MIM 13-4"), Ch. 5, § 4499 Exhibits 1, 15, and 21 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating, for example, in § 1.15 that ; "the auditor should request . . . [p]olicies and procedures relating to the determination and collection of bad debts"; in § 15.01 "[t]he auditor should review the provider's policies and procedures to obtain an understanding of the method used to determine bad debts, bad debt collection effort and the method used to record the recovery of bad debts previously written off"; and in § 21.05(A)(1) "[r]eview the provider's 'bad debt' policy and determine whether its application to both Medicare and other patients is consistent"). A copy of § 4499 Exhibit 15 is included in Exhibit P-27. The hospital audit program was designed for use by both intermediaries and CPA firms to test the hospital's internal controls and adherence to Medicare policies. *See* MIM 13-4, Ch. 5, § 4402 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating that "the audit program was designed so that an intermediary or CPA could express an opinion as to whether or not the provider is adhering to Medicare Reimbursement Principles as explained in the Provider Reimbursement Manual, HCFA Pub. 15-1"); MIM 13-4, Ch. 5, § 4499 Exhibit 1 at § 1 (stating that "The Audit Program was developed to assist an intermediary or CPA firm in determining if the correct amount of reimbursement was made to the provider for the cost report being audited. Also, the audit program was designed so that an intermediary or CPA [firm] could express an opinion as to whether or not the provider is adhering to Medicare Reimbursement Principles as explained in the Provider Reimbursement Manual, HCFA Pub. 15-1."); MIM 13-4, Ch. 5, § 4499 Exhibit 21 at ¶¶ 21.01, 21.05(A)(1) (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating in § 21.01 "the scope of an audit of the balance sheet accounts for Medicare purposes is dependent upon the. . . effectiveness of the internal controls" and in § 21.05 "[r]eview the provider's 'bad debt' policy and determine whether its application to both Medicare and other patients is consistent"). *See also, e.g., Buckeye Home Health Serv. Inc. v. Blue Cross of Central Ohio*, PRRB Dec. No. 1983-D108 (July 14, 1983), *review declined*, CMS Administrator (Sept. 1, 1983) (PRRB decision issued prior to the Bad Debt Moratorium where bad debts were disallowed due to the Provider's failure to follow its bad debt collection policy).

[25] MIM 13-4, Ch. 5, § 4499, Exhibit 15 at § 15.01 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (note that Chapter 5 is entitled "Hospital Audit Program") (emphasis added) (copy at Exhibit P-27).

[26] *See* MIM 13-4, Ch. 5, § 4499 Exhibit 1 at §§ 1, 1.04(B)(15), 1.15 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (citing to 42 C.F.R. §§ 405.406, and 405.453 which were later relocated to 42 C.F.R. §§ 413.20 and 413.24 as authorities for the hospital audit program which includes among other things, review of the written bad debt collection policy).

> (a) *General*. The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.

Similarly, 42 C.F.R. § 413.24(c) specifies in pertinent part:

> (c) *Adequacy of cost information*. Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.

The Medicare program's expectation that the provider maintain a policy to memorialize the process for its actual "collection effort" is reflected in the use of the word "customary" in the Presumption of Noncollectibility delineated in PRM 15-1 § 310.2. In order to obtain the benefit of this presumption, a provider must follow its own policies for its "reasonable *and* customary attempts to collect"[27] for more than 120 days prior to writing off a bad debt.

The Board finds that the plain language of the Presumption of Noncollectibility does not create an automatic presumption after the passage of 120 days. Rather, it is discretionary presumption and does not foreclose the possibility that a debt may still be deemed collectible after 120 days as demonstrated by the use of the words "may be deemed."

In this regard, the Board notes that the Presumption of Noncollectibility does not excuse a provider from satisfying the other criteria specified in 42 C.F.R. § 413.89(e).[28] Rather, in order to satisfy the criteria of 42 C.F.R. § 413.89(e)(3), the provider must first determine that the debt is "uncollectible" by which it must exhaust what it has established as its reasonable and customary collection efforts. If a provider chooses to utilize a collection agency, these efforts must be exhausted before the debt can be determined to be uncollectable and, therefore, worthless.

---

[27] PRM 15-1 § 310.2 (emphasis added).

[28] The Board notes that "presumption" is referenced only in the title of PRM 15-1 § 310.2 and uses the prefix "non": "Presumption of Noncollectability." In contrast, the text of the manual provisions uses the prefix "un" when referring to debts as "uncollectible." Both of these prefixes generally mean not but the prefix "un" can be stronger than mere negativity and mean the opposite of or contrary to (*e.g*., compare the meaning of nonacademic to unacademic). *See* http://www.merriam-webster.com/dictionary/ (compare definitions of the prefix "un-" to the prefix "non-"); http://www.oxforddictionaries.com/us/definition/american_english/un-. As a result, the Board notes that it makes sense that the Agency adopted a weaker prefix with the presumption itself.

A close reading of the conditional clause in the Presumption of Noncollectibility ("[i]f after reasonable *and* customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary. . . .") confirms that a provider gets the benefit of the presumption for a debt only under certain circumstances. Specifically, a debt may be deemed uncollectible only if: (1) the provider has completed its customary collection attempts for that debt; (2) the actual collection attempts for the debt being claimed are "reasonable"; and (3) the collection attempts for the debt are completed more than 120 days from the date the first bill was sent to the patient for that debt. When the prepositional phrase, "[i]f after reasonable *and* customary attempts to collect a bill," is read in conjunction with the words "remains unpaid more than 120 days," it is clear that the prepositional phrase operates independent of the phrase "remains unpaid more than 120 days" and that the reasonable and customary attempts must be completed before a debt "may be deemed uncollectible."[29] Otherwise, the words "remains unpaid more than" would be rendered superfluous and would reduce the Presumption of Noncollectibility to simply meaning that, after 120 days of reasonable and customary collection attempts, a debt "may be deemed uncollectible."[30] In summary, the Presumption of Noncollectibility does not excuse a provider from satisfying the other criteria specified in 42 C.F.R. § 413.89(e), nor does it create an automatic presumption of uncollectability after the passage of 120 days. Rather, a provider must exhaust its reasonable and customary collection efforts, including the use of an OCA (if applicable) and more than 120 days must pass, before a debt can be deemed uncollectible.

Based on the above analysis, the Board finds that the policy of not allowing providers to claim bad debts until they are returned from a collection agency is consistent with the regulations and manual sections in effect on August 1, 1987. Therefore, the Medicare Contractor's disallowance of the bad debts at issue is not in conflict with the first prong or prohibition of the Bad Debt Moratorium. The Board finds the UHS Providers chose to utilize an OCA as part of their "customary collection effort." The fact that the UHS Providers wrote off the debts at issue *prior to* sending them to the OCA does not mean that the UHS Providers' use of the OCA was not part of the UHS Providers' actual and customary "collection effort." The UHS Providers' policy and procedure specifically list the use of the OCA as part of its collection effort and, through this

---

[29] The Board notes that, prior to the Bad Debt Moratorium, it was not uncommon for providers to have Medicare collection processes that ended in 120 days or less. *See, e.g*., *Wadsworth-Rittman Hosp. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 1991-D85 (Sept. 26, 1991) (addressing 1986 cost reporting period); *King's Daughters' Hosp. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 1991-D5 (Nov. 14, 1990), *review declined*, CMS Administrator (Dec. 26, 1990) (addressing 1984 cost reporting period).

[30] The Board's reading is consistent with the one Board decision issued prior to the Bad Debt Moratorium that considered the Presumption of Noncollectibility – *Davie Cty. Hosp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 1984-D89 (Mar. 22, 1984) ("*Davie County*"). In *Davie County*, the provider did not write bad debts off until six months after the date of service and, accordingly, the provider asserted that the Presumption of Noncollectibility was applicable. The intermediary argued that the provider's collection efforts were unreasonable because: (1) "[t]he non-Medicare uncollectible accounts were referred to an outside collection agency for *further* collection attempts while the Medicare uncollectible accounts were not similarly referred, but were written off as bad debts" and the provider did not even make in-house telephone or letter-writing efforts comparable to those of the outside collection agency to collect the past-due Medicare accounts prior to writing them off and claiming them as bad debts. The Board did not apply the presumption, but rather found that the provider failed to establish that it had made reasonable collection efforts because, in deciding not to refer the Medicare accounts to the outside collection agency, the provider failed to establish that it used an acceptable in-house alternative to referral to a collection agency.

referral, the UHS Providers clearly expected and desired some portion of the referred bad debts to be collected.[31]

The Board recognizes that the UHS Provider's decision to send bad debts to an OCA may have been above and beyond the *minimum* needed to establish a "reasonable collection effort." However, the Board notes that, because the Provider must treat Medicare and non-Medicare accounts equally, the Provider's decision to incorporate use of an OCA into its customary collection efforts for non-Medicare accounts necessarily means that the OCA activities get incorporated into the "reasonable collection effort" standard for Medicare accounts. Therefore, the Board finds the UHS Providers' collection effort is not complete until the OCA has completed its efforts or the account can be proven "worthless" with "no likelihood of recovery at any time in the future" by some other means. The UHS Providers would not qualify under the "Presumption of Noncollectibility," even though the "debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary" because this presumption only applies "*after* reasonable *and* customary attempts to collect a bill."[32]

The Board recognizes that some of the UHS Providers are located in the U.S. Circuit Courts of Appeals for the Sixth, Seventh, and Eleventh Circuits and that there are decisions in these circuits addressing bad debt issues similar to those before the Board. Accordingly, the Board reviewed these Circuit Court decisions to determine whether they are applicable to its analysis of Medicare bad debt policy and the associated first prong of the Bad Debt Moratorium.

The 1999 Seventh Circuit decision in *Mount Sinai Hosp. Med. Ctr. v. Shalala*[33] upheld the Secretary's application of the PRM 15-1 § 310 requirement to treat Medicare and non-Medicare accounts alike. Specifically, the Court upheld the Secretary's finding that the provider violated this requirement when it referred non-Medicare accounts to an OCA while failing to do the same with Medicare accounts and, accordingly, the provider failed to engage in reasonable collection efforts on Medicare accounts.[34] The Seventh Circuit did consider the first prong of the Bad Debt Moratorium in rendering this decision and determined that the Secretary did not violate that prong.[35] In applying the first prong of the Bad Debt Moratorium, the Board's findings in the instant case, regarding the Presumption of Noncollectibility, are consistent with the Seventh Circuit's decision.

In the 2007 decision, *Battle Creek Health Sys. v. Leavitt*,[36] the Sixth Circuit upheld the Secretary's interpretation and application of the PRM 15-1 manual provisions addressing bad debts to require providers to discontinue collection efforts by collection agencies before seeking Medicare reimbursement of debts outstanding for more than 120 days.[37] Although the Sixth Circuit did not consider the Bad Debt Moratorium in rendering this decision, in its application of

[31] Exhibit P-2 at 3, ¶ 2 (stating 2 "Uncollectible accounts are transferred to a bad debt collection agency at least 120 days from the first statement date per Medicare guidelines.").
[32] PRM 15-1 § 310.2 (emphasis added).
[33] 196 F.3d 703 (7th Cir. 1999).
[34] *Id.* at 708-709.
[35] *Id.* at 710-11.
[36] 498 F.3d 401 (6th Cir. 2007).
[37] *Id.* at 411.

the first prong of the Bad Debt Moratorium, the Board's findings regarding the Presumption of Noncollectibility remain consistent with the Sixth Circuit's decision.

In the 1997 decision, *University Health Servs., Inc. v. Health & Human Servs.*,[38] the Eleventh Circuit found that "the Secretary's conclusion that [the provider] failed adequately to show that it had engaged in reasonable collection efforts based on sound business judgment is supported by substantial evidence."[39] In this regard, the Secretary had found that the provider had disparate treatment of Medicare and non-Medicare accounts because the provider wrote off as bad debt all delinquent accounts following 120 days of collection efforts and then referred only its non-Medicare accounts to an OCA.[40] The Eleventh Circuit also found that the first prong of the Bad Debt Moratorium was not triggered under this fact scenario.[41] While this case is not directly on point, the Board's findings remain consistent with this decision.

UHS urges the Board to follow the decisions of the District Court for the District of Columbia in the *District Hospital Partners* case (previously noted) and *Foothill Hosp.—Morris L. Johnston Mem'l v. Leavitt* ("*Foothill*"),[42] and ignore the more recent decisions of this same court in *Lakeland Reg'l Health Sys. v. Sebelius* ("*Lakeland*")[43] and *Community Health Sys, Inc. v. Burwell* ("*Community*").[44] However, the Board disagrees with the District Court's findings in *Foothill* and *District Hospital Partners*. The Board finds nothing in the Medicare Bad Debt Audit Program from December 1985 indicating that CMS had a policy of allowing Medicare bad debts to be reimbursed while the debts were still at an OCA.

The D.C. Court in *Foothill* discusses the 1985 guidance as follows:

> Not only is there a lack of support for defendant's current position, but several agency sources predating the Moratorium suggest that this new view is contrary to defendant's policy as of August 1, 1987. . . . Second, the Hospital Audit Program, dated December 1985, and found in the Intermediary Manual (Pub. HIM 13), uses the term "uncollectible" to refer to debts held by a collection agency.[45]

The following excerpt from the 1985 Hospital Audit Program shows the context in which the term "uncollectible" is used:

> 15.04 Where a provider utilizes the services of a collection agency, the provider need not refer all uncollected patient charges to the agency, but it may refer only uncollected charges above a specified minimum amount. *If reasonable collection effort was*

[38] 120 F.3d 1145 (11th Cir. 1997), *cert. denied*, 524 U.S. 904 (1998).
[39] *Id.* at 1151.
[40] *Id.* at 1150-1151.
[41] *Id.* at 1152-1153.
[42] 558 F. Supp. 2d 1 (D.D.C. 2008).
[43] 958 F. Supp. 2d 1 (D.D.C. 2013).
[44] 113 F. Supp. 3d 197 (D.D.C. 2015).
[45] *Foothill*, 558 F. Supp. 2d at 10-11 (citation to record omitted).

