PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D9

PROVIDER -Peachtree Rehabilitation Ctr.
Peachtree City, Georgia

Provider No. 11-6571

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING-
September 10, 1998

Cost Reporting Period Ended -
December 31, 1991

CASE NO. 94-2203

INDEX

ISSUE:

Was the Intermediary's adjustment to bad debts proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Peachtree Rehabilitation Center ("Provider") was a Medicare certified rehabilitation agency located in Peachtree City, Georgia. During its Medicare cost reporting period ended December 31, 1991, the Provider furnished outpatient physical therapy services, occupational therapy services, and speech therapy services to various skilled nursing facilities on a contractual basis.[1]

On its cost report for the subject reporting period, the Provider claimed program reimbursement for bad debts resulting from uncollected Medicare coinsurance and deductible amounts. Mutual of Omaha Insurance Company ("Intermediary") reviewed the Provider's bad debt claim as part of its audit of the Provider's cost report. After reviewing a sample of fifty-six patient files the Intermediary determined that the Provider had not made a reasonable effort to collect the coinsurance and deductible amounts and, therefore, denied reimbursement of the Provider's bad debts.[2]

On September 28, 1993, the Intermediary issued a Notice of Program Reimbursement reflecting its disallowance of the Provider's bad debts. On March 17, 1994, the Provider appealed the Intermediary's 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 approximately $103,000.[3]

The Provider was represented by Mohamad A. Zayan, Administrator, Peachtree Rehabilitation Center. The Intermediary was represented by Tom Bruce, Senior Consultant, Mutual of Omaha Insurance Company. .

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustment disallowing its claim for Medicare bad debts is improper. The Provider asserts that it successfully documented the medical

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1 Intermediary's Position Paper at 2.

2 Id.

3 Id.

indigence of the patients attributed with the debts, the inability to collect the debts from other sources such as Medicaid, and the fact that the debts were actually uncollectible when claimed as worthless.[4]

The Provider contends that its collection policies and collection efforts comply with program instructions contained in the Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 308. The Provider explains that the Intermediary audited each of its prior period cost reports, i.e., for the Provider's cost reporting periods ended in 1986 through 1990, and accepted the Provider's collection policies, practices and bad debt claims.[5]

The Provider contends that it furnished the Intermediary with copies of collection effort documents that it obtained directly from its contracted therapists. The Provider questions the Intermediary's rejection of these documents as proper support for its bad debts in the subject cost reporting period while accepting them in each previous reporting period. The Provider believes that if something is wrong with its documentation, it was the Intermediary's responsibility to bring that matter to its attention so it could be corrected. The Provider does not believe it should carry the burden for procedural errors caused by the Intermediary. [6]

The Provider contends that almost 98 percent of the patients it treated were medically indigent. Each of the patients was a resident of a nursing home located in a financially poor area. The Provider asserts that the reason the Intermediary's auditors never questioned its bad debts in prior years is because they were familiar with the nursing homes with which it contracted; the auditors knew the patient population was essentially Medicaid eligible which indicates indigence. The Provider also explains that because the patients it treated were essentially Medicaid eligible individuals residing in nursing homes is the reason it did not make telephone calls to the patients to help try to collect the debts, i.e., as a follow-up effort to collection letters. The Provider emphasizes that the Intermediary's auditor's never questioned its collection efforts in prior periods which employed the same collection letter and no follow-up telephone calls.[7]

In support of its position, the Provider refers to Exhibit P-3 at Attachment H of its Position Paper. In part, the exhibit contains a listing of Medicaid numbers applicable to the patients charged with the Provider's 1992 bad debts. The Provider acknowledges that this data does not pertain specifically to the subject cost reporting period. However, the Provider asserts that this information serves as an example of the indigence of the patients it treated. In addition, the Provider explains that it furnished the Medicaid numbers applicable to its 1992 cost reporting

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4 Provider's Position Paper at 4 of 4.

