PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D42

PROVIDER -Parkview Community Hospital Medical Center
Riverside, California

Provider No. 05-0102

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of California

DATE OF HEARING-
April 2, 1998

Cost Reporting Period Ended -
December 31, 1990

CASE NO. 93-0048

INDEX

ISSUE:

Was the Intermediary's adjustment disallowing Medicare bad debts proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Parkview Community Hospital Medical Center ("Provider") is a non-profit, general acute care facility located in Riverside, California. The Provider was certified to participate in the Medicare program on May 21, 1967.[1]

On January 30, 1992, during an audit of the Provider's Medicare cost report, Blue Cross of California ("Intermediary") requested that the Provider furnish specific documentation to support the amount of Medicare bad debts claimed for program reimbursement. The Provider furnished certain documents which the Intermediary found to be inadequate. Since the Intermediary concluded that it could not determine whether or not the bad debts were appropriate based upon the Provider's documentation, it made an adjustment disallowing the entire amount of Medicare bad debts claimed.[2]

On October 13, 1992, the Provider appealed the Intermediary's adjustment to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is $43,835.

The Provider was represented by Douglas S. Cumming, Esq. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it properly documented its Medicare bad debts and that it otherwise complied with required practices relative to bad debt collection.

The Provider contends that the controlling regulation regarding Medicare bad debts is found at 42 C.F.R. § 413.80. In part, this regulation provides that for bad debts to be allowable:

> (1)The debt must be related to covered services and derived from deductible and co-insurance amounts.

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1 Intermediary's Position Paper at 1.

2 Intermediary's Position Paper at 4.

(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 judgement established that there was no likelihood of recovery at any time in the future.

42 C.F.R. § 413.80(e).

Similarly, program instructions contained in the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 310 require that for Medicare bad debts to be allowable a "reasonable collection effort" must be made, and comparable efforts must be made to collect Medicare bad debts as are made to collect non-Medicare accounts. The manual instructions also require that "(t)he provider's collection efforts should be documented in the patient's file by copies of the bill(s), follow up letters, reports of telephone and personal contact, etc."

The Provider contends that consistent with the aforementioned rules it provided the Intermediary with a copy of its bad debt policy, examples of collection letters used to request payments from beneficiaries, and a listing of its Medicare bad debts for the subject cost reporting period. The Provider asserts that these documents reflect full compliance with the regulatory and manual requirements both in terms of collection policy and documentation.

In support of its position, the Provider cites King's Daughter's Hospital v. Blue Cross and Blue Shield Association, PRRB Decision No. 91-D5, November 14, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,950, decl'd rev., HCFA Administrator, December 26, 1990, where the Board rejected the intermediary's contention that a hospital's collection policy for bad debts failed to comply with the required scope of collection efforts; Parkland Memorial Hospital v. Blue Cross and Blue Shield Association, PRRB Decision No. 93-D106, September 30, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,923, rev'd HCFA Administrator, November 29, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,987, where the Board held that a hospital's exercise of "sound business judgment" in pursuing collection of Medicare bad debts was deemed sufficient to comply with the requirements of the regulatory and manual provisions; and, University Hospital (Augusta, GA.) v. Blue Cross and Blue Shield Association, PRRB Decision No. 95-D43, June 23, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,482, rev'd HCFA Administrator, August 21, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,692, Lourdes Hospital v. Blue Cross and Blue Shield Association, PRRB Decision No. 95-D58, August 31, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,585, aff"d in relevant part, HCFA Administrator, October 27, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,723, and Mt. Sinai Hospital and Medical Center v. Blue Cross and Blue Shield Association, PRRB Decision No. 95-D49, August 8, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,594, rev'd HCFA Administrator, September 29, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,724, where similar results were reached.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment disallowing the Provider's Medicare bad debts is proper. The Provider did not furnish sufficient information to support its claim in accordance with program regulations and manual instructions. The information and documentation contained in the Provider's position paper is the same information and documentation that was available during the audit of the Provider's cost report. This includes a copy of the Provider's bad debt collection policy, sample formats of collection letters, and a Medicare bad debt listing.

Medicare regulations at 42 C.F.R. §§ 413.20 and 413.24, and program instructions at HCFA Pub. 15-1 §§ 2300, 2304 and 2404.2, require providers to maintain sufficient financial records and statistical data for the proper determination of costs payable under the program. Such data must be accurate and capable of verification by the Intermediary. With respect to the instant case, the Intermediary asserts that the Provider's bad debt listing, or computerized patient file, did not contain the information necessary to make such a determination. Specifically, the listing did not contain the admission or discharge date for Part A services, service date for Part B services, date of account write-off, amounts recovered subsequent to write-off, deductible and coinsurance amounts, non-covered charges, etc.

