PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D80

PROVIDER - California Hospitals Outpatient Crossover Bad Debts Group Appeal

Provider Nos. Various

vs.

INTERMEDIARY - Blue Cross of California/Mutual of Omaha/Ætna Life Insurance Company

DATE OF HEARING-
September 3, 1998

Cost Reporting Periods Ended - Various

CASE NO. 96-0184G

INDEX

ISSUE:[1]

Whether claims of welfare bad debt under Provider Reimbursement Manual Part 1, Section 322, must be based on a bill to the Medicaid agency, and if not, what must the provider document to receive bad debt reimbursement?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

General Facts:

The Providers (or AGroup@) are a group of California hospitals requesting reimbursement for certain outpatient bad debts claimed on cost reports for fiscal years ending between 1989 and 1995. The appeal concerns Medicare requirements for documenting outpatient bad debt related to claims for service provided to Qualified Medicare Beneficiaries (AQMBs@)[2], who are also known as crossover patients, because state Medicaid agencies are generally responsible for paying their Medicare coinsurance and deductible amounts. The Providers are disputing the procedure, followed by Blue Cross of California (ABCC@), Aetna Life Insurance Company, and utual of Omaha, (collectively, the AIntermediaries@), of not allowing Medicare crossover bad debt unless a provider bills the related amounts to Medi-Cal, and Medi-Cal rejects in part or totally the payment of the billed amount. This procedure, referred to as an Aillegal per se must bill policy@ by the Providers, was announced in a AMedi-Cal update@ in June of 1989 after California implemented a statutory payment limitation (effective July 1, 1989) that placed a ceiling on the State=s cost sharing responsibility for crossover patients based on a Medi-Cal allowed amount.[3] This "Medi-Cal update" instructed the Providers on how to bill the State. Id.

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1 Providers= Post Hearing Brief, Exhibit A, (Issue as originally stated in Providers= request of November 13, 1995 to establish group appeal.)

2 QMBs are individuals entitled to Medicare Part A (including those enrolled through payment of the Part A premium) whose family incomes do not exceed 100% of the federal poverty line and whose resources do not exceed twice the resource-eligibility standard for SSI. See Medicare & Medicaid Guide (CCH) &14,231.

3 Transcript (ATr.@) at 42, 305, Intermediaries= Exhibit 3, Intermediaries= Post Hearing Brief at 4-5, Providers= Post Hearing Brief at 2, Providers= Exhibit P-1A, See also California Welfare and Inst. Code '14109.5.

Prior to July 1, 1989, Medi-Cal routinely paid the co-payment and deductibles for QMBs. Hospitals were not required to prepare a detailed billing to Medi-Cal for crossover coinsurance and deductibles.[4] Hospitals only had to submit a bill evidenced by the Medicare remittance advice and Medi-Cal would pay the entire coinsurance and deductible amount without subjecting it to payment limits. Id. Because of full Medi-Cal payment, no bad debt existed.

In order to limit its payout, California changed its Medicaid program to pay no more on a QMB claim, than what it would pay if there were no Medicare coverage. This payment change was referred to as the "cut-back". The application of the payment ceiling to outpatient hospital services in 1989 required the hospitals to prepare a full detailed bill to Medi-Cal in order for Medi-Cal to price the service if it were the primary payer and compare that price to what Medicare had already paid so they could pay the difference if there was any balance still due. Id. The Providers assert that this was a very cumbersome billing process for the hospitals. Id. The Providers point out that Medicare does not crossover claims for hospital outpatient bad debt electronically to Medi-Cal.[5] Because Medi-Cal had a coding system which differed from the Medicare coding systems, the Providers contend that the hospitals could not produce a computerized bill for the crossover claims.[6] Any crossover billings had to be done manually. The Providers assert that approximately 80 percent of crossover claims result in non-payment or payment in very small amounts.[7]

Because of the small amount of return and the labor intensive process of billing Medi-Cal, some hospitals ceased billing Medi-Cal in 1989, some billed as many crossover claims as they could, but not all, and some continued to bill all crossover claims to Medi-Cal.[8]

It is the Providers= position that such limitations or ceilings give rise to Medicare bad debts under Provider Reimbursement Manual, Part 1, (HCFA Pub. 15-1), ' 322. The parties are at issue because the Intermediaries took a position from the initial announcement of the change in Medi-Cal payment

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4 Tr. at 42.

5 Id. at 45-46.

6 Id. at 43.

7 Tr. at 47-48, Provider Exhibit 1B, pg. 7.

8 Id.

methodology that the only way to properly present a Medicare bad debt claim was to bill Medi-Cal, regardless of the expected payment, and submit its bad debt claim as the difference between the total outpatient Part B co-payment and the Medi-Cal payment. It is the Intermediaries= position that the only acceptable documentation of the bad debt is the Medi-Cal remittance advice. The cut back on the Medi-Cal co-payment responsibility was in full force after January 1, 1990.[9]

The Group asserts that under the Intermediaries= per se policy, it could not claim outpatient crossover bad debts under HCFA Pub. 15-1, '322 unless it billed Medi-Cal and received a Medi-Cal remittance advice denying all or a portion of the amount billed. The Providers contend that billing Medi-Cal, just to receive a remittance advice evidencing denial of crossover deductible and co-insurance amounts, was time consuming, expensive, and in contravention to the regulations at 42 C.F.R. '413.80(e), would actually be poor business judgment to bill Medi-Cal.

On October 27, 1989, the California Association of Hospitals and Health Systems (ACAHHS@) asked the Intermediaries, 1) whether it was in fact necessary to bill Medi-Cal and receive a pro forma denial to claim Medicare bad debt for outpatient crossover claims or 2) whether it was sufficient for the hospital to keep records of the Medi-Cal eligibility of crossover patients and the Medi-Cal rates.[10] CAHHS also requested advice on the type of documentation that would be acceptable to the Intermediaries' auditors. Id. The Intermediaries responded that it was their policy, and the policy of HCFA Region IX, to require hospitals to bill Medi-Cal and receive a formal denial in order to claim outpatient crossover bad debt.[11]

According to the Providers, from at least June of 1992 through the present, the Providers' representative has attempted to submit alternative documentation (other than Medi-Cal remittance advices) supporting the Providers' claims for unbilled bad debt to the Intermediaries, however, the Intermediaries have steadfastly refused to audit the lists of unbilled claims, in accordance with their per se must-bill policy.[12] The Providers' representative

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[9] Intermediaries= Post Hearing Brief at 5, Tr. at 293-294.

[10] Tr. at 49-51, Intermediaries= Exhibit I-7.

[11] Tr. at 52, Providers= Exhibit P-1C, Intermediaries= Exhibit I-5.

[12] Tr. at 57-59, 231-232.

had periodic meetings with Intermediaries= representatives and HCFA Region IX throughout the next several years to discuss the Intermediaries' per se must-bill policy, but the Intermediaries continued to insist that a Medi-Cal remittance advice was the only acceptable documentation of outpatient crossover bad debt, and that this was the policy of HCFA Region IX.[13] Based on the Intermediaries' per se must-bill policy, the Providers self-disallowed their claims for unbilled outpatient crossover bad debt for many of the fiscal years in this appeal.[14]

In January 1997, in a further attempt to provide documentation that the Intermediaries would accept other than a Medi-Cal remittance advice, the Providers' representative began discussions with the State of California and its Medi-Cal fiscal agent, Electronic Data Systems Corporation ("EDS") to design and develop bad debt reports evidencing the Medi-Cal eligibility of the crossover patients at the time the service was rendered and the amount that Medi-Cal would not have paid for the service due to the crossover payment ceiling, (i.e., the amount of the bad debt).[15] The Providers assert that they have attempted to submit this documentation to the Intermediaries as proof of their claims for outpatient crossover bad debt, however the Intermediaries have refused to review or audit it, based on their per se must-bill policy.[16]

On December 13, 1995, the Providers filed an appeal with the Provider Reimbursement Review Board (ABoard@) and requested that a group appeal be established regarding the Intermediaries= determination of the bad debt crossover payments. The Board accepted jurisdiction over the appeal having been satisfied that the Providers met all the regulatory requirements. See 42 C.F.R. '405.1835-.1841. The Providers are represented in this appeal by Sanford E. Pitler, Esquire, of Bennett, Bigelow, & Leedom, P.S. The Intermediaries are represented by Bernard Talbert, Esquire, of Blue Cross and Blue Shield Association. The amount of Medicare reimbursement in

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[13] Tr. at 60-61, 65.

[14] Tr. at 91-93.

[15] Tr. at 93, 97-98, see also Providers= Exhibits 8A-8G for descriptions of meetings and discussions.

[16] Tr. at 230-233, Intermediaries= Post Hearing Brief at 8.

controversy is approximately $23,591,254.[17]

Statutory and Regulatory Background

The Medicaid program is a joint federal and state-funded system which subsidizes medical care for the needy. California participates in Medicaid through its Medical Assistance Plan administered by California's Department of Health Services ("DHS"), and receives substantial federal financial support for its program.

The Health Care Financing Administration (AHCFA@) and DHS entered into an agreement. pursuant to 42 U.S.C. ' 1396v(a) under which DHS enrolls State resident crossovers in Medicare Part B and pays for their beneficiary costs. This agreement is described as a "buy-in" agreement because DHS agrees to buy into or enroll in the Medicare program for the benefit of its crossovers. Rehabilitation Ass=n of VA v. Kozlowski, 42 F.3d 1447-1448, (4th Cir. 1994), cert. denied, 516 U.S. 811 (1995), (AKozlowski@). By enrolling crossovers in Medicare Part B, DHS agrees to assume responsibility for those costs which otherwise are the responsibility of the individual beneficiary. 42 U.S.C. ' 1396a(a)(10)(E)(I). Under a process known as "Medicare cost-sharing", DHS assumes responsibility for, among other things. the following costs, normally paid for by Medicare beneficiaries:

a. The Medicare Part B premiums:
b. The Medicare Part B deductible: and
c.. The Medicare Part B coinsurance.

42 U. S. C. ' 1396d(p)(3).

In addition, a state may limit its responsibility for Medicare cost-sharing by implementing a payment ceiling which limits the state's Medicare cost-sharing responsibility to the amount that the state's Medicaid program would pay for a service, even if Medicare would pay more for the same service:

> [a] State is not required to provide any payment for any expenses incurred relating to payment for

[17] See Attached Schedule of Providers in Group.

> deductibles, coinsurance, or copayments for Medicare cost-sharing to the extent that payment under title XVIII [Medicare] for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a Medicare beneficiary.

42 U.S.C. ' 1396a(n)(2).

California implemented such a payment ceiling and in 1989 applied it to outpatient hospital services.[18]

With respect to Medicare bad debts, the regulations recognize that "the failure of beneficiaries to pay deductible and coinsurance amounts can result in the related costs of covered services being borne by other than Medicare beneficiaries." 42 C.F.R. ' 413.80(d). In order to prevent such costs from being transferred to non-Medicare beneficiaries, the regulations establish that costs associated with unpaid deductible and coinsurance amounts associated with Medicare beneficiaries may be added to Medicare's share of allowable costs. However, in order for such costs to be added to Medicare's share of allowable costs, providers must demonstrate certain criteria. Specifically, providers must establish that (1) the bad debts were related to covered services and derived from deductible and coinsurance amounts, (2) reasonable efforts were made to collect the Medicare bad debts, (3) the bad debts were actually uncollectible when claimed, and (4) sound business judgment established that there was no likelihood of future recovery. 42 C.F.R. ' 413.80(e). See also HCFA Pub, 15-1 ' 308.

The Medicare program instructions provide further clarification with respect to the nonpayment of deductible and coinsurance amounts as a result of indigence. The program instructions establish that, in cases of indigence, bad debts may be deemed uncollectible under the program without applying additional criteria designed to demonstrate reasonable collection effort. HCFA Pub. 15-1 ' 312. Indigence may be evidenced under this section by Medicaid

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[18] Tr. at 11, 305, Providers= Exhibit P-1A, see also California Welfare and Inst.Code ' 14109.5.

eligibility. Id.

In addition to providing guidance with respect to bad debts arising from indigence, the Medicare program instructions also explain the program's position with respect to a state's obligation. The program instructions declare that "[w]hen 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." HCFA Pub. 15-1 ' 322. However, the instructions allow that "[a]ny 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." Id. In addition, a provider may claim as a bad debt amounts which "the State has an obligation to pay, but either does not pay anything or pays only part of the deductible or coinsurance amounts because of a State payment ceiling." Id.

PROVIDERS= CONTENTIONS:

The Group contends that it is entitled to reimbursement for crossover bad debt if it can document two things: 1) Medicaid eligibility of the patient at the time the service was rendered, and 2) the amount that the State would not pay because of a Medicaid payment limitation ("ceiling"). The Providers argue that not only does the applicable law fail to support the Intermediaries' argument that these two things can only be documented by a bill submitted to Medi-Cal, they actually specify that such a bill is not necessary to claim crossover bad debt when a state has a payment "ceiling."

It is the Providers= position that in order to claim Medicare bad debt when a state fails to pay the Provider the coinsurance and deductible because of a payment ceiling, the regulations and program instructions are clear as to what is required of the Provider to claim the bad debt. The Providers note that the governing regulations at 42 C.F.R. '413.80(e) require that a Provider must establish that :

> (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; and
> (4) sound business judgment established that there was no likelihood of recovery at any time in the future.

42 C.F.R. '413.80(e)

The Providers= acknowledge that a reasonable collection effort under 42 C.F.R. '413.80(e) usually involves the issuance of a bill for the unpaid coinsurance or deductibles to the party responsible for the patient's financial obligation on or shortly after discharge. HCFA Pub. 15-1 '310. However, in the special circumstance of indigent patients, where a state fails to pay coinsurance or deductibles because of a state payment "ceiling", the Providers believe that the Section 310 collection requirement is explicitly omitted:

> [i]n 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 the requirements of [HCFA Pub. 15-1] ' 312 are met.

HCFA Pub. 15-1 '322 (emphasis in original).

The Providers point out that HCFA Pub. 15-1 ' 312 states that Medicaid beneficiaries may be deemed indigent and that debts of indigent patients may be deemed uncollectible without applying reasonable collection effort procedures of HCFA Pub. 15-1 ' 310. HCFA Pub. 15-1 '312.

The Providers reject the Intermediaries= argument that the timeliness of a reasonable collection effort, referred to in Section 310, is the main issue in this appeal.[19] The Providers point out that the Intermediaries' argument ignores the fact that Section 310 (reasonable collection effort) does not apply to the Providers= claims for bad debt for indigent patients. Despite the Intermediaries' argument that 42 C.F.R. '413.80 somehow imposes a

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[19] Providers= Post Hearing Brief at 34, Tr. at 306-307, 362.

reasonable collection effort requirement that the Providers have not satisfied,[20] the Providers contend that HCFA Pub. 15-1 ' 322 clarifies, and the evidence at the hearing establishes, that there is no reasonable collection effort that could be mounted for these bad debts. The Providers contend that there was nothing they could do to make the state pay where it has a payment limitation, and no one else can be billed for the unpaid amounts. The Providers also point to the Intermediaries= witness who testified that no collection effort is "reasonable" for the amounts the state would not pay due to a ceiling:

> Q. And you do agree, do you not, that there are amounts, if we bill a claim, that the state may not pay as a result of that ceiling?
> A. That's correct.
> Q. And no collection effort in the world is going to get the state to pay that, would you agree with that?
> A. Yes.

Tr. at 306.

The Providers also point out that federal and California law prohibit billing the crossover patient.[21] Thus, the Providers contend that if "timeliness" is the Intermediaries' "main issue,"[22] their main argument is based on a false premise and should be disregarded by the Board. The Providers contend that the above testimony makes it clear that billing the unpaid coinsurance and deductibles was a costly, cumbersome, and often futile exercise, which rather than demonstrating sound business judgment, would in many cases, demonstrate poor business judgment, in contravention of 42 C.F.R. '413.80(e). The Providers contend that the evidence and testimony has established that when the billing system became extraordinarily complex and inefficient, and when billing Medi-Cal resulted in substantial zero payments, many Providers, already short-staffed, placed little priority on the futile Medi-Cal billing.

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[20] Tr. at 304.

[21] Id. at 82-83.

[22] Id. at 362.

The Group contends that for those Providers that initially billed the state, approximately 80 percent of the bills came back with zero payment.[23] The Group asserts that Medi-Cal told the Providers not to submit bills if the state would not pay for them.[24] As a result, the Group contends that some Providers exercised sound business judgment and never billed, while others billed some claims but not others.[25]

It is the Providers= position that HCFA Pub. 15-1 '322 does not require a Medi-Cal remittance advice as the only manner in which to document the required elements. The Providers contend that the express language of HCFA Pub. 15-1 '312 unequivocally states that the Section 310 procedures (such as submitting a bill) need not be applied when the patient is indigent. The Providers believe that the law recognizes that bad debts due to a State payment "ceiling" differ from other bad debts and different documentation criteria apply to them.

The Group also contends that HCFA=s own instructions support its position regarding what must be documented to claim crossover bad debt under a state payment ceiling.[26] The Group contends that in November 1995, HCFA issued a revised Provider Cost Report Reimbursement Questionnaire, instructing

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[23] Tr. at 47, Provider Exhibit 1B, pg.7.

[24] Id. at 226-227.

[25] Id. at 48.

[26] At the hearing, the Board asked the Intermediaries to provide it with any correspondence or memoranda that might explain HCFA=s interpretation of the requirements for bad debts. Id. at 356-359. The Board gave the parties 10 extra days to submit their post-hearing briefs in order to give the parties time to address anything that the Intermediaries produced in response to the Board=s request. Tr. at 374. On October 23, 1998, the Intermediaries submitted additional information in response to the Board=s request. On October 27, 1998, along with its post hearing brief, the Providers submitted a Motion to Strike the documents submitted by the Intermediaries, since the documents were provided to the Providers by facsimile on October 23, more than 6 weeks after the hearing and only 3 working days before the post hearing briefs were due to the Board. On March 10, 1999, the Board issued an order granting the Providers= Motion to Strike. Accordingly, Intermediaries= Exhibits I-9, I-10, and I-11 are stricken from the record.

providers that in order to claim crossover bad debts for indigent patients, a provider need not bill Medicaid, and need show only two things to support its claim for bad debts:

> [i]n lieu of billing the Medicaid program, the provider must furnish documentation of:
>
> -Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number), and
>
> -non-payment that would have occurred if the crossover claim had actually been filed with Medicaid.
>
> The payment calculation will be audited based on the state's Medicaid plan in effect on the date that the services were furnished. Providers should be aware of any change in the Medicaid payment formula that might impact the crossover calculation,, and ensure that these changes are reflected in the claimed Medicare bad debt.

Form HCFA-339, ' 1102.3 (Nov. 1995).

The Providers reject the Intermediaries= claim that this instruction is limited to claims for bad debt for services that are categorically excluded from Medi-Cal coverage, as opposed to claims for general crossover bad debt subject to a state payment "ceiling."[27] The Providers contend that it is clear the instruction applies to all claims for crossover bad debt, not only those that are due to a categorical exclusion from the state plan. As the Intermediaries acknowledged, when a state payment "ceiling" is in place, there is no way that the state is going to pay the coinsurance and deductibles above the ceiling.[28]

The Providers also reject the Intermediaries argument[29] that Form 339 was not effective until November 1995. The Providers point out that even though Form 339 was not issued until November 1995, the regulations and the workbooks provided for bad debt claims without submitting a Medicaid remittance advice were in place well before Form 339.[30] The Providers contend that the form simply reduced the rule to writing.

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[27] See Tr. at 283-286, 350-351.

[28] Id. at 306.

[29] Intermediaries= Position Paper at 10.

[30] Providers= Post Hearing Brief at 43.

The Providers contend that in addition to the regulation, manual provisions, and instructions above, the Board has recognized that a provider need not bill state Medicaid agencies in order to establish reimbursable bad debt under 42 C.F.R. ' 413.80 and HCFA Pub. 15-1 ''310, 312, and 322 where the state does not pay due to a payment limitation. Communi-Care Pro Rehab, Inc. v. Blue Cross & Blue Shield Ass'n., PRRB Dec. 97-D24, Jan. 29, 1997), Medicare & Medicaid Guide (CCH), & 45,053, rev'd HCFA Admin. Dec. Mar. 31, 1997, Medicare & Medicaid Guide (CCH) & 45,231, (ACommuni-Care@); see also Santa Marta Hospital v. Blue Cross & Blue Shield Ass'n., PRRB Dec., 97-D16, Dec. 5, 1996 Medicare & Medicaid Guide (CCH), &44,937, HCFA Adm. declined rev., January 20, 1997, (ASanta Marta@).

In Communi-Care, the provider appealed its intermediary's adjustment to its bad debt reimbursement. The intermediary's adjustment disallowed bad debts associated with dually eligible patients. The intermediary's stated reason for adjusting the provider's bad debts was that the State of Virginia, through its Medicare buy-in agreement under Part B, "agreed to pay the Medicare deductible and coinsurance amounts for all Medicare/Medicaid patients." Communi-Care & 45,053 at p. 52,642. The Providers point out that Virginia's Medicaid program imposed a ceiling on payment of coinsurance and deductible amounts. Id. at 52,648. The Providers note that the Board held that the intermediary's adjustment disallowing bad debts was improper. The Board concluded, based on HCFA Pub. 15-1 '' 312 and 322, that the provider need not have billed the state and have received a rejection in order to claim the unpaid cost-sharing amounts as bad debts because the State of Virginia had informed providers it would not pay coinsurance and deductible amounts for nursing home services. Id. at 52,648-52,649 The Board remanded the case to the intermediary for consideration of the documentation submitted by the provider and ordered the intermediary to adjust the provider's bad debt reimbursement. Id.

The Providers note that the HCFA Administrator reversed the Board=s decision in Communi-Care, but on the grounds that it concluded that, as a threshold matter, there was no evidence in the record that Virginia limited payment of crossover payments for the services at issue. &45,231 at p. 53,742. The Provider=s point out that the Board's conclusions regarding the need to bill when a State has a payment ceiling were untouched by the Administrator. Contrary to the HCFA Administrator=s reason for reversing the Board=s decision in Communi-Care, the Provider=s contend that it is undisputed in the instant case that California Medi-Cal had such a payment ceiling.[31]

In Santa Marta, a case involving one of the Intermediaries, the Board reiterated the principle that a provider, A. . . need not bill the Medi-Cal program for Medicare Part B deductible and coinsurance amounts in order for the Provider to sustain bad debt claims, . . ." Id. &44937 at p. 51,906.

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[31] Tr. at 305, Intermediaries= Exhibit I-3, Providers= Exhibit P-1A.

Consistent with the facts and analysis of Communi-Care, and the principle set forth in Santa Marta, the Group asserts that the Providers can document crossover bad debts without billing Medi-Cal for the unpaid coinsurance and deductibles. The Providers assert that based upon the regulatory requirements of 42 C.F.R. ' 413.80, as clarified by HCFA Pub. 15-1 '' 322, 312, and 310, to claim crossover bad debt, a provider must document the patient's Medicaid eligibility on the date of service and the amount the State would not pay due to its payment "ceiling." The Providers acknowledge that although a Medi-Cal remittance advice would document these two elements, the regulation and manual provisions do not require a remittance advice as the only acceptable form of documentation. In fact, the Providers point to testimony where the Intermediaries= witness admitted that the applicable regulations and manual provisions do not require billing Medi-Cal to claim bad debt.[32] The Group asserts that the Providers can provide the State of California documentation of crossover bad debt that is more accurate than a Medi-Cal remittance advice, however as previously stated, the Intermediaries refuse to even review this documentation.

The Providers reject the Intermediaries claim that the instant case concerns bad debt regulations and manual provisions. The Providers assert that all parties agree that this case is really about adequate documentation. The Providers point to the Intermediaries= counsel=s opening remarks at the hearing in which counsel stated that the Providers have Anot come up with a successful surrogate. [for a Medi-Cal remittance advice] That=s really what this case is about.@ Tr. at 17. The Intermediaries= counsel went on to comment as follows:

> A[w]e believe that it is necessary to bill Medi-Cal regardless of the payment outcome since there is really no other way for a provider to precisely know what payments would or would not be without billing. As you'll see, I think that statement is the meat of this case.@

Id. at 24.

The Providers contend that the Intermediaries are erroneous in their position that they do not have a Asuccessful surrogate@ to a Medi-Cal remittance advice. The Providers further contend that evidence presented at the hearing supports its assertion that the Medi-Cal contractor for the State of California, EDS, can actually provide better information for documenting crossover bad debts than the actual Medi-Cal remittance advice. The Providers contend that the EDS system verifies Medi-Cal eligibility, just as if a bill was submitted to Medi-Cal, and arrives at a Acut-back@ amount, which is the amount the state did not pay due to the payment limitation.[33] The Providers contend that the Intermediaries have continually refused to look at any other documentation than a Medi-Cal remittance advice, even though the EDS reports are more reliable, accurate and informative than the Medi-Cal remittance advice. The Providers assert that the

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[32] Tr. at 361-362.

[33] Providers= Post Hearing Brief at 48.

remittance advice was never intended to be an accurate portrayal of Medicare bad debt.[34]

The Providers contend that after the State was made aware of the problem, it agreed to help, and expressly instructed EDS, the vendor and fiscal agent that produces Medi-Cal information for the State, to work with the Providers to use the State's Medi-Cal eligibility and payment information to develop crossover documentation.[35] The Providers assert that evidence was presented at the hearing that the documentation established by the Providers was authorized and developed in part by the State of California itself.[36]

It is the Providers= position that the system was designed for the sole purpose of documenting crossover bad debt, and it does so timely, accurately and in detail.[37] It provided essentially the same information as the Medi-Cal remittance advice, and utilized the same or more accurate sources of information. The Providers contend that the system verifies Medi-Cal eligibility and arrives at a Acut-back@ amount, which is the amount the State did not pay due to the payment limitation. The Providers contend that its electronic nature reduces significantly the possibility of human error, which is a major problem for the Medi-Cal remittance advice process. Its system provides for an easy audit trail. The Providers also point out that the Intermediaries witness made numerous unsupported criticisms about the EDS reports, despite his admission that he has never reviewed them.[38]

The Providers also reject the Intermediaries= argument that using EDS=s reports, in lieu of the Medi-Cal remittance advices to establish crossover bad debt, will violate the requirements of 42 C.F.R. '' 413.20 and 413.24 because the Providers= documentation does not come from its ordinary business records.[39] The Providers maintain that the data used to generate the reports is obtained from the Providers' records, is quite detailed, is more accurate than the Medi-Cal remittance advice, and, unlike the Medi-Cal remittance advice, is generated solely for the purposes for which it is intended-reimbursement of crossover bad debt.[40] The Providers contend that the purpose of the regulations is to ensure that claims for cost-based

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34 Providers= Post Hearing Brief at 46.

35 Tr. at 95.

36 Id. at 98, Provider Exhibits P8-8F, P-9.

37 See Providers= Post Hearing Brief at Exhibit C.

38 Tr. at 109-110.

39 Id. at 35-37.

40 Tr. at 40-45.

reimbursement are supported by readily auditable records. The Providers contend that the contractor documentation clearly meets these standards.

In summary, the Providers contend that the EDS reports provide accurate and reliable documentation of crossover bad debt and that data from the reports comes from the Intermediaries' own Medicare tapes and from the State's Medi-Cal records. The Providers further contend that the electronic system is more efficient and accurate than the Medi-Cal remittance advice. The Providers assert that the Intermediaries have no real basis to reject the EDS reports. The Intermediaries simply did not want to consider the reports. The Providers believe that the Intermediaries did not want to do their job and audit the reports, even though this would entail the same process as auditing a provider=s bad debt list for claims billed to Medi-Cal. The Providers contend that the Intermediaries have no valid basis to summarily reject the EDS reports as an alternative to the Medi-Cal remittance advices.

For the reasons discussed above, the Providers ask the Board to hold that the Intermediaries' per se must-bill policy is unlawful. The Providers also ask the Board to hold that under applicable regulations and manual provisions, all that is required to document crossover bad debts under a state payment "ceiling" is proof of Medicaid eligibility at the time a service is rendered, and the amount that the state would not pay due to its payment "ceiling." The Providers further request that the Board direct the Intermediaries to accept, review and audit the state contractor documentation of crossover bad debts submitted by the Providers, and after audit, reimburse the Providers for their crossover bad debts as evidenced by the audited documentation.

INTERMEDIARIES= CONTENTIONS:

The Intermediaries contend that their Amust bill policy@ regarding payments for Medicare deductible and coinsurance amounts that relate to QMBs is in accordance with Medicare and Medicaid policies. The Intermediaries further contend that the Group's pursuit of this appeal is tantamount to a challenge of these policies.

The Intermediaries also contend that the fact that the State agency has assisted the Group in establishing the beneficiaries Medi-Cal eligibility is a moot point. The Intermediaries assert that this action does not relieve the Providers from their obligation of submitting the claims to Medi-Cal for payment as required under these policies. Unless the Providers have filed the related claims, Medi-Cal would not have a basis to determine its payment obligation under the State's approved plan. In addition, there would be no record that supports Medi-Cal's determination of payments under the payment rate "ceiling."

It is the Intermediaries= primary position that hospital outpatient Part B cross-over claims can be recognized

as an allowable bad debt only if the hospital billed Medi-Cal and established the payment amount (even if zero) on a remittance advice before the bad debt would be allowed. The Intermediaries contend this position is supported by the Medicare regulation at 42 C.F.R. ' 413.80(e) which sets forth the criteria for allowable bad debts. They are:

> (e) Criteria for allowable bad debt. A bad debt 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 judgement established that there was no likelihood of recovery at any time in the future.

Id.

The Intermediaries acknowledge that criteria (1) is not an issue.[41] However, the Intermediaries assert that the lack of a determination and follow-up payment of any Medi-Cal share disqualifies any co-payment amount from meeting the tests of (e)(2), (3) and (4). Id.

The Intermediaries point out that the regulation requires that all criteria be satisfied when a bad debt claim is presented for reimbursement. The Intermediaries acknowledge that it is undisputed that Medi-Cal has liability for at least part of the co-payment. As evidenced in the record, the amount may be zero, or it may be considerably higher. The record contains examples of aggregate payments of 20% and higher of the co-payments.[42]

The Intermediaries also argue that the lack of a reasonable collection effort applies to the share due from the State, not the beneficiary as argued by the Provider. The Intermediaries further contend that unless that amount is definitely ascertained, the actual unrecovered balance is never known.

The Intermediaries refer to the Providers= witness=s testimony that there is a 13-month window to submit claims to Medicare.[43] The Intermediaries contend that this limit has to be considered with regard to criteria

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[41] Intermediaries= Post Hearing Brief at 9.

[42] See Providers= Exhibit P-18B, p. 187.

[43] Tr. at 113.

(3) and (4) in ' 413.80(e). The Intermediaries further contend that a provider must establish that no further effort would produce additional payment. It is the Intermediaries: position that by declining to pursue the responsible third party (Medi-Cal), the debt became uncollectible from Medi-Cal only because of the Providers: inaction. From a jurisdictional standpoint, the Intermediaries assert that it is difficult to pinpoint when a bad debt claim was actually asserted. The Intermediaries point out that typically bad debt claims are made in the cost report, so the claiming hospital inherently considered the item worthless and further collection futile in the fiscal year of the cost report claim. Therefore, the opportunity to collect from the responsible payor (even if partially) was forfeited by inaction.

Through a straight forward analysis of the regulation at ' 413.80(e), the Intermediaries contend that the requirement for billing Medi-Cal under the facts for the crossover bad debts is sound. Accordingly, the Intermediaries: believe that its policy of Amust bill, per se", as characterized by the Providers, is correct.

The Intermediaries reject the Providers: argument that the cost reporting instructions transmitted through Form HCFA-339 supported its position that the Intermediary was wrong in requiring billing. Without regard to any issue over effective dates, the Intermediaries respond that a fair reading of the text of the section cited by the Providers actually supports its position.

> Column 4 - Indigency/Welfare Recipient. Medicare beneficiaries may be dual eligible for Medicaid coverage. Under these circumstances, the Medicare program is the primary payor with any related deductible and coinsurance amounts being the responsibility of Medicaid for indigent patients subject to the criteria in '' 312 and 322. Any portion of the deductible/coinsurance not paid by Medicaid under those criteria is deemed a Medicare bad debt and claimed on the provider's Medicare cost report in the year in which the bad debt arises. When those criteria are met, place a check mark in the column provided and include the beneficiary's Medicaid number. Include documentation in the beneficiary's file to support the patient's indigency. (See '' 312, 322 and 42 C.F.R. '413.80).
>
> Evidence of the bad debt arising from Medicare/Medicaid crossovers may include a copy of the Medicaid remittance showing the cross-over claim and resulting Medicaid payment or non-payment. However,

> it may not be necessary for a provider to actually bill the Medicaid 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 (via valid Medicaid eligibility number), and
> > -Non-payment that would have occurred if the crossover claim had actually been filed with Medicaid.
>
> The payment calculation will be audited on the state's Medicaid plan in effect on the date that services were furnished. Providers should be aware of any change in the Medicaid payment formula that might impact the cross-over calculation, and ensure that these changes are reflected in the claimed Medicare bad debt.

Form HCFA-339, '1102.3 (Nov. 1995) (emphasis added in Intermediaries= brief).

The Intermediaries contend that the difference of opinion comes from the use of the word Amay@ in the 2nd paragraph above. The Intermediaries argue that this language does not give a provider discretion, when there is potential for a state Medicaid payment on the crossover amount, to decide whether it wants to pursue such payment or come up with a way to approximate what the payment would be.

The Intermediaries assert that there are situations where a state Medicaid program will categorically not cover a particular class of service either by the nature of the patient's eligibility or the nature of the service. In those situations, there would be nothing to bill.[44] The Intermediaries believe, however, that in situations where there is potential for state payment, the language in the cost report instruction does not obviate the need to pursue payment.

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[44] Tr. at 284.

The Intermediaries recognize the well executed effort of the Providers= in working with the State=s contractor (EDS) to duplicate what Medi-Cal would have paid had crossover claims been submitted in the ordinary course of business. However, the Intermediaries contend that the reports fail to perfect any Providers= claims for two reasons:

1. they do not meet the regulatory tests for adequate documentation;
2. there are too many inherent problems with the output.

To support these reasons, the Intermediaries point to the regulation at 42 C.F.R. ' 413.20 (a), regarding adequate cost data, which requires that, Aproviders maintain sufficient records and statistical data for proper determination of costs payable under the program,@ and that Acosts payable under Medicare involve making use of data available from the institution=s basis accounts, as usually maintained . . .@ Id. The Intermediary also cites '413.24 which states that adequate cost data, Amust be based on their financial and statistical records which must be capable of verification by qualified auditors.@ Id.

The Intermediaries argue that if a Provider follows through and bills Medi-Cal for the crossover amount and gets a remittance advice back, the allowable Medicare bad debt is documented in the Provider's financial records. Documentation from a Provider's own records to compute the bad debt will be forever missing if the facility declines to bill. It is the Intermediaries= position that a report developed in an attempt to proxy the result of billing can never be part of the data available from basic accounting records. The output simply does not satisfy regulatory requirements.

The Intermediaries also point to testimony regarding numerous questions and problems related to shift of costs, other insurance, and split billings it found when reviewing the Aproxy@ reports.[45]

The Intermediaries reject the Providers= argument that similar deficiencies and errors might occur in using the Medi-Cal remittance advices in the normal course of business. The Intermediaries contend that the Medicare audit would still track documents generated in a normal business transaction to

[45] Tr. at 276, 284.

establish a reimbursable cost. Based on the above, it is the Intermediaries= position that the Aproxy@ reports could never be an acceptable substitute for the Medi-Cal remittance advices.[46]

In summary, the Intermediaries believe that the problem in this case is how to establish the cross-over bad debt amount. Since the inception of the cut back, the Intermediaries contend that it simply asked the Providers to follow common and accepted practice of pursuing payments from third parties who may be responsible for co-payments and using the answer to calculate bad debts. The Intermediaries believe that the record supports a conclusion that what it wanted was doable. The bad debt determination would then satisfy all requirements of 42 C.F.R. ' 413.80(e) from records maintained by the Providers through its accounting system and financial records. The Intermediaries assert that there is no reason to encourage some after the fact effort to replicate the results.

The Intermediaries point out for the Board that the Providers are not seeking reversal of an Intermediary adjustment rejecting costs. Instead, they are seeking a declaratory order to have the Intermediary accept and audit a surrogate for what the Providers should have done during the cost reporting periods. Respectfully, the Board should not cure the Providers= inaction and should hold that the Intermediaries were correct all along.

CITATIONS OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

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

' 1396v(a)	-	Authority or Requirements to Cover Additional Individuals
' 1396a et seq	-	State Plans for Medical Assistance
' 1396d(p)(3)	-	Qualified Medicare Beneficiaries

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

' 405.1835-.1841	-	Board Jurisdiction

[46] Intermediaries= Post Hearing Brief at 17.

' 413.20 et seq.	-	Financial Data and Reports
' 413.24	-	Adequate Cost Data and Cost Finding
' 413.80	-	Bad Debts, Charity, and Courtesy Allowances
' 413.80(d)	-	Requirements for Medicare
' 413.80(e) et seq.	-	Criteria of Allowable Bad Debt

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

' 308	-	Criteria for Allowable Bad Debts
' 310	-	Reasonable Collection Effort
' 312	-	Indigent or Medically Indigent Patients
' 322	-	Medicare Bad Debts under State Welfare Programs

4. Case Law:

Communi-Care Pro Rehab, Inc. v. Blue Cross & Blue Shield Ass'n., PRRB Dec. 97-D24, Jan. 29, 1997, Medicare & Medicaid Guide (CCH), & 45,053, rev'd HCFA Admin. Dec. Mar. 31, 1997, Medicare & Medicaid Guide (CCH) & 45,231.

Santa Marta Hospital v. Blue Cross & Blue Shield Ass'n., PRRB Dec. 97-D16, Dec. 5, 1996 Medicare & Medicaid Guide (CCH), &44,937, HCFA Adm. declined rev., January 20. 1997.

Rehabilitation Ass=n of VA v. Kozlowski, 42 F.3d 1447-1448, (4th Cir. 1994), cert. denied, 516 U.S. 811 (1995).

5. Other:

California Welfare and Inst. Code ' 14109.5.

Form HCFA-339, ' 1102.3 (Nov. 1995).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, parties= contentions, evidence presented, testimony elicited at the hearing, and the parties= post hearing briefs, finds and concludes that the Intermediaries= policy, of not allowing Medicare crossover bad debts unless a provider bills the related amounts to Medi-Cal, and Medi-Cal rejects the payment of the billed amount, is improper. In arriving at its conclusion, the Board majority first had to determine if there was in fact a State payment ceiling in place, and then whether there were any regulations or program instructions that prohibited the Providers= from using alternative documentation (other than a Medi-Cal remittance advice) to substantiate their crossover bad debts. Once the Board majority made a determination on these issues, it had to consider if this alternative documentation was in contravention to the regulations on adequate cost data and financial data and reports at 42 C.F.R. '' 413.20 and 413.24 respectively. The findings of the Board majority in this decision are limited to individual provider situations where the cross-over bad debts were claimed on the cost report.

Regarding the State payment ceiling, the Board majority finds that in 1989, the State did in fact set up a payment ceiling that was effective on July 1, 1989,[47] and that there is no dispute between the parties that a payment ceiling, within the terms of the requirements of HCFA Pub. 15-1 ' 322, did exist.[48] This ceiling limited the combined Medicare/Medi-Cal payment to no more than the amount allowed by Medi-Cal. Id. The Board majority also finds that with notification of the State payment ceiling in the AMedi-Cal Update,@ the Providers were also informed that the Intermediaries were requiring Medi-Cal billing to document crossover bad debts. Id. Furthermore, the Board majority finds that, while it may have been in the Providers= best interest to follow the Intermediaries=billing requirements and to submit the documentation earlier, Board regulations and procedures allow for the submittal of evidence up to the time of the hearing. In addition, while the Intermediaries argued timeliness of the data submitted,[49] the Board majority finds that the Intermediaries did not provide regulations or program cites to support their argument of timely submission of the type of bad debt claims in this case.

The Board majority next looked to the regulations at 42 C.F.R. ' 413.80(e) to determine what is required of the Providers to sustain a claim for bad debts. The Board majority finds that the Providers must demonstrate that (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, and (4) sound business judgment established that there was no likelihood of recovery at any time in the future. 42 C.F.R. '

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47 Intermediary Exhibit I-3.

48 Tr. at 305.

49 Tr. at 362.

413.80(e). In cases of indigence, the Board majority finds that providers must meet the requirements of HCFA Pub. 15-1 ' 312, whereby a bad debt may be deemed uncollectible without applying additional procedures to satisfy the determination of a reasonable collection effort as described in HCFA Pub. 15-1 ' 310.

In addition to the preceding requirements, the Providers must abide by the requirements of section 322 of the Provider Reimbursement Manual. That section states in pertinent part:

> [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 anything or pays only part of the deductible or coinsurance amounts because of a State payment Aceiling." . . . 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 the requirements of ' 312 are met.

HCFA Pub. 15-1 ' 322.

The Board majority finds that section 322 allows for payment of Medicare bad debts of the same type that are the subject of this appeal. Under section 322, in instances where Athe State has an obligation to pay, but either does not pay anything or pays only part,@ the Providers may claim the unpaid deductibles and coinsurance amounts as Medicare bad debts provided that the requirements of section 312 of the Provider Reimbursement Manual are met. In this case, the QMBs satisfy the requirements of indigence by the fact that they are Medi-Cal eligible. Accordingly, the Board majority finds that the Providers are entitled to claim the unpaid deductibles and coinsurance amounts related to the QMBs/crossover patients as bad debts on the Medicare cost reports.

Having found that section 322 allows the Providers to claim, as bad debts, the unpaid deductibles and coinsurance amounts attributable to QMBs, the Board majority next examined the question of what the Providers= billing obligations were (to Medi-Cal) to document the crossover bad debt. The Board majority had to decide if in fact a bill to Medi-Cal (followed by a Medi-Cal remittance advice evidencing the amount (of deductibles and coinsurance) the State would not pay due to its ceiling) was the only method in which the Providers could document the crossover bad debts. The Board majority

finds that various resolutions were attempted over the years to come up with alternative solutions rather than actually billing Medi-Cal and receiving a remittance advice documenting the bad debt.

Further, the Board majority finds no testimony or evidence in the record that the surrogate (i.e. EDS reports) documentation would not have mirrored the information found on the Medi-Cal remittance advice. The Board majority finds that the information on the EDS reports appears to satisfy two important criteria for claiming crossover bad debts. The EDS reports documented the Medicaid eligibility of the patient on the date of service, and the amount that the State would not pay for that patient due to its payment Aceiling@. (i.e. the amount of the bad debt). Therefore, the Board majority finds that the surrogate at Providers= Exhibit P-18B essentially provides the same documentation as the Medi-Cal remittance advice at Providers= Exhibit P-24.

The Board majority concludes there is evidence in the record to indicate that the bad debts that are the subject of this appeal were in fact attributable to crossover patients and that these bad debts were the result of the Medi-Cal payment ceiling. The Board majority finds nothing in the regulations or manual that would prevent the Providers from supplying an alternative type of documentation (other that a Medi-Cal remittance advice) to substantiate its crossover bad debts. In addition, the Board majority found nothing in the regulations or manual that would prohibit the Intermediaries from auditing the alternative documentation. Based on the above findings and conclusions, the Board majority concludes that the Intermediaries= Aper se must bill policy,@ which requires Providers to bill the State and receive a Medi-Cal remittance advice in order to claim outpatient crossover bad debt, imposes a requirement beyond those found in the regulations and program instructions.

The Board majority next looked to the Intermediaries= contentions and arguments. The Board majority takes exception to the Intermediaries= primary argument that the only way to document a crossover bad debt is to bill the State, and in turn, receive a remittance advice evidencing an amount of what the State would not have paid due to its ceiling.

The Board majority notes that it found nothing in the regulations or program instructions to support the Intermediaries= billing requirement. The Board majority finds that section 322 allows the Providers to depart from the norm and claim as a bad debt, an amount which the State has an obligation to pay, but does not pay, because of a payment ceiling. Therefore, section 322 allows for the bad debt provided the patient is deemed indigent under section 312. Once the patient is deemed indigent, the debts of indigent patients may be deemed uncollectible without applying the reasonable collection effort procedures of section 310.

Continuing to address the Intermediaries arguments, the Board majority rejects the Intermediaries= argument that the Providers are disqualified from claiming the crossover bad debts because the Providers did not meet the tests of 42 C.F.R. ' 413.80(e)(2), (3), and (4).[50]

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[50] See Intermediaries Post Hearing Brief at 9.

(2) The Provider must be able to establish that reasonable collection efforts were made.

The Board majority notes that, since there is no argument in evidence that the patients were not in fact Medicaid eligible, section 312 obviates the need for the Providers to apply the reasonable collection efforts of section 310. It is the Board majority=s position that the surrogate (i.e. EDS reports) information has established Medicaid eligibility.

(3) The debt was actually uncollectible when claimed as worthless.

The Board majority notes that once indigence is determined, the debt may be deemed uncollectible, as noted in section 312.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

The Board majority notes evidence in the record that suggests that once the payment ceiling was implemented, the amount of time and effort to bill crossover patients increased significantly. The Board majority also notes evidence that recoveries were minimal and insignificant. The Board majority finds that once indigence was determined, the Providers did not have to follow the reasonable collection effort procedures under section 310. Based on the above, the Board majority finds that it was sound business judgment on the Providers= part to assume that the likelihood of recovery for indigent patients was slim, and therefore, not bill in the traditional manner.

Therefore, the Board majority does not agree that all criteria of section 413.80(e) must be met in order to have a valid Medicare bad debt. Since the Providers have apparently met the criteria established in section 312, then section 310's collection efforts would not apply.

The Board majority notes that the Providers have made numerous attempts to recreate the Medi-Cal remittance advice. It appears to the Board majority that the surrogate report on Provider Exhibit P-18B has at a minimum, the same basic information as on a Medi-Cal remittance advice.

The Board majority also rejects the Intermediaries= argument that by accepting a surrogate to the Medi-Cal remittance advice, they would be violating the requirements of 42 C.F.R. '' 413.20 and 413.24 regarding adequate cost data and the Providers= financial records. The Board majority notes that in developing the surrogate, the Providers used the State=s system, in place during the years at issue, as well as the Medicaid eligibility files. In addition, the data on the surrogate came from the Medicare payment tapes as well as the State=s eligibility files. It is the Board majority=s opinion that the data

contained on the surrogate reports was in fact Aadequate,@ as well as originating from the Providers= financial records. Accordingly, the Board majority maintains that using the surrogate would not violate the requirements of sections 413.20 and 413.24.

Based on the above findings and conclusions, the Intermediaries= procedure of requiring the Providers to submit a bill to Medi-Cal in order to substantiate crossover bad debt is reversed. The Board majority remands the case to the Intermediaries to review and audit the EDS/surrogate reports of crossover bad debts. The Board majority suggests that the Providers and Intermediaries should consider employing the services of a third party to perform the audit.

DECISION AND ORDER:

The Intermediaries= procedure of requiring the Providers to submit a bill to Medi-Cal in order to substantiate crossover bad debt is reversed. The case is remanded to the Intermediaries to review and audit the EDS/surrogate reports to determine the validity of the crossover bad debts claimed by the Providers. At the conclusion of the audit, the Board majority orders the Intermediaries to reimburse the Providers for the crossover bad debts as evidenced on the EDS/surrogate reports.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq. (dissenting)
Martin W. Hoover, Jr., Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: September 06, 2000

For the Board:

Irvin W. Kues
Chairman

Dissenting Opinion of Henry C. Wessman, Esquire

I respectfully dissent.

42 U.S.C. ' 1396d(p)(3) provides the basis for Medicare to cover the Abad debt@ incurred by Providers who are unsuccessful in securing payment from State-sponsored Acrossover@ Medicaid programs due to factors such as Apayment ceilings@ imposed by State programs. 42 C.F.R. '413.80(d), the rule promulgated to implement 42 U.S.C. ' 1395x(v)(1)(A) dealing with Across-subsidization@, is clear on its face: In order for a Provider to successfully claim a Abad debt@ as an allowable Medicare cost, the Provider must, following 42 C.F.R. '413.80(e), establish that 1) the bad debts were related to covered services and derived from deductible and coinsurance amounts, 2) reasonable efforts were made to collect the Medicare bad debts, 3) the bad debts were actually uncollectible when claimed, and, 4) sound business judgment established that there was no likelihood of future recovery. The Rules are then operationalized at HCFA Pub. 15-1 ' 308, with specific reference to the issue in this case, the State Acrossover@ bad debt, further clarified at HCFA Pub. 15-1'' 322, 312, and 310. In my opinion, the Provider, who must prove that the debt is uncollectible when claimed, that reasonable collection efforts using sound business judgment were employed, has simply failed to do so.

The production of duplicative, cost increasing surrogate Aindigency@ records may be appropriate in a situation where original, contemporaneous, methods of proving indigency were either not available, or such records were destroyed, and where such records, and the ensuing Abad debt,@ were generated, and authenticated, by the entity creating the non-payment. That is not the case here. The Provider, who bears the responsibility of determining the patient=s indigency (HCFA Pub. 15-1 ' 312), must Adetermine that no source other than the patient would be legally responsible for the patient=s medical bill.@ (' 312 C) In the instant case, the only Asource other@ for crossover patients would be Medi-Cal, and if the Providers made a conscious decision to not pursue that only source, to not seek the straight-forward, contemporaneous, entity generated Remittance Advice, then ' 312 is not satisfied from a legal standpoint, and ' 310, which levels the cross-subsidization playing field, kicks in. It is clear, at least to me, that ' 310 has not been satisfied in this case.

I am not convinced by the Provider=s argument of Aequivalency@ of the surrogate data to that of a Remittance Advice received by the Provider from the responsible party for each crossover patient - in this case, Medi-Cal. Despite the claims of the Provider that the surrogate is Ameeting our [Medi-Cal] commitment to high quality standards@ (Provider Post-Hearing Brief, Exhibit C), the data is still Provider-generated, third-party manipulated and collated, and payor (Medi-Cal) unverified. The

record does not emanate from the payor, Medi-Cal, and is, therefore, simply not a denial of payment in a legal sense. The surrogate does not obviate the obvious - '' 322, 312, and 310 are not trumped by Exhibit 18 (Provider Supplemental Exhibit List) because that data is not contemporaneous, does not represent a demand for payment, does not evidence a denial of payment, and is not payor generated nor verified, such as would have been the straightforward
Remittance Advice. Similarly, I can not clear the Provider of the requirement to use Asound business judgment@ (42 C.F.R. ' 413.80 (e)(4)) with the obvious recognition that simply securing a Remittance Advice would guarantee payment of 80% of the crossover bad debts, now pegged at approximately $53 million for this Group, while nonpursuit would result, at best, in being able to present the Asurrogate equivalency@ argument before the PRRB. Which brings me to my final concern: if there was not an adjustment of costs by the Intermediary in the instant case for Aunbilled bad debts@ (Provider Post-Hearing Brief at 9), do we even have the appeal-triggering Acase or controversy?@

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Henry C. Wessman, Esquire