5 Provider's Position Paper at 2 of 4 and 4 of 4. Transcript ("Tr.") at 7 and 22.

6 Tr. at 21 and 33.

7 Provider's Position Paper at 3 of 4. Tr. at 9, 20, and 28.

period when it was asked to do so by the Intermediary's auditors. The Provider also explains that it was never asked to furnish this information for the subject cost reporting period, and probably could not do so at this time because it terminated operations and stored its accounting records, and because the accountant is no longer available.[8]

The Provider rejects the Intermediary's argument that it should have billed the Georgia State Medicaid Agency for the unpaid Medicare deductibles and coinsurance since that would have generated documentation from the State indicating the patients' Medicaid eligibility and apparent indigence. The Provider explains that billing the State agency would not be helpful since the Georgia Medicaid program does not pay Medicare deductibles and coinsurance.[9]

The Provider rejects the Intermediary's argument that the form of the letter it used to try to collect the Medicare debts does not comply with the provisions of HCFA Pub. 15-1 § 310. The Provider argues again that the Intermediary had always accepted this letter in its previous audits and never acknowledged any deficiencies.[10]

Moreover, the Provider rejects the Intermediary's argument that its collection letters are improper because they were all dated the first day of the month even though that day may have been a Saturday or Sunday. The Provider explains that it is not unusual in a business environment for work to be done at home and on weekends.[11]

The Provider also rejects the Intermediary's argument that it had not determined the Medicare debts to be uncollectible when they were claimed as worthless, or that sound business judgment established that there was no likelihood of a future recovery of the debts. The Intermediary bases these arguments on the Provider's policy that allows bad debts to be written-off in less than 120 days. However, the Provider argues that the Intermediary has failed to check its own records. The Provider asserts that its 60-day write off period was accepted by the Intermediary's auditors in each of the Provider's previous cost reporting periods. Moreover, the Provider asserts that the Intermediary never requested that it make a "case-by-case" finding that there was no likelihood of future recoveries of the debts.[12]

Finally, the Provider contends that there was more than sufficient evidence that the subject debts were actually uncollectible when claimed as worthless. If the Intermediary's auditors

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[8] Tr. at 10, 18 and 27.

[9] Tr. at 9. Provider Attachment H at Exhibit P-1.

[10] Provider's Position Paper 3 of 4.

[11] Tr. at 8.

[12] Provider's Position Paper at 4 of 4.

had actually attempted to verify patient records they would have clearly recognized that all patients in their audit sample were medically indigent.[13]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment disallowing the Provider's claim for Medicare bad debts is proper. The adjustment is based upon an appropriate application of Medicare regulations and program policies.[14]

The Intermediary contends that the Provider did not comply with the criteria for allowing bad debts found at 42 C.F.R. § 413.80 by establishing that reasonable efforts were made to collect the debts; that the debts were actually uncollectible when claimed for program reimbursement; and, that sound business judgement established that there was no likelihood of recovering the debts at any time in the future.[15]

Program instructions at HCFA Pub. 15-1 § 310 explain, in part, that a reasonable collection effort includes "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."

With respect to the instant case, the Intermediary asserts that it reviewed 56 patient files obtained directly from the Provider's contract therapists, and found that the Provider's collection documentation consisted of a series of forms. Each form is dated the first day of successive months and reflects a statement directed toward the patient indicating that Medicare has been billed for their therapy services. The series of forms purports that the Provider sent an initial statement to a patient the first day of a month, a payment letter on the first day of the next month, a friendly reminder letter on the first day of the month after that, a payment past due letter on the first of the next month, a delinquent notice a month later, and finally a legal proceedings notice on the first day of the next succeeding month. However, no actual copies of any of these letters and notices were in the patients' files.[16]

The Intermediary refers to an example of the Provider's documentation at Exhibit I-4. This documentation, a series of forms, shows that the Provider furnished physical therapy services to Patient 1 from January 2 to January 28, and that Patient 1 was liable for a $100 deductible

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[13] Provider's Position Paper at 3 of 4.

[14] Intermediary's Position Paper at 5.

[15] Id.

[16] Intermediary's Position Paper at 5 and 6.

and a $324 coinsurance amount. Moreover, the series of forms indicate that the Provider sent a statement to Patient 1 on March 1, a payment letter on April 1, a friendly reminder letter on May 1, a payment past due letter on June 1, a delinquent notice on July 1, and a legal proceedings notice on August 1. However, as noted above, actual copies of the letters and notices were apparently not in Patient 1's file.[17]

The Intermediary asserts that the series of forms used by the Provider is nothing more than a clumsy effort to disguise the fact that no effort was actually made to collect Patient 1's debt. Each form indicates a letter or notice was mailed on the first day of the month regardless of whether that day fell on Saturday or Sunday. The form appears to have been filled out once, photocopied, and the letter dates written in during one sitting. There is no indication that the Provider attempted to telephone Patient 1, or that Patient 1, despite having been sent several demands for payment including a notice of legal proceedings, attempted to contact the Provider.[18]

The Intermediary asserts that the deficiencies in the Provider's collection effort documentation for Medicare patients are uniform. The Intermediary obtained identical collection effort documentation as that obtained for Patient 1 in each of the 56 cases it reviewed. All collection letters are dated the first day of the month, including January 1. The letters all appear to have been filled out once, photocopied, and letter dates written in during one sitting. The Intermediary asserts that it is difficult to believe that not a single Medicare patient contacted the Provider regarding the debt they owed if they were, in fact, billed for the services.[19]

The Intermediary contends that the Provider has not furnished any documentation to show that the patients attributed with the subject bad debts were indigent by virtue of their eligibility for Medicaid in accordance with HCFA Pub. 15-1 § 312, which states: "[p]roviders can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." As demonstrated by Patient 1's file at Exhibit 1-6, the Provider furnished no Medicaid cards or any other indication that the patients were Medicaid eligible.[20]

The Intermediary contends that the patients' files also gave no indication that the Provider determined patient indigence based upon its own efforts. In accordance with HCFA Pub. 15-

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[17] Id.

[18] Id.

[19] Id.

[20] Intermediary's Position Paper at 7. Tr. At 13.

1 § 312, if patients are not eligible for Medicaid a provider should apply its customary methods for determining their indigence, and the patient file should contain all the backup information to substantiate the determinations. The Intermediary asserts that the patient files contained no such backup data.[21]

The Intermediary contends that a copy of a collection letter included in the Provider's draft position paper, Exhibit I-7, does not meet the description of a reasonable collection effort provided at HCFA Pub. 15-1 § 310. Initially, the Intermediary argues that this document was not furnished during the audit of the Provider's cost report. Nevertheless, the Intermediary asserts that the letter, in and of itself, is insufficient evidence of a reasonable collection effort. The Intermediary again asserts that there is no evidence that the Provider attempted to telephone or make personal contact with the patient to whom the letter was sent, or that the patient attempted to telephone or contact the Provider.[22]

The Intermediary contends that there is no evidence the debts claimed by the Provider were actually uncollectible when claimed as worthless, or that sound business judgment established that there was no likelihood of recovering the debts in the future. The Intermediary asserts that even if the Provider had actually followed the collection policy submitted in its draft position paper, Exhibit I-8, the debts would still be unallowable because the collection policy does not comply with HCFA Pub. 15-1 § 310.2. 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." The Provider's policy permits a write-off of the debt 60 days after the initial collection effort is sent to the patient or responsible party, well short of the 120 day guideline. This guideline does permit a write-off in less than 120 days in those instances where a provider explains, on a case-by-case basis, why a debt is worthless. The fact the Provider's collection policy permits this premature write-off indicates no case-by-case finding of noncollectiblity will be made. Moreover, none of the documentation submitted by the Provider, whether housed in the Intermediary's workpapers or the Provider's draft position paper, furnishes evidence that the Provider made a case-by-case finding that there was no likelihood of future recoveries.[23]

Finally, the Intermediary rejects the Provider's argument regarding its earlier period cost reports, i.e., the Provider's contention that the Intermediary's auditors reviewed its bad debt policies and collection efforts in each of its prior period cost reports, and accepted the Provider's bad debts for program reimbursement. The Intermediary asserts that it reviewed its records and found that the Provider had submitted a cost report for each of its accounting periods ended December 31, 1987 through December 31, 1990. The extent and result of the

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[21] Id.

[22] Id.

[23] Intermediary's Position Paper at 8

Intermediary's review of each of these periods is as follows:[24]

o The Provider's cost report for the period ended December 31, 1987, was audited. Minor adjustments were made to the Provider's bad debts claim due, in part, to inadequate documentation of collection effort.

o The Provider's cost report for the period ended December 31, 1988, was subjected to an in-house desk review. Substantial adjustments were made to the Provider's claim for bad debts. The explanation for the greater part of the adjustments was that the debts were written off in less than 120 days from the date of the first billing.

o The Provider's cost reports for the periods ended December 31, 1989 and December 31, 1990, were subjected to an in-house desk review. The only audit procedure performed by the Intermediary was to verify that the patients on the Provider's bad debt listing were Medicare beneficiaries. No adjustments were made to the Provider's bad debt claim.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:
   §1395x(v) - Reasonable Cost

2. Regulations - 42 C.F.R.:
   §§ 405.1835-.1841 - Board Jurisdiction

   § 413.80 - Bad Debts, Charity and Courtesy Allowances

3. Program Instructions-Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):
   § 308 - Criteria for Allowable Bad Debt

   § 310 - Reasonable Collection Effort

   § 310.2. - Presumption of Noncollectibility

   § 312 - Indigent or Medically Indigent Patients

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented,

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[24] Intermediary's Post-Hearing Brief at 7. Intermediary's Post-Hearing Brief at Exhibits I-1 through I-4.

testimony elicited at the hearing, and post-hearing briefs, finds and concludes that the Intermediary properly disallowed the Provider's claim for reimbursement of Medicare bad debts. The Provider failed to establish that it made a reasonable effort to collect the debts as required by Medicare regulations, or establish the debts to be uncollectible by virtue of the patients' eligibility for Medicaid.