Moreover, the Intermediary asserts that due to insufficient information and documentation it did not have an adequate basis to allow the Provider's bad debts pursuant to 42 C.F.R. § 413.80, HCFA Pub. 15-1 § 300ff, and the Part A Intermediary Manual, Part 4 ("HCFA Pub. 13-4")
§ 4198 at Exhibit A-11. Specifically, the Provider failed to demonstrate with compelling or convincing evidence that:

- the claimed amounts pertained to covered services and were derived from deductible and coinsurance amounts pursuant to HCFA Pub. 15-1 § § 302.5, 304 and 306;

- it exerted and properly documented reasonable collection efforts pursuant to HCFA Pub. 15-1 § 310;

- the claimed amounts were actually worthless pursuant to HCFA Pub. 15-1 § 310.2;

- it determined the beneficiary's indigent status in accordance with HCFA Pub. 15-1 § 312;

- it accounted for the bad debts and subsequent recovery of bad debts in accordance with HCFA Pub. 15-1 § § 314 and 316; and

- it determined the Medicare bad debts under the State Welfare Programs in accordance with HCFA Pub. 15-1 § 322.

Finally, the Intermediary contends that the Provider did not adequately present its position to the Board in accordance with 42 C.F.R. § 405.1853 and HCFA Pub. 15-1 § 2921.5. Specifically, the Provider did not prepare a Position Paper that adequately stated all facts and included detailed information including supporting documentation regarding amounts claimed.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost

2. Regulations - 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1853	-	Prehearing Discovery and Other Proceedings Prior to the Board Hearing
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.80	-	Bad Debts, Charity, and Courtesy Allowances

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 300ff	-	Bad Debts, Charity, and Courtesy Allowances
§ 2300ff	-	Adequate Cost Data and Cost Finding
§ 2404.2	-	Examination of Pertinent Data and Information
§ 2921.5	-	Position Papers

4. Program InstructionsPart A Intermediary Manual, Part IV (HCFA Pub. 13-4):

§ 4198 at Exhibit 11	-	Guidelines for Performing Provider Audits - Medicare Bad Debts

5. Case Law:

King's Daughter's Hospital v. Blue Cross and Blue Shield Association, PRRB Decision No. 91-D5, November 14, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,950, decl'd rev., HCFA Administrator, December 26, 1990.

Parkland Memorial Hospital v. Blue Cross and Blue Shield Association, PRRB Decision No. 93-D106, September 30, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,923, rev'd HCFA Administrator, November 29, 1993, Medicare & Medicaid Guide (CCH)
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¶ 43,724.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that the Intermediary properly disallowed the Provider's claim for reimbursement of Medicare bad debt expenses. The Provider did not furnish adequate documentation to support its claim in accordance with program regulations and manual instructions.

The Board finds that bad debts are an allowable program expense where a provider can demonstrate that certain criteria have been met. In part, the Provider's efforts to collect the debts should be documented in the patients' files by copies of pertinent data such as bills, collection letters and reports of telephone contact. 42 C.F.R. § 413.80(e) and HCFA Pub. 15-1 §§ 308 and 310. With respect to the instant case, the Board finds no evidence in the record other than the Provider's stated bad debt collection policy which meets these program requirements. In particular, there is no documentation associated with individual patients' files that establishes that reasonable collection efforts were made, that each debt was actually uncollectible when claimed as worthless, or that the Provider properly accounted for bad debt recoveries or had determined patient indigency.

The Board also finds that the Provider failed to comply with the record-keeping requirements of 42 C.F.R. §§ 413.20 and 413.24. These regulations require providers to maintain sufficient financial records and statistical data for proper determination of costs payable under the Medicare program. Such data and documentation must be based on the financial and statistical records of the Provider and be furnished to the Intermediary for the purpose of ascertaining whether the information is accurate and pertinent to the determination of program payments. In this case, the Board holds that the Provider did not furnish adequate documentation capable of being verified by the Intermediary.

DECISION AND ORDER:

The Intermediary properly disallowed the Provider's claim for reimbursement of Medicare bad debts. The Provider did not furnish adequate documentation to support its claim in accordance with program rules and regulations. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: April 21, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman