PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D1

PROVIDER -Greenview Hospital
Bowling Green, Kentucky

Provider No. 18-0124

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Anthem Blue Cross and Blue Shield

DATE OF HEARING-
September 17, 1998

Cost Reporting Period Ended -
September 30, 1990

CASE NO. 93-0824+

INDEX

ISSUE:

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

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Greenview Hospital is a general short term hospital owned and operated by Hospital Corporation of America (HCA). It is located in Bowling Green, Kentucky.[1] The Provider timely filed its Medicare cost report for the fiscal year ended September 30, 1990, in which it claimed reimbursement for $65,291 in Medicare bad debts.[2] On September 28, 1992, Anthem Blue Cross and Blue Shield ("Intermediary") issued a Notice of Program Reimbursement ("NPR") which reflected a disallowance of $12,327 in Medicare bad debts.[3] The basis of the adjustment was to remove those claimed bad debts written off prior to 120 days from the date of the first bill.[4]

On February 24, 1993, the Provider appealed the Intermediary's bad debt disallowance to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841, and met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is the entire adjustment of $12,327.

The Provider was represented by Charles S. McCandless, Esquire, Manager, Appeals, Columbia/HCA Healthcare Corporation, the Provider's parent organization. The Intermediary was represented by Bernard M. Talbert, Esquire, Associate Counsel, Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it met the regulatory requirements of 42 C.F.R. § 413.80, even though several of the bad debts were written off in less than 120 days. The Medicare bad debts related only to deductible and coinsurance amounts owed by Medicare beneficiaries for covered inpatient and outpatient services. The bad debts were claimed in the cost reporting period in which the amounts due from the Medicare beneficiaries were deemed worthless. Collection efforts were applied uniformly for both Medicare and non-Medicare patients. Exercising sound judgment, the Provider wrote off bad debts after the delinquent accounts

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1 Provider's Position Paper at 1.

2 Provider's Position Paper at 4.

3 Intermediary's Position Paper at 2 and 3.

4 Id. Also see Intermediary Exhibit 1.

were deemed worthless; which on occasion was prior to the expiration of the 120 day period. Furthermore, the Provider contends

that the Intermediary acknowledged that, with the sole exception of the 120 day criteria, the Provider's collection process was adequate.

The Provider contends that the Intermediary's interpretation of the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 310.2 is improper. The Provider argues that the manual instruction was created to serve as a presumptive test and not as a "rule" that establishes a mandatory holding period of 120 days before delinquent accounts may be deemed allowable Medicare bad debts.

The Provider asserts that HCFA Pub. 15-1 § 310.2 is one of several guidelines used to establish proof of a reasonable collection effort. The other guidelines of HCFA Pub. 15-1 § 310 must be considered in assessing whether a reasonable collection effort was made by a provider under the particular circumstances. Therefore, a provider's reasonable collection efforts are ultimately assessed by the existence or nonexistence of other criteria (i.e., similar collection effort for Medicare and non-Medicare billings, prompt issuances of billing, use of subsequent bills, collection letters, telephone calls and collection agencies) delineated by Medicare regulations and manual instructions. In the instant case, the Provider contends that it clearly met all of the regulatory requirements of 42 C.F.R. § 413.80 regarding reimbursement of Medicare bad debts.
In that its collection process and efforts were deemed adequate,[5] the Provider asserts that the bad debts written off in less than 120 days should be allowable.

The Provider cites two Board decisions wherein it was held that the 120 day factor was not controlling in the determination of whether or not a provider exercised adequate collection efforts. In Lourdes Hospital (Paducah, Ky.) v. Blue Cross and Blue Shield Association/ AdminaStar of Kentucky, PRRB Dec. 95-D58, August 31, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,585, modif'd HCFA Admin., October 25, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,723 ("Lourdes"), the Board stated in pertinent part that:

> [t]he Intermediary's application of HCFA Pub. 15-1 § 310.2 as the sole basis to disallow the Provider's bad debts was improper. The Board finds that section 310.2 is merely a guideline for establishing reasonable collection efforts and noncollectibility. Other factors delineated in 42 C.F.R. § 413.80(e) and HCFA Pub. 15-1 § 310 also must be considered. Such factors include similar collection efforts for Medicare and non-Medicare patients, prompt issuance of billings, use of subsequent bills, collection letters, telephone calls and collection agencies. 42 C.F.R. § 413.80(e) and HCFA Pub. 15 -1 § 310.

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[5] Id.

Lourdes, Medicare & Medicaid Guide (CCH) ¶ 43,585.

Additionally, in Kings Daughters' Hospital (Ashland, Ky.) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Kentucky, Inc., PRRB Dec. 91-D5, Nov. 14, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,950, decl'd rev. HCFA Admin., December 26,1990 ("King's Daughters"), the Board concluded that the provider's Medicare bad debts which were written off less than 120 days from the date of the initial billing to patients should be allowed. The Board held that the intermediary's application of HCFA Pub. § 310.2, Presumption of Noncollectibility to disallow the under 120 day bad debt write-offs was improper.

The Provider rejects the Intermediary's contention that it is precluded by Section 4008(c) of the Omnibus Budget Reconciliation Act ("OBRA") of 1987, as amended by the Technical and Miscellaneous Revenue Act of 1988 and OBRA of 1989, from allowing bad debts claimed in 120 days or less. That section, commonly referred to as the "moratorium" prohibits any change in the bad debt policy in effect as of August 1, 1987. The Provider contends the Intermediary has not presented clear and convincing evidence that its actual practice prior to August 1, 1987 was in every manner consistent with its written policy. Nor has the Intermediary presented evidence that its written policy was actually communicated to the Provider.

Finally, the Provider contends that HCFA's interpretation of OBRA 1987 is incorrect. Section 4008 of OBRA 1987 prohibited the Secretary from making any changes in provider collection policies that were in effect on August 1, 1987. Further guidance was provided by Section 6023 of OBRA 1989, which amended OBRA 1987 by stating:

> [t]he 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 indigence 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.

Id. (Emphasis added.)

The Provider asserts that OBRA 1987 and OBRA 1989 do not mandate consistent application of the 120 day rule, even when application of that rule was the intermediary's policy as of August 1, 1987. Rather, these laws forbid any application of the Medicare bad debt regulations that would result in the intermediary disapproval of the provider's collection policies that were approved by the intermediary on or before August 1, 1987.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that the disallowance of bad debts written off prior to 120 days after the date of the first billing is supported by 42 C.F.R. § 413.80 and HCFA Pub. 15-1, Section 300ff. Regulation 42 C.F.R. § 413.80(e) and HCFA Pub. 15-1, Section 308, list the four criteria for a Medicare bad debt to be deemed allowable:

(1) The bad 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.

HCFA Pub. 15-1, Section 310ff, explains the characteristics of a reasonable collection effort and the presumption of non-collectibility. This presumption, described at HCFA Pub. 15-1, Section 310.2 states: "[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." Id. This section relieves the Provider of having to prove that the debt is uncollectible if the bill has been outstanding for at least 120 days. However, if the debt has been written off prior to 120 days from the first bill, the Provider must prove and document that the debt was actually uncollectible at the time of write-off.

The Intermediary contends that it has two arguments in this case:

1. the Provider has not proven that these accounts are actually uncollectible, and

2. the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) prevents the Intermediary from changing its policy as of Aug. 1, 1987, of disallowing all accounts written off before 120 days.

The first argument is supported by a letter dated Sept. 15, 1995, from the Health Care Financing Administration (HCFA's) Bureau of Policy Development to the HCFA attorney advisor regarding the Lourdes Hospital case.[6] This letter states:

As discussed above, the policy permits claiming of bad debts in 120 days or

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[6] Intermediary Exhibit I-2.

> less only when providers are able to show that a particular debt was actually uncollectible when claimed as worthless in accordance with the criterion in Section 308(3). If providers were permitted to satisfy this criterion based merely on a showing of vigorous collection efforts for some shorter period after mailing the first bill, the effect would be to afford the provider the "same" presumption
>
> contained in Section 310.2, but prior to the expiration of the 120 day period. Such an interpretation would not be in keeping with the policy.

Id.

Thus, bad debts must be shown to be uncollectible on a case-by-case basis if not written off at least 120 days after the first bill. In its preliminary position paper, the Provider has merely argued that it has uniformly applied collection efforts to Medicare and non-Medicare patients, and in some cases this process did not last 120 days from the first billing. There has been no showing on a case-by-case basis that there is something unique about these accounts that makes them uncollectible.

The Intermediary's second argument is that even if the Board determines that the Provider has shown these accounts to be uncollectible on a case-by-case basis, Section 4008(c) of OBRA 1987, as amended by Section 8402 of the Technical and Miscellaneous Revenue Act of 1988, and Section 6023 of OBRA 1989 precludes the Intermediary from allowing these accounts as Medicare bad debts. This section, commonly referred to as the "moratorium," prohibits any change in bad debt policy in effect as of Aug. 1, 1987. HCFA's Bureau of Policy Development, in its letter of April 1, 1992, to all Regional Administrators clarifies how the moratorium relates to the 120 day rule:[7]

> [t]herefore, under the moratorium, if an intermediary's practice as of August 1, 1987, was to permit bad debts claimed in 120 days or less, with adequate proof that the debt was uncollectible, the intermediary should continue that practice. In the same manner, an intermediary should continue to disallow any bad debts claimed in 120 days or less if that was the intermediary's consistent policy as of August 1, 1987.

Id.

The Intermediary contends that its policy as of Aug. 1, 1987 was to disallow any bad debts

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[7] Intermediary Exhibit I-3.

written off prior to 120 days from the first billing. This is evidenced by a copy of the audit program for the used for the Provider's FYE Sept. 30, 1986, cost report settlement completed on July 30, 1987.[8] Step G. states "[d]etermine that the period of time from the first billing to the write off is at least 120 days unless the patient is considered indigent or medically indigent." Work paper E-0, page 2, concludes that the period from the first billing to the W/O date is at least 120 days. In addition, the Intermediary work papers reflect that various accounts were reviewed for the 120-day criterion. Since the Intermediary removed any accounts not meeting the 120 day criterion as of August 1, 1987, the Intermediary contends it must continue to do so.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§§ 405.1835-.1841	-	Board Jurisdiction
§ 413.80	-	Bad debts, charity, and courtesy allowances
§ 413.80(e)	-	Criteria for allowable bad debt

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

§ 300	-	Principle
§ 308	-	Criteria for allowable bad debt
§ 310 et seq.	-	Reasonable Collection Effort
§ 310.2	-	Presumption of Noncollectibility

3. Case Law:

Lourdes Hospital (Paducah, Ky.) v. Blue Cross and Blue Shield Association/AdminaStar of Kentucky, PRRB Dec. 95-D58, August 31, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,585, modif'd HCFA Admin., October 25, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,723.

King's Daughters' Hospital (Ashland, Ky.) v. Blue Cross and Blue Shield Association/

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[8] Intermediary Exhibit I-4

Blue Cross and Blue Shield of Kentucky, Inc., PRRB Dec. 91-D5, Nov. 14, 1990, Medicare & Medicaid Guide (CCH) ¶ 38,950 decl'd rev, HCFA Admin., December 26, 1990.

4. Other:

HCFA letter dated April 1, 1992.
HCFA letter dated September 15, 1995.
Omnibus Budget Reconciliation Act of 1987 § 4008
Omnibus Budget Reconciliation Act of 1989 § 6023
Technical and Miscellaneous Revenue Act of 1988

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that the Intermediary properly disallowed a portion of the Medicare bad debts claimed by the Provider. The Provider did not establish that the debts at issue were actually uncollectible when they were claimed as worthless as required by program regulations.

Regulation 42 C.F.R. § 413.80(e) provides four (4) criteria that a provider must meet with respect to a receivable from a beneficiary in order to claim that receivable as a bad debt. In general, a provider must establish that the debt relates to covered services and is derived from deductible and coinsurance amounts, that reasonable collection efforts were made, that the debt was actually uncollectible when claimed, and that sound business judgment indicates there is no likelihood of future recovery.

Program instructions at HCFA Pub. 15-1 § 310.2 address "noncollectibility", the criteria underscored above. The manual states "[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". Id. In addition, HCFA Pub. 15-1 § 310 B.
states: 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 contacts, etc. The Board majority concludes that unless a provider demonstrates that a Medicare debt is uncollectible by other means, the provider must comply with the 120 day requirement. This conclusion is the logical outgrowth of the Provider's contention that the 120 day "rule" is a "presumptive test" in law, a presumption can only be overcome with sufficient rebuttable evidence directed at that element of the test.

With respect to the instant case, the Board majority finds no documentary evidence in the record establishing the subject bad debts as uncollectible. The Board majority agrees with the Intermediary's contention that the Provider has merely argued that it has uniformly applied collection efforts to both Medicare and non-Medicare patients. The Board majority finds that the Intermediary's work papers specifically note that if the Provider is claiming a bad debt in less than 120 days, the Provider is to note on the bad debt work sheet why the amount is being claimed. There is no evidence distinguishing the subject accounts as uncollectible. Accordingly, the Board majority is compelled to rely upon the 120 day rule to determine uncollectibility because it is not rebutted, as did the Intermediary, and find that the subject accounts are not reimbursable.

The Board majority acknowledges the Provider's reference to the decisions rendered in Lourdes and King's Daughters' to support its position that the 120 day rule is merely one of many guidelines that must be consideration in determining whether or not a receivable can be

claimed as a bad debt. The Board majority, however, distinguishes the instant case from Lourdes, in that, in Lourdes there was substantial evidence including testimony and the provider's historical experience that established the subject debts as uncollectible. Similarly, in King's Daughters' the

facts and evidence clearly indicated that the provider met all of the Medicare bad debt criteria with the one exception of the 120 day rule, thus providing sufficient rebutted evidence.

Finally, the Board majority agrees with HCFA's application of the bad debt moratorium enacted by OBRA 1987, as amended, to the 120 day rule, stated as follows:

> [t]herefore, under the moratorium, if an intermediary's practice as of August 1, 1987 was to permit bad debts claimed in 120 days or less, with adequate proof that the debt was uncollectible, the intermediary should continue that practice. In the same manner, an intermediary should continue to disallow any bad debts claimed in 120 days or less if that was the intermediary's consistent policy as of August 1, 1987.

HCFA letter dated April 1, 1992.

The Board majority finds sufficient evidence in the file to support the Intermediary's contention that its policy as of August 1, 1987 was to disallow any bad debts written off prior to 120 days from the first billing.

DECISION AND ORDER:

The Intermediary properly disallowed a portion of the Medicare bad debts claimed by the Provider. The Intermediary's adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr. Esq. (Dissenting Opinion)
Charles R. Barker

Date of Decision: October 05, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover, Jr.

I respectfully dissent.

The Provider contends that the facts in this case show that it met all regulatory requirements of 42 C.F.R. § 413.80. The criteria for allowable bad debt can be found in 42 C.F.R. § 413.80(e) which provides:

(1) The debt must be related to covered services and derived from deductible and co-insurance 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 judgement established that there was no likelihood of recovery at any time in the future.

Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) § 310.2 provides "[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." Id.

The Provider contends that the Intermediary acknowledged that, with the sole exception of the 120 day criteria, the Provider's collection process was adequate.

The Board majority has determined that Provider Reimbursement Manual HCFA Pub. 15-1 § 310.2 requires the provider to somehow provide additional proof that the debt is worthless. This manual section does not place any additional burden of proof requirements on the Provider. It appears that the majority would also allow the bad debt if it were written off and claimed after 120 days but would disallow the bad debt if it were written off and claimed on the 119th day. The Board's Majority's finding that there was no documentary evidence in the record establishing the subject bad debts as uncollectible goes beyond the requirements of the Manual, in my opinion. Had the HCFA Administrator wanted to make the section non-presumptive and require additional proof on the part of the Provider, it would have been very easy to do so by placing this

requirement in the manual section. Since this was not done, it does not appear that the Provider is required to offer additional proof as to why the subject bad debts were written off prior the the 120 days.

The Intermediary's adjustment to bad debt should be reversed.

Martin W. Hoover, Jr., Esq.
Board Member