Regulations at 42 C.F.R. § 413.80 provide the criteria that a bad debt must meet in order to be reimbursed by the Medicare program. In part, the regulations state: "[t]he provider must be able to establish that reasonable collection efforts were made." Id. (Emphasis added.) Program instructions at HCFA Pub. 15-1 § 310 define a reasonable collection effort to include the issuance of a bill to the patient or responsible party in addition to other actions such as subsequent billings, collection letters, and telephone calls. Moreover, HCFA Pub. 15-1 § 310 B. explains that providers should document their collection effort by maintaining copies of patient bills, collection letters, and reports of contact, etc. Clearly, providers must be able to show, with documentation, that they made a sincere effort to collect Medicare debts before they can be deemed to be bad debts and be reimbursed by the program.

With respect to the instant case, the Board finds that the Provider's documentation fails to establish that a reasonable effort was made to collect the subject Medicare debts. The Board finds that the Provider's documentation consists only of a series of identical forms placed in its patients' files indicating that collection actions had occurred. For example, a form placed in a patient's file may indicate that a collection letter was issued on March 1, and another form in the file may indicate that a second collection letter was issued 30 days later on April 1. However, the patient's file would not contain copies of these letters. The Board notes that the series of forms used by the Provider indicate that 6 different collection mailings were sent to Medicare beneficiaries including a delinquent notice and a notice of legal proceedings. However, no copies of any of these documents were found in the patients' files. The Board notes that the patient files were also void of any letters, reports of contact, etc. from patients responding to the Provider's collection efforts.

The Board rejects the Provider's argument that the subject disallowance is improper since the Intermediary had reviewed its bad debt practices in each of its prior cost reporting periods and had always accepted its bad debt claims. The Board finds that the Provider submitted a cost report for the prior reporting periods ended December 31, 1987 through December 31, 1990. The Intermediary audited the 1987 cost report, and made some adjustments to the Provider's bad debts for inadequate documentation pertaining to a reasonable collection effort. In each of the three subsequent periods the Intermediary conducted only a desk review of the Provider's cost reports, which apparently included only a perfunctory review of bad debts. The Board adds that "past practices" may, in some circumstances, represent substantive evidence to help support or refute a party's contentions. However, past practices, such as the absence of an adjustment in prior period audits, does not justify the continuation of improper program payments.

The Board also rejects the Provider's argument that the Intermediary's adjustment is improper since practically 100 percent of the patients attributed with the debts were eligible for Medicaid.
The Board finds that HCFA Pub. 15-1 § 312 allows a debt to be deemed uncollectible without applying a reasonable collection effort if a patient is determined to be indigent. Moreover, the manual states that: "providers can deem Medicare beneficiaries indigent. . . . when such individuals have also been determined eligible for Medicaid. . . .Id.

With respect to this matter, the Board finds no substantive evidence indicating the Medicaid status of the patients at issue in this case. The Provider's bad debt listing indicates that each patient is indigent and that the indigence is documented in its records. However, no such evidence was presented to the Board, and the Intermediary's review of a sample of 56 patient files also did not reveal any such documentation.

The Board acknowledges the Provider's argument that the subject patients' indigence is evidenced by the fact that they all resided in nursing homes located in financially poor areas.

The Board, however, cannot rely upon this assertion to uphold the Provider's claim. While the Board agrees that a large percentage of nursing home populations consist of Medicaid eligible individuals, it is not true that they are 100 percent Medicaid. Therefore, the Provider's records must adequately document which patients are Medicaid eligible individuals and which are not in order for the amount of debts to be reimbursed by the program to be accurately determined.

DECISION AND ORDER:
The Provider's documentation is inadequate. The documentation does not establish that a reasonable effort was made to collect Medicare debts, or establish the debts to be uncollectible by virtue of the patients' eligibility for Medicaid. The Intermediary's adjustment disallowing the Provider's claim for reimbursement of Medicare bad debts is affirmed.

Board Members Participating:
Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: November 24, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman