PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D59

PROVIDER -
Village Green Nursing Home
Phoenix, Arizona

Provider No. 03-5104

vs.

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

DATE OF HEARING-
July 21, 1999

Cost Reporting Period Ended -
December 31, 1994

CASE NO. 96-2619

ISSUE:

INDEX

Was the Intermediary\s adjustment disallowing indigent Part B bad debts proper?

STATEMENT OF CASE AND PROCEDURAL HISTORY:

Village Green Nursing Home ("Provider") is a 120-bed skilled nursing facility ("SNF") located in Phoenix, Arizona. The State of Arizona has a unique Medicaid program called the Arizona Health Care Cost Containment System ("AHCCCS"). AHCCCS operates two branches, one which handles acute care health plans, and another which is responsible for long term care services. The branch responsible for long term care is called the Arizona Long Term Care System ("ALTCS"). ALTCS provides for long term care by contracting with "program contractors", which are typically county agencies. In the instant case, the program contractor is the Maricopa Managed Care System ("MMCS"), an agency of Maricopa County.

Medicaid recipients are enrolled with the program contractors. The program contractors contract with providers to provide actual services to the beneficiaries. Under the contract, the program contractors are responsible for reimbursing the providers, who in turn are bound to submit their claims and bills to the program contractors. In the instant case, the Provider has a contract with MMCS. Under the MMCS contract, providers are to provide primary care physician authorized services to clients eligible for Medicare at no cost to MMCS. The Provider is required to submit a billing form for physical therapy services but this is only for program statistical purposes, and not payment. The Provider did not initially seek reimbursement for the coinsurance or deductible amount for Medicare Part B services provided from either MMCS or AHCCCS. The Provider claimed the unpaid coinsurance and deductible amounts as bad debts on its FYE 1994 cost report.

After learning of the Intermediary's proposed adjustments, the Provider contacted MMCS regarding the proper treatment of Part B coinsurance and deductibles. MMCS responded in a January 23, 1996 memorandum[1] that stated:

> [t]his memo is to eliminate some of the confusion regarding Maricopa Managed Care Systems (MMCS) contract with the nursing facilities as to how therapy services will be reimbursed. The basic capitation rate does not include reimbursement for therapy services. All authorized therapy services performed on MMCS Medicare patients should be billed to Medicare for payment in full. MMCS will not reimburse for these services. All non-Medicare MMCS will be capitated at a rate of $4.67 per diem as payment in full for their authorized therapy services. Although MMCS will not be reimbursing for therapy services on a

[1] Provider Exhibit 6.

> fee-for service basis we will still require a[n] UB-92 claim for encounter information only for these services.

This billing instruction from MMCS is consistent with the provisions in the Provider's contract with MMCS that denied the Provider's reimbursement for Part B therapy services.

Blue Cross and Blue Shield of Arizona ("Intermediary") denied the Provider's bad debts because it claims that AHCCCS is liable to reimburse the full Medicare deductible and coinsurance for AHCCCS and Medicare covered services provided to eligible recipients.[2] The Intermediary claims that the Provider failed to follow AHCCCS program policy and obtain payment from AHCCCS.

By letter dated December 17, 1999, after the evidentiary hearing on July 21, 1999, the Provider requested that the Board allow the record to be supplemented with additional evidence not requested by the Board.[3] The Board denied the Provider's request and did not consider the new evidence in making its determination.

The Provider requested a Provider Reimbursement Review Board ("Board") hearing pursuant to Medicare regulations at 42 C.F.R. '' 405.1835-.1841 and has meet the jurisdictional requirements of the regulations. The Medicare reimbursement amount is controversy is approximately $55,000.

The Provider was represented by Kevin M. O'Connor, Esquire, of Arnall, Golden and Gregory, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the governing federal regulation and manual provision state that a provider's bad debts are allowable if four criteria are satisfied. See 42 C.F.R. ' 413.80 et seq.; HCFA Pub. 15-1 ' 300. The Provider contends that it satisfied each criterion for the allowance of bad debts.

The Provider asserts that there is no dispute that the bad debts claimed were related to covered services and derived from deductible and coinsurance amounts. Thus, the first criteria concerning the allowance of bad debts was satisfied.

The second criteria for the allowance of bad debts is central to this case. In the audit adjustment report

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[2] See Intermediary Position Paper at 4 referring to Section 300 of the AHCCCS Policy and Procedure Manual.

[3] See Provider Exhibit 29.

the Intermediary cited HCFA Pub. 15-1 '' 308 and 310 to support its disallowance of the Provider's bad debts. HCFA Pub. 15-1 ' 308 mimics the federal regulation's four criteria for the allowance of bad debts. HCFA Pub. 15-1 ' 310 then elaborates on the second criteria by describing what actions constitute reasonable collection efforts.

The Intermediary witness testified that the collection efforts described in HCFA Pub. 15-1 ' 310 does not have to be employed by a provider when the debt at issue is derived from the provision of services to an indigent patient. Furthermore, relying on HCFA Pub. 15-1 ' 312, the Intermediary witness testified that a patient is deemed indigent if the patient is a Medicaid recipient. The Intermediary's witness agreed that the collection efforts set forth in HCFA Pub. 15-1 ' 310 do not have to be used when a patient is indigent.

The bad debts at issue in this appeal resulted from the provision of services to Medicaid patients. In accordance with HCFA Pub. 15-1 ' 312, the Provider deemed these patients indigent and concluded that the collection efforts of HCFA Pub. 15-1 ' 310 did not have to be applied. The Intermediary's witness concurred that "the Provider did deem the patient indigent, correctly, as it [sic] is enrolled in AHCCCS" and agreed that once an indigence determination is made, the collection efforts of HCFA Pub. 15-1 ' 310 do not have to be employed.[4] Thus, because the bad debts at issue are derived from the provision of services to Medicaid patients, the Provider contends that the reasonable collection efforts anticipated by HCFA Pub. 15-1 '' 308 and 310 do not have to be employed, and the second prong of the bad debt analysis is satisfied.

The next issue in the analysis is whether the debts were uncollectible when they were claimed as worthless. See 42 C.F.R. ' 413.80(e)(3) and HCFA Pub. 15-1 ' 308. Given the patients' status as Medicaid recipients, the Provider determined that the debts were uncollectible. This conclusion is supported by HCFA Pub. 15-1 ' 312, which states that "once indigence is determined, . . . the debt may be deemed uncollectible . . ." See HCFA Pub. 15-1 ' 312.

Finally, the last criterion of 42 C.F.R. ' 413.80(e) was satisfied because, given the indigence of the patients involved, sound business judgment indicated that there was no likelihood of recovery of these amounts in the future. The Intermediary offered no evidence to rebut the Provider's testimony that the debts were uncollectible and not recoverable in the future. Thus, the Provider satisfied the federal regulation and the Manual provision which govern the allowance of Medicare bad debts.

The Intermediary instructed the Provider to bill "all possible payors, including ALTCS, AHCCCS and the beneficiary."[5] The Provider contends that the Intermediary did not adequately understand the

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[4] Tr. at 114.

[5] See Provider Exhibit 1.

structure of the Arizona Medicaid program and did not know who the "possible payors" were. As a result, the Intermediary denied the Provider reimbursement to which it is entitled because it had not taken action that it is prohibited from taking contractually.

The Intermediary's instruction is inconsistent with the mechanics of the Arizona Medicaid program. First, by instructing the Provider to bill the beneficiary, the Intermediary is instructing the Provider to violate the terms of its contract with MMCS. The provider contract states that "MMCS, AHCCCS and ALTCS members, their families, guardians or conservators, shall not be billed for any service or supplies provided to clients covered under this Contract."[6] Thus, billing the beneficiary, one of the "possible payors" according to the Intermediary, was not a realistic or legal option.

The other two possible payors according to the Intermediary were AHCCCS and ALTCS. The Provider points out that AHCCCS could not be billed because it was not its program contractor. Similarly, ALTCS is a part of AHCCCS that is responsible for contracting with program contractors which in turn contract with providers, but ALTCS does not have any direct reimbursement responsibility. MMCS is the agency that the Provider is required to bill for purposes of Medicaid reimbursement. Thus, the suggestion to bill either AHCCCS or ALTCS is inconsistent with the operation of the Arizona Medicaid program and its contractual obligations under that program.

In addition, the contract between MMCS and the Provider stated that it would not be reimbursed for Part B services. When the Provider asked MMCS about reimbursement for Part B coinsurance and deductibles, it was referred to a memo which clearly stated that MMCS would not reimburse Village Green for those amounts. In fact, that memo informed the Provider that Medicare would pay for those amounts "in full."[7] Contrary to the Intermediary's insistence that the Arizona Medicaid program would pay for the Part B coinsurance and deductible amounts at issue, the Arizona Medicaid program, through its program contractor, MMCS, had made it clear that it would not reimburse the Provider for these amounts.[8]

The Provider contends that its position is consistent with HCFA Form 339, which is a form developed by HCFA that provides instructions for reviewing the provider's cost report form. Providers and intermediaries use HCFA 339 alike. In discussing the allowance of Medicare bad debts, HCFA Form 339 Instructions[9] state that:

> it may not be necessary for a provider to actually bill the Medicaid

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[6] Provider Exhibit 25.

[7] See Provider Exhibit 6.

[8] Id.

[9] See Provider Exhibit 11 at 2.

program to establish a Medicare crossover bad debt where the provider can establish that Medicaid is not responsible for payment. In lieu of billing the Medicaid program, the provider must furnish documentation of:

- Medicaid eligibility at the time services were rendered, and
- Non-payment that would have occurred if the crossover claim had actually been filed with Medicaid.

Both Provider witnesses testified that the coinsurance and deductible amounts at issue in this case were derived from the provision of services to Medicaid patients. Therefore, the first prong of HCFA Form 339 is satisfied. In addition, the Provider's contract with MMCS and the billing instructions it received from MMCS prove that non-payment would have occurred had the Medicaid program been billed. Thus, using HCFA's form for determining the allowance of Medicare bad debts, the Provider's Medicare bad debts should have been allowed.

The Provider notes that subsequent to the disallowance on October 28, 1996, the Intermediary's auditor wrote to the ALTCS to request a meeting with the ALTCS to discuss the proper treatment of Medicare bad debts. In this letter, the Intermediary notes that the documentation "on AHCCCS is quite old and may not be reflective of current policy."[10] The letter further indicates that "some hospital and nursing home staff are not billing AHCCCS/ALTCS on dual eligible patients because they claim that they were told not to bill or that AHCCCS/ALTCS would not have paid the claim."[11] This "after-the-fact" inquiry into the structure and mechanics of the Arizona Medicaid program is further evidence that the Intermediary did not understand the Arizona Medicaid program at the time the audit was conducted and the disallowance was made.

A meeting was held on December 12, 1996 between the Intermediary and AHCCCS and ALTCS staff to discuss the proper treatment of Medicare bad debts. This meeting is described in a letter dated April 8, 1997, from Mr. Dillman to HCFA.[12] At this meeting the Intermediary learned that as of April 15, 1996, it was AHCCCS and ALTCS policy to pay for Medicare deductibles and coinsurance. It is unclear from his letter whether this was a policy that Arizona Medicaid program contractors were bound by or if this policy only applied when AHCCCS acted as the direct payor (which, for the Provider, is a small percentage of cases). In any event, the Intermediary had disallowed the Provider's

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[10] Provider Exhibit 9.

[11] Id.

[12] Provider Exhibit 8.

Medicare bad debts for fiscal year 1994 and now appeared to be relying on a policy implemented in 1996 to defend their adjustment.

In addition to a discussion of the December 1996 meeting, Mr. Dillman's April 8, 1997 letter provides other evidence of the Intermediary's confusion on this issue. This letter indicates that the Intermediary was unaware at the time it conducted its audit that the responsibility for Medicaid reimbursement in Arizona rested with program contractors, like MMCS. Mr. Dillman indicates that he only recently learned of the existence of the program contractors. His letter also indicates that as of the spring of 1997, Arizona=s Medicaid program contractors did not think that they were responsible for Medicare coinsurance and deductibles.

The Intermediary\s mistaken understanding of the structure of, and players in, the Arizona Medicaid program at the time it conducted the audit of the Provider was further underscored by the Intermediary\s witness in this case. The Intermediary\s witness agreed that the Intermediary did not take the program contractor, MMCS, into account when it conducted its inquiry into whether non-payment would have occurred had the Provider billed the Medicaid program.[13] In other words, in determining if Medicaid would reimburse this Provider for Medicare coinsurance and deductibles, the Intermediary neglected to consider the Provider\s Medicaid payor.

The Intermediary\s witness also testified that the auditor did not consider the contract between MMCS and the Provider. He testified that the auditor did not have an understanding of the structure of the Arizona Medicaid program or the role of the program contractor. When asked to review the auditor\s work papers and management letter with the Provider, the Intermediary witness conceded that the auditor never mentions MMCS as a possible payor.

Finally, the Intermediary agreed that the State of Arizona has never paid the Provider for its Medicare coinsurance and deductible amounts, despite the Intermediary\s contention that the State of Arizona is the responsible payor for these amounts.[14]

INTERMEDIARY'S CONTENTIONS:

The Intermediary\s adjustment is based on HCFA Pub. 15-1 '' 308 through 312 and 322, 42 C.F.R. ' 413.80(e), and Section 300 of the AHCCCS Encounter/Claims Policy and Procedure Manual.[15] HCFA Pub. 15-1 ' 308 and 42 C.F.R. ' 413.80(e) states:

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[13] Tr. at 130-131.

[14] Tr. at 43-44, 73-75, 97-98 and 131.

[15] Intermediary Exhibit 6.

(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.

The Provider has not pursued adequate collection effort as required by (2) above. HCFA Pub. 15-1 ' 310 states:

> [t]o 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.

HCFA Pub. 15-1 ' 310.2 states:

> [p]resumption 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.

HCFA Pub. 15-1 ' 312(c) states:

> [t]he provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX. local welfare agency and guardian.

HCFA Pub. 15-1 ' 322 states:

> [w]here the State is obligated either by statute or under the terms of its plan to pay all or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that

> the State is not obligated to pay can be included as a bad debt under, Medicare, provided that the requirements of ' 312 or, if applicable, ' 310 are met.
>
> In some instances, the State has an obligation to pay, but either does not pay or pays only part of the deductible or coinsurance because of a State payment "ceiling". . . . In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of ' 312 are met.

The Intermediary contends that AHCCCS/ALTCS was responsible for the payment of deductible and coinsurance amounts based on the policy stated in Section 300 of the AHCCCS Policy and Procedure Manual. It states that:

> [i]t is the policy of the AHCCCS Administration to reimburse the full Medicare deductible and coinsurance for AHCCCS - and Medicare covered services provided to eligible recipients. AHCCCS is liable for the Medicare coinsurance and/or deductible less any amount paid by other third party payors.

The HCFA Regional Office letter of April 23, 1997 states that:[16]

> [t]o us, the State's obligation is a critical factor here. For QMB recipients, the State=s policy (as furnished by you) has established its obligation to encompass full Medicare coinsurance and deductible amounts. For non-QMB recipients, the State is to reimburse Medicare coinsurance and deductible amounts for AHCCCS-covered services. The contracted plans are in this instance agents of the State and are subject to the State\s crossover reimbursement policies. Coinsurance and deductible amounts unpaid by the contracted plans due to the plans failure to Implement State policy are not reimbursable as Medicare bad debts.

Id.

Another HCFA Regional Office letter,[17] explains that in accordance with the Arizona State Plan

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[16] Intermediary Exhibit 7.

Amendment ("ASPA") 96-013, AHCCCS and its plans are required to provide full cost sharing with the following exceptions:

> For non-QMBs, AHCCCS is not responsible unless the services are provided in the beneficiary's health plan or program contractor's network. AHCCCS is also not responsible for non-QMB cost sharing when the services are not covered by AHCCCS under the State Plan.
>
> For QMB Duals, AHCCCS is not responsible for services provided outside of the beneficiary's health plan or program contractor network. However, with respect to services covered by Medicare but not by AHCCCS under the State Plan (e.g., chiropractic services), AHCCCS pays the Medicare coinsurance and deductible amounts regardless of whether the provider is in the beneficiary's health plan or program contractor network.

ASPA 96-013.

Based on the above, despite the general AHCCCS policy of full cost sharing for QMB Onlys, non-QMBs and QMB Duals, there are situations under the State Plan in which AHCCCS is not obligated for full cost sharing and therefore, prior authorization may be reasonable. For example, if AHCCCS-covered services are furnished out-of-plan, AHCCCS may require prior authorization for such services as a condition of Medicare cost sharing.

If the bad debt should be as a result of being out-of-plan, Medicare may be liable for this debt. However, it is the responsibility of the Provider to submit adequate documentation in support of this claim. For the bad debts in question in the instant case, the Intermediary has not received any documentation or support to indicate that the bad debts in question fall under this ruling.

The Medicare program is not responsible for payment of bad debts when the Provider has failed to comply with established policies. If the Provider had followed policy and properly billed the AHCCCS program, these debts should have been reimbursed. Failure of the Provider to comply with the policies stated above does not constitute an obligation of the Medicare program to cover these debts.

The Administrator of HCFA, in Communi-Care Pro Rehab, Inc. v Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Virginia, PRRB Case No. 97-D24, January 29,1997, Medicare and Medicaid Guide (CCH) ¶ 45,053, rev'd, HCFA Administrator, March 31, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,231, states that HCFA Pub. 15-1 § 312 clearly requires

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[17] Intermediary Exhibit 8.

that a provider must determine that no source other than the patient would be legally responsible for the patient=s medical bill, e.g. Title XIX. It states that "the Administrator finds that the Provider failed to request payment from the Commonwealth or NFs [nursing facilities] for deductibles and coinsurance amounts attributable to Medicare/Medicaid patients which the Commonwealth was obligated to pay, those accounts are not properly included as bad debts under 42 CFR ' 413.80(e)." Id. at 53,744. The Intermediary contends that a similar conclusion is proper in the instant case.

The Intermediary further contends that AHCCCS was responsible for payment of the deductible and coinsurance amounts for dual eligible patients. The Provider did not request payment from AHCCCS. Therefore, the bad debts are not allowable.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

'' 405.1835-.1841	-	Right to Board Hearing - Time Place, Form and Content of Request for Board Hearing
' 413.80 et seq.	-	Bad Debts

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

' 300	-	Bad Debts, Charity, and Courtesy Allowances
' 308	-	Criteria for Allowable Bad Debts
' 310	-	Reasonable Collection Effort
' 310.2	-	Presumption of Noncollectibility
' 312 et seq.	-	Indigent or Medically Indigent Patients
' 322	-	Medicare Bad Debts Under State Welfare Programs

3. Cases:

Communi-Care Pro Rehab, Inc. v Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Virginia, PRRB Case No. 97-D24, January 29, 1997, Medicare and Medicaid Guide (CCH) & 45,053, revld, HCFA Administrator, March 31, 1997, Medicare and

Medicaid Guide (CCH) **&** 45,231

4. Other:

HCFA Form 339 Instructions

AHCCCS Policy and Procedure Manual ' 300

ASPA 96-013

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, evidence presented, testimony elicited at the hearing, and post hearing brief, finds and concludes as follows:

The Board finds that the Provider followed the steps available to them in pursuing the claims for Medicare coinsurance and deductibles from the State Medicaid program in which it participated. The Board notes that the State Medicaid program contractors advised the Provider that coinsurance and deductibles would not be paid before the Provider sought reimbursement for them as bad debts. The record contains evidence that the State Medicaid program=s policy was to pay the coinsurance and deductibles, but that it took intervention by the state nursing home association and the HCFA regional office to get the State to implement the necessary procedures to allow providers to recover these amounts. In addition, neither the State of Arizona nor the program contractor, despite improperly denying the Provider=s claim, ever paid the coinsurance and deductibles to the Provider for the fiscal year at issue. The Board finds that where the Provider properly sought payment and the State Medicaid agency and its representative have not paid the claim, the Provider may claim them as bad debts. See HCFA Pub. 15-1 ' 312.

The Board finds that the Provider took reasonable steps to collect coinsurance and deductibles before claiming them as bad debts. First, the Provider determined that the claims pertained to dually eligible indigent patients, and the amounts could be deemed uncollectible under HCFA Pub. 15-1 ' 312. Second, the Provider sought to determine whether the State Medicaid agency was obligated to pay the claims as required by HCFA Pub. 15-1 ' 322. Under the structure of the AHCCCS program, the Provider had a contract with the program contractor, MMCS. The Provider was obligated to submit its bills to the MMCS and was prohibited from billing AHCCCS patients.[18] The record contains evidence that the Provider sent its program contractor a letter requesting guidance on whether they would be

[18] See Provider Exhibit 25.

reimbursed for Medicare coinsurance and deductible amounts.[19] MMCS responded, albeit incorrectly, that the Provider would not be reimbursed under the program for the Medicare coinsurance and deductibles.[20] It was only after the Provider sought payment from the State Medicaid agency that it listed the unpaid amounts as uncollectible bad debts, and sought reimbursement from HCFA.

The Board notes that the record indicates that the program contractor was liable for the coinsurance and deductible amounts.[21] The HCFA regional office directed the Intermediary not to pay these bills due to the State Medicaid agency's obligation to pay the bills.[22] The AHCCCS administration also acknowledged the liability of its subcontractors to pay the coinsurance and deductibles.[23] The record contains considerable correspondence from the HCFA Regional Office, the Intermediary, the AHCCCS administration, and the Arizona Nursing Home Association directed at clarifying the responsibility of the state to pay for coinsurance and deductible amounts and insuring that the policy be implemented.[24] The Board finds, however, that despite the recognition of the State Medicaid program's obligation, the program contractors have not paid the Provider for its claims. In correspondence from the HCFA Regional Office it notes that despite recognition that the program contractors were to have paid these claims, they are still refusing to pay them due to a delay in submission of the claim.[25]

The Board notes that the manual at HCFA Pub. 15-1 ' 322 identifies a situation where a state is obligated to pay deductible and coinsurance amounts but does not pay these claims because of budgetary ceilings. In this situation, any unpaid amounts are allowable as bad debts if the provider has otherwise complied with HCFA Pub. 15-1 ' 312. The Board finds the situation in the instant case to be analogous. The AHCCCS program, despite being aware of its obligation and the instant problem, has simply not paid the claim or directed its program contractor to pay these claims. The Provider has otherwise complied with HCFA Pub. 15-1 ' 312 and should be allowed to claim the unpaid coinsurance and deductibles as bad debts under Medicare.

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[19] Provider Exhibits 20 and 22.

[20] Provider Exhibits 4, 21, 23 and 24.

[21] Intermediary Exhibits 11 and 15.

[22] Intermediary Exhibit 8 at 1.

[23] Intermediary Exhibit 15.

[24] See Intermediary Exhibits 8, 9, 10, 13, 14, 15 and 16 and Provider Exhibits 8 and 26.

[25] See Provider Exhibit 8 at 2.

In summary, the Board finds that the Provider did properly seek to recover these costs from the state Medicaid program in accordance with HCFA Pub. 15-1 ' 312 and despite its obligation, the state has denied payment. The Board finds that the Provider is entitled to claim the unpaid coinsurance and deductible amounts as bad debts under HCFA Pub. 15-1 ' 322.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the Provider's bad debts was improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Martin Hoover, Jr., Esquire
Charles R. Barker

FOR THE BOARD:

Irvin W. Kues
Chairman