> *applied, fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider. To determine the acceptability of collection agency services,* perform the following audit steps.
>
> A. Review provider contracts with the collection agency to determine that both Medicare and non-Medicare *uncollectible* amounts are handled in a similar manner.
>
> B. Determine that the patient's file is properly documented to substantiate the collection effort by reviewing the patient's file for copies of the agency's billing, follow-up letters and reports of telephone and personal contacts.
>
> C. Determine that the bad debt amounts recovered by the collection agency are properly recorded by verifying that the full amount collected is credited to the patient's account and the collection fee is charged to administrative expense.[46]

When examining the context of 1985 Hospital Audit Program, the Board notes that § 15.04 addresses the allowability of collection agency *fees* (and tracks PRM 15-1 § 310.1) by conditioning the allowability of collection agency *fees* on the collection agency first attempting reasonable collection efforts, a key element of which is the similar treatment of Medicare and non-Medicare debts of like amount. Section 15.04 focuses on the allowability of the collection agency *fees* as an administrative cost for services already performed and directs the auditor to review the provider contracts with the collection agency to ensure that the non-Medicare and Medicare uncollectible debts *returned* from the collection agency have been treated similarly in compliance with PRM 15-1 § 310. Thus, the Board maintains that the *Foothill* court misinterpreted § 15.04 as describing bad debts *going* ***to*** the collection agency as "uncollectible" rather than, as the Board has consistently held, describing uncollectible bad debts *coming back* ***from*** the collection agency to the provider.[47]

Further, contrary to the *Foothill* court, the Board finds the Administrator's decision in 1995 in *Lourdes Hospital v. Blue Cross and Blue Shield Association* ("*Lourdes*")[48] inconclusive as to CMS policy related to debts that were still at a collection agency. In *Lourdes*, the Administrator reimbursed the provider for bad debts claimed less than 120 days from the first billing because, based on the evidence in the case, the provider established the bad debts were actually uncollectible. The provider's policy in *Lourdes* was that Medicare bad debts were written off

---

[46] (Emphasis added.) (copy at Exhibit P-27).

[47] The Board notes that, notwithstanding PRM 15-1 § 310.1, the Board historically has refused to limit the allowability of collection agency fees to situations only where Medicare and non-Medicare accounts are both referred out to a collection agency. The Board's refusal to make this limitation predates the Bad Debt Moratorium. *See, e.g., Mercy Hosp. of Laredo v. Blue Cross Ass'n*, PRRB Dec. No. 1982-D111 (June 29, 1982), *declined review*, Adm'r (July 27, 1982). However, this refusal to fully apply § 310.1 does ***not*** diminish the usefulness or import of § 310.1 in deciphering the construction and meaning of the PRM 15-1 provisions regarding what is needed to establish that a reasonable collection effort was made.

[48] Adm'r Dec. (Oct. 27, 1995), *modifying*, PRRB Dec. Nos. 1995-D58, 1995-D59 and 1995-D60, (Aug. 31, 1995).

prior to being sent to collection agency. The Administrator in its decision did not address this fact. Rather, the Administrator only focused on the provider establishing through evidence that the Medicare bad debts were actually uncollectible. Therefore, the Board draws no policy conclusions regarding the issue in this case from *Lourdes*.[49]

Similarly, the Board reviewed the decision in *District Hospital*. In *District Hospital*, the court used the same bases addressed in *Foothill* to make its ruling, except that it added the following reference to *Scotland Mem. Hosp. v. Blue Cross & Blue Shield Ass'n* ("*Scotland Memorial*"), Administrator Dec. (Nov. 8, 1984):

> Moreover, a pre-Moratorium Administrator decision, *Scotland Mem. Hosp. v. Blue Cross & Blue Shield Ass'n . . .*, directly contradicts the presumption of collectability. In *Scotland Memorial*, the Administrator noted that the presumption of noncollectability established in PRM section 310.2 deserved "more weight than the subjective and unrealistic opinion of the provider's witness, who felt the bad debts were not uncollectible because she expected the collection agency to collect them.". . . . Thus, as of 1984, the presumption of noncollectability in section 310.2 applied to accounts that had been sent to collection agencies.[50]

The Board disagrees with this finding. As noted in the Administrator's *Scotland Memorial* decision "[t]he Medicare policy in effect during the cost year at issue set forth in [PRM 15-1] Sec. 310 . . . prohibited the use or threat of legal action to collect Medicare deductible and coinsurance amounts" and that "[t]his difference in permissible treatment of the different types of accounts prevented the providers from affording identical treatment to both Medicare and non-Medicare accounts." It was *this* prohibition that was the premise for not referring Medicare accounts to a collection agency, creating the difference in treatment of Medicare and non-Medicare accounts.[51] Upon this basis, the Administrator concluded that the Board acted reasonably in finding that the § 310 requirement for similar treatment of Medicare and non-Medicare accounts had been met. Thus, it is clear that, before applying the Presumption of Noncollectability, the Administrator had to first determine whether the § 310 requirement for similar treatment had been met.

In connection with both the *District Hospital* case and the case at hand, PRM 15-1 § 310 (as revised by Transmittal 278) did not prohibit the use or threat of legal action to collect Medicare accounts and, accordingly, the Administrator's *Scotland Memorial* decision is not directly applicable or relevant because the justification in *Scotland Memorial* decision for treating Medicare accounts differently (*i.e*., the prohibition on threatening legal action for Medicare accounts) no longer exists. Notwithstanding, the principle in the Administrator's *Scotland*

---

[49] The *Foothill* court found that the "CMS Administrator's categorical stance" that bad debts at a collection agency could not be claimed until returned in conflict with bad debts allowed in *Lourdes. See Foothill,* 558 F. Supp. 2d at 7 n.9.

[50] 932 F. Supp. 2d at 205-206 (citations to administrative record omitted).

[51] *See* PRM 15-1, Transmittal 278 (Jan. 1983) (revising § 310 "to eliminate the restriction against using or threatening court action to collect bad debts from Medicare beneficiaries" for cost reporting periods on or after January 1, 1983).

Memorial decision - that the § 310 requirement for similar treatment has to be met before the presumption can be applied – is still controlling.

Subsequent to the *Foothill* and *District Hospital Partners* decisions, the D.C. District Court upheld the Administrator's finding in *Lakeland*[52] stating: "that it has always been the Secretary's policy that accounts pending at collection agencies cannot be written off as bad debts until collection activity has terminated."[53] In particular, the D.C. District Court notes the following:

> The Secretary's Policy is encompassed by 42 C.F.R. § 413.89(e), which expressly provides that a debt is not reimbursable unless it is "actually uncollectible when claimed as worthless" and "[s]ound business judgment established that there was no likelihood of recovery at any time in the future." Where, as here, an outside collection agency continues collection efforts on behalf of a provider, these criteria cannot be met. After all, what provider exercising sound business judgment would spend his precious resources on the fool's errand of pursuing an uncollectible debt with no likelihood of future recovery? By prohibiting double-recovery, PRM § 316 eliminates any incentive a provider might conceivably have to simultaneously pursue collection from a beneficiary and reimbursement from CMS.[54]

In upholding the Secretary's policy on the use of collection agencies, the *Lakeland* court found that the policy did not violate the Bad Debt Moratorium because it "is reflected in the agency's pre- and post-Moratorium interpretive guidance."[55] In this regard, similar to the Board, the D.C. District Court used the 1985 guidelines for the Hospital Audit Program as evidence to support its finding that this policy was in effect prior to the Bad Debt Moratorium.[56]

Roughly two years after *Lakeland*, the D.C. District Court issued its decision in *Community* and, similar to *Lakeland*, upheld the Board's application of Medicare bad debt policy and the Presumption of Noncollectability as laid out in this case, including that this application does not violate the first prong of the Bad Debt Moratorium.[57]

Based on the above analysis, the Board finds that the policy of not allowing providers to claim bad debts until they are returned from a collection agency is consistent with the regulations and Manual sections in effect prior to August 1, 1987. Furthermore, careful review of the case law reveals no basis for the Board to reach a contrary conclusion now. Accordingly, the Board finds

---

[52] 958 F. Supp. 2d 1 (D.D.C. 2013).
[53] *Id.* at 5.
[54] *Id.* (citations omitted).
[55] *Id.* at 6.
[56] *Id.* Specifically, the D.C. Court stated: "The [1985 Hospital Audit Program] guidelines allow a provider to recoup fees paid to an outside collection agency 'as an allowable administrative cost' only '[i]f reasonable collection effort *was* applied.' The use of the past tense ('*was* applied') precludes reimbursement prior to the application of reasonable collection effort." *Id.* (citations omitted and italics emphasis in original). *See also El Centro Reg'l Med. Ctr. v. Leavitt*, 2008 WL 5046057 at *7 (S.D. Cal. 2008) (upholding the Administrator's interpretation of PRM 15-1 § 310 "as being applicable to both in house and outside collection efforts").
[57] 113 F. Supp. 3d at 217-18, 229.

that the Medicare Contractor's disallowance of the UHS Providers' protested bad debts is a permissible interpretation of the first prong of the Bad Debt Moratorium because it is reasonable and consistent with the rules and regulations as they existed prior to August 1, 1987.[58]

2. The Second Prong of the Bad Debt Moratorium – The UHS Providers' Policy

The Board also finds, based on the evidence in this case, that the Medicare Contractor's disallowance of the UHS Providers' protested bad debt amounts did not violate the second prong of the Bad Debt Moratorium. The second prong states:

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.[59]

There is no evidence that the Medicare Contractor or CMS allowed any claims submitted by the UHS Providers prior to August 1, 1987 for bad debt claims still pending with OCAs. Nor is there any evidence that the Medicare Contractor or CMS approved the UHS Providers' alleged pre-August 1, 1987 bad debt collection policy to claim bad debts still pending with OCAs (or required the UHS Providers to change their alleged pre-1987 bad debt collection policy). Rather, the earliest UHS Providers' bad debt document in the record is from 2004: a UHS bad debt collection policy with an effective date of March 1, 2004 (well after 1987).[60] Accordingly, The Board finds that the second prong is not relevant because the UHS Providers have presented no evidence showing that the Medicare Contractor or CMS violated the prohibition of the second prong of the Bad Debt Moratorium.[61] The Board decision is consistent with case law applying the second prong.[62]

3. Summary on the UHS Providers' Collection Efforts

As extensively discussed above, a provider must complete or exhaust its reasonable and customary collection efforts, including the use of an OCA (if use of an OCA is incorporated into the customary collection process) and more than 120 days must pass, before a debt can be deemed uncollectible. In this case, the UHS Providers chose to utilize OCAs as part of their

---

[58] In reaching its decision, the Board relies on neither the June 11, 1990 Joint Signature Memorandum issued by HCFA Central to all HCFA Regional Administrators (copy at Exhibit P-29) nor MIM 13-4, Transmittal 28, § 4198, Exhibit A-11 (Sept. 1989) (copy at Exhibit P-25) as these documents were both was issued subsequent to the Bad Debt Moratorium. Notwithstanding, the Board notes that its decision is consistent with these documents.

[59] *See supra* note 11.

[60] Exhibit P-2.

[61] For example, the UHS Providers' final position paper presents its position on the second prong of the Bad Debt Moratorium in 5 sentences without any citations to evidence in the record and only with citations to case law. Providers' Final Position Paper at 25.

[62] *See, e.g., University Health Servs., Inc. v. Health & Human Servs.*, 120 F.3d 1145, 1151-1155 (11th Cir. 1997), *cert denied*, 524 U.S. 904 (1998); *Hennepin County Med. Ctr. v. Shalala*, 81 F.3d 743, 751 (8th Cir. 1996).

customary bad debt collection effort. The fact that the UHS Providers wrote off the debts at issue *prior to* sending them to the OCAs does not mean that the UHS Providers' use of OCAs was not part of the UHS Providers' customary collection effort. Rather, and importantly, the UHS Providers' policy and procedure specifically includes the use of OCAs as part of their customary collection effort.[63]

The Board recognizes that a provider's decision to send bad debts to OCAs may be above and beyond the *minimum* needed to establish a "reasonable collection effort." However, because a provider must treat Medicare and non-Medicare accounts similarly, a provider's business decision to incorporate the use of OCAs into its customary collection efforts for non-Medicare accounts necessarily means OCA activities must be incorporated into the "reasonable collection effort" standard for Medicare accounts – if the provider wishes to claim reimbursement for the Medicare accounts as bad debts. Therefore, in a case such as the one before the Board now, where a provider expressly incorporates the use of OCAs in its customary collection efforts for non-Medicare accounts, the Board finds a provider's collection effort is not complete until the OCA has completed its efforts or the account can be proven "worthless" with "no likelihood of recovery at any time in the future" by some other means for the Medicare accounts.[64] Such a non-uniform collection policy would not qualify under the "Presumption of Noncollectibility," even though the "debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary" because this presumption only applies "*after* reasonable *and* customary attempts to collect a bill."[65] Accordingly, the Board finds that these kinds of collection efforts did not satisfy the requirements for declaring Medicare bad debts uncollectable and, as a result, are not allowable Medicare costs.

B. RES JUDICATA

The Board has considered whether it has the authority under 42 U.S.C. § 1395oo and 42 C.F.R. Part 405, Subpart R (including, in particular, § 405.1867) to apply *res judicata* based on the D.C. District Court decision in *District Hospital*. That decision addressed the same legal issue that is involved in these appeals except that the *District Hospital* decision involved an earlier fiscal year. As set forth below, the Board finds it does not have the authority to apply *res judicata* in the manner requested.

The term "*res judicata*" encompasses two distinct doctrines – claim preclusion and issue preclusion.[66] UHS has invoked the doctrine of issue preclusion (also known as collateral estoppel) and this doctrine "precludes a party from relitigating an issue actually decided in a prior case and necessary to the judgement."[67] More specifically, UHS is requesting that the Board apply this doctrine in these appeals in order to prohibit the Secretary (which, at this stage of UHS' appeals, necessarily includes the Board) from relitigating an issue that was resolved for an earlier fiscal year in *District Hospital*. Our discussion of issue preclusion is limited to this requested application.

---

[63] *See* Stipulations at ¶ 2; Exhibit P-2.
[64] 42 C.F.R. § 413.89(e).
[65] PRM 15-1 § 310.2 (emphasis added).
[66] *Lucky Brand Dungarees, Inc. v. Marcel Fashions Group, Inc.*, 590 U.S. __, 140 S. Ct. 1589, 1594-1595 (2020)
[67] *Id.* (citations omitted).

The Board is an administrative forum which has specific, and limited, authority defined by 42 U.S.C. § 1395oo and the implementing regulations at 42 C.F.R. Part 405, Subpart R. The regulation at 42 C.F.R. § 405.1867 defines the scope of the Board's authority:

> In exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.

The Board is not granted general powers of equity. Congress has dictated in the Board's governing statute that "[a] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole."[68] Based on these authorities, the Board finds that Congress did not confer power to the Board to apply issue preclusion in the manner requested.

Similarly, it is the Board's finding that the Secretary did not confer on the Board the authority to apply issue preclusion in the manner requested. The Secretary promulgated regulations at 42 C.F.R. Part 405, Subpart R to govern proceedings before the Board. Specifically, the Board finds that these regulations do confer on the Board the authority to prohibit relitigation of an issue across fiscal years[69] and, in this regard, the Board notes that neither its decisions nor those of the Administrator have general controlling precedence.[70] In deciding that it has no authority to apply the doctrine of issue preclusion in the manner requested, the Board does not reach the question of whether the UHS Providers meet all the requirements for issue preclusion, including the requirement that there be privity between the parties.[71]

The Board has also considered whether it should grant, on its own motion, expedited judicial review ("EJR") of the issue preclusion question.[72] The Board's governing statute specifies that "[p]roviders shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a

---

[68] 42 U.S.C. § 1395oo(d).

[69] The Board notes that Rule 8(c)(1) of the Federal Rules of Civil Procedure ("FRCP") lists *res judicata* as an affirmative defense and the Secretary has not required the Board to apply the FRCP except in certain limited discovery circumstances specified in 42 C.F.R. Part 405, Subpart R.

[70] *See* PRM 15-1 § 2927(e) (entitled "Nonprecedential Nature of the Administrator's Review Decision").

[71] Notwithstanding, the Board notes that, contrary to UHS' assertion, the Medicare Contractor has not conceded that all of the Providers would satisfy the privity element of *res judicata*. *See* MAC's Supplemental Brief Regarding Res Judicata at 6 (stating that "[a]ssuming Providers satisfy all of the elements of collateral estoppel" is "a dubious proposition since several members of the group cases were not parties to the *District Hospital Partners* case").

[72] The Board notes that UHS also requested that the Board consider whether EJR is appropriate if the Board rules that it had no authority to apply *res judicata* in the manner requested. Provider Supplemental Reply Brief In Support of *Res Judicata* Issues at 2 (July 24, 2019).

provider . . .) that it is without authority to decide the question."[73] The Secretary promulgated the regulation at 42 C.F.R. § 405.1842 to implement this statutory provision. In particular, § 405.1842(a)(1) states that EJR may be granted when there is "a legal question *relevant to a specific matter at issue* in a Board appeal if the Board has jurisdiction to conduct a hearing on the matter . . . and the Board determines it lacks the authority to decide the legal question (*as described in § 405.1867* of this subpart, which explains the scope of the Board's legal authority)."[74]

The Board finds that EJR cannot be granted in these cases based on the issue preclusion question posed. Section 405.1842(a)(1) limits the Board's authority to grant EJR to legal questions that are "relevant to a specific matter at issue" and are "described in § 405.1867." The Board recognizes that the *District Hospital* decision interprets and applies "provisions of Title XVIII of the Act and regulations issued thereunder;" however, that the decision was issued by a U.S. federal district court and, as a result, the decision has no *general* controlling precedence. Further, the legal question of issue preclusion as posed does not itself entail a legal challenge to or legal question under "the provisions of Title XVIII of the Act and regulations issued thereunder" and, as such, necessarily falls outside the scope of the Board's authority to grant EJR in the first instance (as well as the scope of the Board hearing proceedings).[75] Accordingly, the Board declines to grant EJR in these appeals on the question of issue preclusion as presented.

DECISION:

After considering the Medicare law, regulations and program instructions, arguments presented, and evidence admitted, the Board finds that the Medicare Contractor properly disallowed the Medicare bad debts protested by the UHS Providers for the FYs 2006 through 2009, because the bad debts remained at OCAs and that these disallowances did not violate the Bad Debt Moratorium. Accordingly, the Board affirms the Medicare Contractor's adjustments in these appeals.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

8/31/2020

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: Clayton J. Nix -A

[73] 42 U.S.C. § 1395oo(f)(1).
[74] (Emphasis added.)
[75] Rather, FRCP Rule 8(c)(1) lists *res judicata* is an affirmative defense and the proper forum for UHS to raise this issue is in federal district court should this appeal reach federal district court.

APPENDIX A

SCHEDULE OF PROVIDERS

Schedule of Providers in Group

Group Name: UHS 06 Medicare Bad Debts Still At Agency Group
Representative: Tracy A. J. Hale, Esq. Hooper Lundy & Bookman, P.C
Case No.: 08-2236GC
Issue: Disallowance of bad debts still at collection agency

Tab #	Provider No.	Provider Name	FYE/FPE	Intermediary	A Date of Final Determination	B Date of Hear. Req.	C Number of Days	D Audit Adj. No.	E Amount of Reimb.	F Original Case No.	G Date of Add/ Transfer
1	42-0082	Aiken Regional Medical Center Aiken, Aiken, SC	12/31/06	Novitas	09/16/08	10/21/08	35	16	$40,017	N/A	10/21/08
2	11-4032	Anchor Hospital College Park, Clayton, GA	12/31/06	Novitas	02/22/08	07/29/08	158	13	$11,900	N/A	07/29/08
3	50-0015	Auburn Regional Medical Center Auburn, King, WA	12/31/06	Novitas	08/21/08	10/21/08	61	16	$27,432	N/A	10/21/08
4	04-4005	BridgeWay, The N. Little Rock, Pulaski, AR	12/31/06	Novitas	01/18/08	07/01/08	165	17	$4,442	N/A	07/01/08
5	42-4010	Carolina Center for Behavioral Health Gree, Greenville, SC	12/31/06	Novitas	06/10/08	10/21/08	133	12	$0	N/A	10/21/08
6	39-0012	Central Montgomery Medical Center Lansdale, Montgomery, PA	12/31/06	Novitas	06/09/08	10/21/08	134	14	$12,112	N/A	10/21/08
7	19-0185	Chalmette Medical Centers Chalmette, St. Bernard, LA	12/31/06	Novitas	08/18/08	01/29/09	164	1,3,6	$47,725	N/A	01/29/09
8	19-S185	Chalmette Medical Centers Chalmette, St. Bernard, LA	12/31/06	Novitas	08/18/08	01/29/09	164	1,3,6	$7,919	N/A	01/29/09
9	05-0329	Corona Regional Medical Center Corona, Riverside, CA	12/31/06	Novitas	03/25/08	07/11/08	108	25	$55,077	N/A	07/11/08
10	29-0022	Desert Springs Hospital Las Vegas, Clark, NV	12/31/06	Novitas	01/25/08	07/01/08	158	12	$8,000	N/A	07/01/08
11	45-0643	Doctor's Hospital of Laredo Laredo, Webb, TX	12/31/06	Novitas	03/10/08	07/01/08	113	13	$12,522	N/A	07/01/08
12	45-0119	Edinburg Regional Medical Center Edinburg, Hidalgo, TX	12/31/06	Novitas	09/23/08	01/29/09	128	22	$4,169	N/A	01/29/09
13	45-0092	Fort Duncan Regional Medical Center Eagle Pass, Maverick, TX	12/31/06	Novitas	02/29/08	07/01/08	123	14	$6	N/A	07/01/08
14	22-4021	Fuller Memorial Hospital S. Attleboro, Bristol, MA	12/31/06	Novitas	5/2/08	07/01/08	60	14 & 19	$2,484	N/A	07/01/08
15	09-0001	George Washington Univ. Hospital Washington, DC	12/31/06	Novitas	09/22/08	01/29/09	129	29	$19,209	N/A	01/29/09
16	14-4026	Hartgrove Hospital Chicago, Cook, IL	12/31/06	Novitas	03/04/08	08/07/08	156	12	$2,166	N/A	08/07/08
17	22-4018	Human Resource Institute Brookline, Norfolk, MA	12/31/06	Novitas	04/28/08	07/29/08	92	13 & 18	$5,557	N/A	07/29/08
18	44-4004	Lakeside Behavioral Health System Memphis, Shelby, TN	12/31/06	Novitas	09/11/08	03/04/09	174	15 & 22	$59,601	N/A	03/04/09
19	05-0204	Lancaster Community Hospital Lancaster, Los Angeles, CA	12/31/06	Novitas	04/10/08	07/14/08	95	13	$27,989	N/A	07/14/08

Schedule of Providers in Group

Group Name: UHS 06 Medicare Bad Debts Still At Agency Group
Representative: Tracy A. J. Hale, Esq. Hooper Lundy & Bookman, P.C
Case No.: 08-2236GC
Issue: Disallowance of bad debts still at collection agency

Tab #	Provider No.	Provider Name	FYE/FPE	Intermediary	A Date of Final Determination	B Date of Hear. Req.	C Number of Days	D Audit Adj. No.	E Amount of Reimb.	F Original Case No.	G Date of Add/ Transfer
20	10-0035	Manatee Memorial Hospital Bradenton, Manatee, FL	12/31/06	Novitas	02/11/08	07/01/08	141	16	$14,899	N/A	07/01/08
21	45-0811	McAllen Medical Heart Hospital McAllen, Hidalgo, TX	12/31/06	Novitas	06/03/08	07/01/08	28	33	$141,560	N/A	07/01/08
22	29-0032	Northern Nevada Medical Center Sparks, Washoe, NV	12/31/06	Novitas	05/05/08	07/14/08	70	20	$62,244	N/A	07/14/08
23	45-0209	Northwest Texas Hospital Amarillo, Potter, TX	12/31/06	Novitas	03/21/08	07/11/08	112	38	$1,898	N/A	07/11/08
24	11-4010	Peachford Behavioral Health System Atlanta, Dekalb, GA	12/31/06	Novitas	05/06/08	10/21/08	168	14	$517,179	N/A	10/21/08
25	18-4009	Ridge Behavioral Health System Lexington, Fayette, KY	12/31/06	Novitas	05/16/08	10/15/08	152	14	$3,203	N/A	10/15/08
26	37-0026	St. Mary's Regional Medical Center Enid, Garfiled, OK	12/31/06	Novitas	06/16/08	07/09/08	23	18	$49,462	N/A	07/09/08
27	29-0046	Spring Valley Hospital Medical Center Las Vegas, Clark, NV	12/31/06	Novitas	05/12/08	07/29/08	78	11	$4,304	N/A	07/29/08
28	29-0041	Summerlin Hospital Medical Center Las Vegas, Clark, NV	12/31/06	Novitas	06/09/08	07/29/08	50	18	$7,962	N/A	07/29/08
29	11-0209	Turning Point Care Center Moultrie, Colquitt, GA	12/31/06	Novitas	05/27/08	10/21/08	147	11	$267,516	N/A	10/21/08
30	08-4002	UHS of Rockford, Inc. Newark, New Castle, DE	12/31/06	Novitas	02/26/08	07/29/08	154	19 & 21	$19,561	N/A	07/29/08
31	29-0021	Valley Hospital Medical Center Las Vegas, Clark, NV	12/31/06	Novitas	06/13/08	09/16/08	95	19	$5,381	N/A	09/16/08
32	10-0275	Wellington Regional Medical Center W. Palm Beach, Palm Beach, FL	12/31/06	Novitas	02/21/08	07/01/08	131	12	$114,852	N/A	07/01/08
33	22-4023	Westwood Lodge Hospital Westwood, Norfolk, MA	12/31/06	Novitas	05/12/08	10/21/08	162	5	$0	N/A	10/21/08
									$1,558,348		

VOLUME I

Schedule of Providers in Group (Model Form G)

Case No 09-1414GC
Group Name UHS 2007 Medicare Bad Debts Still At Agency CIRP Group
Representative Tracy A J Hale, Esq , Hooper Lundy & Bookman, P C
Intermediary Novitas Solutions, Inc
Issue Disallowance of bad debts still at collection agency

Date Prepared 11/23/15

Tab # VOL I	Provider No	Provider Name	FYE/FPE	Intermediary	A Date of Final Determination	B Date of Hear Req	C Number of Days	D Audit Adj No	E Amount of Reimb	F Original Case No	G Date of Add/ Transfer
1	14-4026	Hartgrove Hospital Chicago, Cook, IL	12/31/07	Novitas	01/16/09	04/06/09	80	11	$2,836	N/A	04/06/09
2	39-4034	Horsham Clinic, The Ambler, Montgomery, PA	06/30/07	Novitas	10/15/08	04/06/09	173	11 & 15	$666	N/A	04/06/09
3	26-4017	Two Rivers Psychiatric Hospital Kansas City, Jackson, MO	12/31/07	Novitas	12/08/08	04/06/09	119	16	$0	N/A	04/06/09
4	10-0299	Lakewood Ranch Medical Center Bradenton, Manatee, FL	12/31/07	Novitas	10/24/12	04/19/13	177	11	$496	N/A	04/19/13
5	39-0012	Central Montgomery Medical Center Lansdale, Mongomery, PA	12/31/07	Novitas	02/19/13	08/06/13	168	17	$7,491	N/A	08/06/13
6	05-0701	Southwest Healthcare System Wildomar, Riverside, CA	12/31/07	Novitas	02/19/13	08/06/13	168	807	$213,034	N/A	08/06/13
7	29-0046	Spring Valley Hospital Medical Center Las Vegas, Clark, NV	12/31/07	Novitas	02/19/13	08/06/13	168	800	$6,496	N/A	08/06/13
8	29-0041	Summerlin Hospital Las Vegas, Clark, NV	12/31/07	Novitas	02/20/13	08/06/13	167	26	$8,412	N/A	08/06/13
9	37-0026	St Mary's Regional Medical Center Enid, Garfield, OK	12/31/07	Novitas	02/26/13	08/06/13	161	29	$13,308	N/A	08/06/13
10	45-0643	Doctor's Hospital of Laredo Laredo, Webb, TX	12/31/07	Novitas	03/06/13	08/06/13	153	14	$10,908	N/A	08/06/13
11	10-0035	Manatee Memorial Hospital Bradenton, Manatee, FL	12/31/07	Novitas	03/07/13	08/06/13	152	29	$9,611	N/A	08/06/13
12	09-0001	George Washington University Hospital Washington, DC	12/31/07	Novitas	03/08/13	08/06/13	151	25	$16,181	N/A	08/06/13
13	45-0811	McAllen Heart Hospital McAllen, Hidalgo, TX	12/31/07	Novitas	03/08/13	08/06/13	151	7	$6,245	N/A	08/06/13
14	10-0275	Wellington Regional Medical Center Wellington, Palm Beach, FL	12/31/07	Novitas	03/08/13	08/06/13	151	16	$56,115	N/A	08/06/13
15	29-0022	Desert Springs Hospital Las Vegas, Clark, NV	12/31/07	Novitas	03/07/13	08/19/13	165	2	$19,485	N/A	08/19/13

Schedule of Providers in Group (Model Form G)

Case No 09-1414GC
Group Name UHS 2007 Medicare Bad Debts Still At Agency CIRP Group
Representative Tracy A J Hale, Esq , Hooper Lundy & Bookman, P C
Date Prepared 11/23/15
Intermediary Novitas Solutions, Inc
Issue Disallowance of bad debts still at collection agency

Tab # VOL II	Provider No	Provider Name	FYE/FPE	Intermediary	A Date of Final Determination	B Date of Hear Req	C Number of Days	D Audit Adj No	E Amount of Reimb	F Original Case No	G Date of Add/ Transfer
16	29-0021	Valley Hospital Medical Center Las Vegas, Clark, NV	12/31/07	Novitas	03/08/13	08/19/13	164	2 & 4	$20,829	N/A	08/19/13
17	45-0119	South Texas Health System Edinburg, Hidalgo, FL	12/31/07	Novitas	03/08/13	08/19/13	164	2	$18,549	N/A	08/19/13
18	45-0209	Northwest Texas Hospitaal Amarillo, Potter, TX	12/31/07	Novitas	03/08/13	08/19/13	164	820	$5,129	N/A	08/19/13
19	42-0082	Aiken Regional Medical Center Aiken, Aiken, SC	12/31/07	Novitas	03/28/13	08/23/13	148	7	$43,359	N/A	08/23/13
20	50-0015	Auburn Regional Medical Center Auburn, King, WA	12/31/07	Novitas	03/28/13	08/23/13	148	22	$4,254	N/A	08/23/13
21	29-0032	Northern Nevada Medical Center Sparks, Washoe, NV	12/31/07	Novitas	03/28/13	08/23/13	148	23	$5,023	N/A	08/23/13
22	05-0204	Lancaster Community Hospital Lancaster, Los Angeles, CA	12/31/07	Novitas	03/28/13	08/23/13	148	18	$0	N/A	08/23/13
23	05-0329	Corona Regional Medical Center Corona, Riverside, CA	12/31/07	Novitas	03/28/13	08/23/13	148	4	$13,769	N/A	08/23/13
									$482,197		

VOLUME I

Schedule of Providers in Group (Model Form G)

Case No 10-1019GC
Group Name UHS 2008 Medicare Bad Debts Still At Agency CIRP Group
Representative Tracy A J Hale, Esq , Hooper Lundy & Bookman, P C
Lead Intermediary Novitas Solutions, Inc
Issue Disallowance of bad debts still at collection agency

Date Prepared 11/23/2015

Tab # VOL I	Provider No	Provider Name	FYE/FPE	Intermediary	A Date of Final Determination	B Date of Hear Req	C Number of Days	D Audit Adj No	E Amount of Reimb	F Original Case No	G Date of Add/ Transfer
1	11-4032	Anchor Hospital College Park, Clayton, GA	12/31/08	Novitas	02/26/10	05/10/10	73	13	$451,917	N/A	05/10/10
2	08-4002	UHS of Rockford Newark, New Castle, DE	12/31/08	Novitas	11/13/09	05/10/10	178	9 & 14	$6,204	N/A	05/10/10
3	18-4009	Ridge Behavioral Health System Lexington, Fayette, KY	12/31/08	Novitas	12/22/09	06/17/10	177	12	$4,247	N/A	06/17/10
4	22-4018	Human Resource Institute Brookline, Norfolk, MA	12/31/08	Novitas	03/26/10	09/20/10	178	13	$4,787	N/A	09/20/10
5	08-4004	Dover Behavioral Health System Dover, New Castle, DE	12/31/08	Novitas	04/26/10	10/20/10	177	10	$14,542	N/A	10/20/10
6	23-4030	Forest View Psychiatric Hospital Grand Rapids, Kent, MI	12/31/08	Novitas	06/01/10	11/18/10	170	15	$188	N/A	11/18/10
7	10-0275	Wellington Regional Medical Center Wellington, Palm Beach, FL	12/31/08	Novitas	02/21/13	08/14/13	174	23	$37,863	N/A	08/14/13
8	45-0209	Northwest Texas Hospital Amarillo, Potter, TX	12/31/08	Novitas	03/06/13	08/14/13	161	19	$2,813	N/A	08/14/13
9	39-0012	Central Montgomery Medical Center Lansdale, Montgomery, PA	12/31/08	Novitas	03/27/13	08/14/13	140	7	$14,554	N/A	08/14/13
10	45-0643	Doctor's Hospital of Laredo Laredo, Webb, TX	12/31/08	Novitas	06/07/13	08/29/13	83	30	$7,736	N/A	08/29/13
11	45-0119	South Texas Health System Edinburg, Hidalgo, TX	12/31/08	Novitas	06/07/13	08/29/13	83	6	$5,900	N/A	08/29/13
12	45-0324	Texoma Medical Center Denison, Grayson, TX	12/31/08	Novitas	06/07/13	08/29/13	83	4	$0	N/A	08/29/13
13	42-0082	Aiken Regional Medical Center Aiken, Aiken, SC	12/31/08	Novitas	06/07/13	10/03/13	118	4	$16,188	N/A	10/03/13
14	09-0001	Geo Washington University Hospital Washington, DC	12/31/08	Novitas	05/31/13	10/03/13	125	21	$17,477	N/A	10/03/13
15	10-0035	Manatee Memorial Hospital Bradenton, Manatee, FL	12/31/08	Novitas	06/07/13	10/03/13	118	809	$11,396	N/A	10/03/13

Schedule of Providers in Group (Model Form G)

Case No 10-1019GC
Group Name UHS 2008 Medicare Bad Debts Still At Agency CIRP Group
Representative Tracy A J Hale, Esq , Hooper Lundy & Bookman, P C
Lead Intermediary Novitas Solutions, Inc
Issue Disallowance of bad debts still at collection agency

Date Prepared 11/23/2015

Tab # VOL II	Provider No	Provider Name	FYE/FPE	Intermediary	A Date of Final Determination	B Date of Hear Req	C Number of Days	D Audit Adj No	E Amount of Reimb	F Original Case No	G Date of Add/ Transfer
16	29-0021	Valley Hospital Medical Center Las Vegas, Clark, NV	12/31/08	Novitas	04/12/13	10/03/13	174	4 & 9	$10,419	N/A	10/03/13
17	10-0299	Lakewood Regional Medical Center Bradenton, Manatee, FL	12/31/08	Novitas	06/07/13	10/03/13	118	4	$3,097	N/A	10/03/13
18	37-0026	St Mary's Regional Medical Center Enid, Garfield, OK	12/31/08	Novitas	06/07/13	10/03/13	118	28	$6,311	N/A	10/03/13
19	29-0046	Spring Valley Hospital Las Vegas, Clark, NV	12/31/08	Novitas	05/09/13	10/21/13	165	2	$10,259	N/A	10/21/13
20	29-0022	Desert Springs Hospital Las Vegas, Clark, NV	12/31/08	Novitas	06/07/13	10/21/13	136	15	$11,578	N/A	10/21/13
21	29-0041	Summerlin Medical Center Las Vegas, Clark, NV	12/31/08	Novitas	06/07/13	10/21/13	136	16	$3,749	N/A	10/21/13
22	50-0015	Auburn Regional Medical Center Auburn, King, WA	12/31/08	Novitas	06/07/13	10/21/13	136	1, 2 & 30	$11,331	N/A	10/21/13
23	05-0329	Corona Regional Medical Center Corona, Riverside, CA	12/31/08	Novitas	06/07/13	10/21/13	136	32	$14,091	N/A	10/21/13
24	05-0701	Southwest Healthcare System Wildomar, Riverside, CA	12/31/08	Novitas	06/07/13	10/21/13	136	14	$2,303	N/A	10/21/13
25	05-0204	Lancaster Community Hospital Lancaster, Los Angeles, CA	12/31/08	Novitas	08/08/13	10/21/13	74	7	$1,267	N/A	10/21/13
26	29-0032	Northern Nevada Medical Center Sparks, Washoe, NV	12/31/08	Novitas	05/31/13	10/21/13	143	1	$5,293	N/A	10/21/13
									$675,511		

Model Form G - Schedule of Providers in Group

Case No 11-0106GC
Group Name UHS 2009 Medicare Bad Debts Still At Agency CIRP Group
Representative Tracy A J Hale, Esq , Hooper Lundy & Bookman, P C
Intermediary Novitas Solutions, Inc
Issue Disallowance of bad debts still at collection agency

Date Prepared 11/23/15

Tab # VOL I	Provider No	Provider Name	FYE/FPE	Intermediary	A Date of Final Determination	B Date of Hear Req	C Number of Days	D Audit Adj No	E Amount of Reimb	F Original Case No	G Date of Add/ Transfer
1	39-4027	Fairmount Behavioral Health System Philadelphia, Philadelphia, PA	06/30/09	Novitas	05/11/10	11/05/10	178	16	$0	N/A	11/05/10
2	39-4034	Horsham Clinic, The Ambler, Montgomery, PA	06/30/09	Novitas	08/04/10	01/25/11	174	13	$2,867	N/A	01/25/11
3	22-4021	Arbour Fuller Hospital South Attleboro, Bristol, MA	12/31/09	Novitas	10/29/10	04/20/11	173	13	$2,462	N/A	04/20/11
4	22-4023	Westwood Lodge Hospital Westwood, Norfolk, MA	12/31/09	Novitas	10/26/10	04/20/11	176	13	$0	N/A	04/20/11
5	08-4008	Dover Behavioral Health System Dover, Kent, DE	12/31/09	Novitas	12/17/10	04/22/11	126	6	$10,948	N/A	04/22/11
6	34-4007	Old Vineyard Youth Services Winston Salem, Forsyth, NC	12/31/09	Novitas	11/08/10	04/22/11	165	10	$0	N/A	04/22/11
7	39-4050	Roxbury Psychiatric Hospital Shippensburg, Franklin, PA	12/31/09	Novitas	11/22/10	04/22/11	151	10	$3,434	N/A	04/22/11
8	11-4032	Southern Crescent Behavioral Atlanta, Clayton, GA	12/31/09	Novitas	12/14/10	04/22/11	129	4	$813	N/A	04/22/11
9	08-4002	UHS of Rockford Newark, New Castle, DE	12/31/09	Novitas	11/09/10	04/22/11	164	10	$0	N/A	04/22/11
10	06-4024	Highlands Behavioral Health System Littleton, Douglas, CO	12/31/09	Novitas	11/24/10	04/26/11	153	4	$17,729	N/A	04/26/11
11	14-4029	Pavilion Behavioral Health, The Champaign, Champaign, IL	12/31/09	Novitas	11/30/10	04/26/11	147	14	$2,152	N/A	04/26/11
12	20-0054	Centennial Hills Hospital Med Center Las Vegas, Clark, NV	12/31/09	Novitas	07/23/13	08/12/13	20	11	$3,342	N/A	08/12/13
13	10-0035	Manatee Memorial Hospital Bradenton, Manatee, FL	12/31/09	Novitas	02/18/13	08/12/13	175	15	$4,012	N/A	08/12/13
14	29-0032	Northern Nevada Medical Center Sparks, Washoe, NV	12/31/09	Novitas	05/31/13	08/12/13	73	4	$4,073	N/A	08/12/13
15	05-0329	Corona Regional Medical Center Corona, Riverside, CA	12/31/09	Novitas	08/16/13	11/06/13	82	6	$12,175	N/A	11/06/13

Model Form G - Schedule of Providers in Group

Case No 11-0106GC
Group Name UHS 2009 Medicare Bad Debts Still At Agency CIRP Group
Representative Tracy A J Hale, Esq , Hooper Lundy & Bookman, P C
Intermediary Novitas Solutions, Inc
Issue Disallowance of bad debts still at collection agency

Date Prepared 11/23/15

Tab # VOL II	Provider No	Provider Name	FYE/FPE	Intermediary	A Date of Final Determination	B Date of Hear Req	C Number of Days	D Audit Adj No	E Amount of Reimb	F Original Case No	G Date of Add/ Transfer
16	50-0015	Auburn Regional Medical Center Auburn, King, WA	12/31/09	Novitas	08/19/13	11/06/13	79	5	$16,942	N/A	11/06/13
17	05-0701	Southwest Healthcare System Wildomar, Riverside, CA	12/31/09	Novitas	08/19/13	11/06/13	79	16	$8,114	N/A	11/06/13
18	29-0022	Desert Springs Hospital Las Vegas, Clark, NV	12/31/09	Novitas	08/26/13	11/06/13	72	16	$5,600	N/A	11/06/13
19	45-0119	South Texas Health System Edinburg, Hidalgo, TX	12/31/09	Novitas	08/26/13	11/06/13	72	6	$64,377	N/A	11/06/13
20	29-0046	Spring Valley Hospital Las Vegas, Clark, NV	12/31/09	Novitas	08/30/13	11/06/13	68	19	$46,359	N/A	11/06/13
21	05-0204	Lancaster Community Hospital Lancaster, Los Angeles, CA	12/31/09	Novitas	09/04/13	11/06/13	63	1	$5,118	N/A	11/06/13
22	45-0209	Northwest Texas Hospital Amarillo, Potter, TX	12/31/09	Novitas	09/05/13	11/06/13	62	6	$18,920	N/A	11/06/13
23	29-0041	Summerlin Medical Center Las Vegas, Clark, NV	12/31/09	Novitas	09/05/13	11/06/13	62	4	$4,198	N/A	11/06/13
24	45-0643	Doctor's Hospital of Laredo Laredo, Webb, TX	12/31/09	Novitas	09/06/13	11/06/13	61	27	$34,733	N/A	11/06/13
25	29-0021	Valley Hospital Medical Center Las Vegas, Clark, NV	12/31/09	Novitas	09/06/13	11/06/13	61	3	$10,538	N/A	11/06/13
26	42-0082	Aiken Regional Medical Center Aiken, Aiken, SC	12/31/09	Novitas	09/03/13	02/24/14	174	6	$11,275	N/A	02/24/14
27	09-0001	George Washington University Hosp Washington, DC	12/31/09	Novitas	09/05/13	02/24/14	172	26	$7,324	N/A	02/24/14
28	10-0275	Wellington Regional Medical Center Wellington, Palm Beach, FL	12/31/09	Novitas	09/05/13	02/24/14	172	4	$1,627	N/A	02/24/14
29	37-0026	St Mary's Regional Medical Center Enid, Garfield, OK	12/31/09	Novitas	09/06/13	02/24/14	171	5	$14,017	N/A	02/24/14
30	10-0299	Lakewood Regional Medical Center Bradenton, Manatee, FL	12/31/09	Novitas	09/06/13	02/24/14	171	11	$2,588	N/A	02/24/14
31	45-0092	Fort Duncan Medical Center Eagle Pass, Maverick, TX	12/31/09	Novitas	09/16/13	02/24/14	161	5	$12,188	N/A	02/24/14
									$327,928		