PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2002-D6

PROVIDER -
Devon Gables Health Care Center
Tucson, AZ

Provider No. 03-5145

vs.

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

DATE OF HEARING-
November 20, 2001

Cost Reporting Period Ended -
December 31, 1995

CASE NO. 98-0511

INDEX

ISSUE:

Did the Intermediary calculate the provider's bad debts properly?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Devon Gables Health Care Center ("Provider") owns and operates a skilled nursing facility consisting of 312 beds, of which 21 are certified under the Medicare Program. The Provider is located in Tucson, Arizona.[1]

The State of Arizona furnishes long-term care services to Medicaid beneficiaries through a demonstration project, known as the Arizona Health Care Cost Containment System ("AHCCCS"), for acute care, outpatient and related services, and the Arizona Long Term Care System ("ALTCS"), for long-term care services (collectively "AHCCCS"). AHCCCS was, at the time of the cost reporting period at issue, responsible for reimbursing providers for Medicare coinsurance and deductible amounts for "qualified Medicare beneficiaries" or "QMBs" (beneficiaries who are dually eligible for both Medicare and Medicaid benefits and have an income level at or below the poverty level) up to the full Medicare rate.[2]

The AHCCCS is a managed care based system, administered by program "contractors." These contractors function like health maintenance organizations and are responsible for entering into contracts with health care facilities and reimbursing providers for the health care services they render. All members who are enrolled in these contractors' plans are, by definition, AHCCCS eligible, and many are also QMBs.

During the fiscal year at issue in this appeal, the Provider entered into an agreement with Pima Health System ("PHS"), an AHCCCS contractor, to provide long-term care services to AHCCCS beneficiaries. The Provider believed, under the terms of the agreement, it was prohibited from billing PHS for any QMB coinsurance and deductible amounts if the Medicare reimbursement for the service exceeded the PHS rate for the service: [3]

> [p]rovider agrees to bill Medicare (Part A & B) and any other third party insurance for all potentially reimbursable goods and services provided to PHS patients under the terms of this agreement. PHS shall be obligated only to pay the difference between the amount the Provider receives from the third party payor and the charges agreed to in this agreement. . . If patient has Medicare Part A, the Provider

[1] See Intermediary's position paper at 1.
[2] See Provider's position paper at 4 and Exhibit 1.
[3] See Provider's position paper at 5 and Exhibit 2.

> will be responsible for recovering payment for services covered by Medicare. PHS shall be responsible for patient share, and shall reimburse Provider at the patient share, or PHS rates, whichever is less.

The contract also states that the Provider's "failure to submit accurate and complete reports as required" in the contract, may result, at the option of the PHS, in forfeiture of right to payment." Id. If the provider breached any term of the agreement, the Provider also risked losing its AHCCCS services contract.

It is uncertain why PHS imposed this payment limit for QMB coinsurance and deductible amounts. The provider asserts that in most cases, however, the PHS contract rate was less than the Medicare Part A coinsurance rate for long-term care services and less than the 80% Medicare reimbursement rate for Part B services. The Provider calculated the difference between the PHS rate and the Medicare rate for its services and claimed this difference as Medicare bad debts on the cost reporting period in question.[4]

The Intermediary proposed adjustment number 30 ($30,270), disallowing the QMB bad debts claimed by the Provider on its as filed cost report. The Intermediary determined that the bad debts were not allowable since the Provider did not bill the primary payor for services rendered and the accounts were written-off less than 120 days after the Medicare remittance advice date.[5]

The Intermediary, Blue Cross and Shield of Arizona, issued the Notice of Program Reimbursement (NPR) on September 9, 1997. The Provider appealed the Intermediary's adjustment for the elimination of bad debts to the Provider Reimbursement Review Board ("Board") on December 22, 1997 and has met the jurisdictional requirements set forth in 42 C.F.R. §§ 405.1835-.1841. The Medicare reimbursement in controversy is approximately $30,270.[6] The provider was represented by Julie Mathis Nelson, Esquire of Coopersmith Gordon Schermer Owens & Nelsen P.L.C. The Intermediary's representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's refusal to reimburse it for its QMB bad debts violates Medicare regulations, violates HCFA's interpretive guidelines and is arbitrary and

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[4] See Provider's position paper at 6.
[5] See Intermediary's position paper at 3.
[6] See Intermediary's position paper at 2.

capricious. This refusal, based on the Provider's alleged failure to make a "reasonable collection effort," reflects the Intermediary's misinterpretations of applicable bad debt reimbursement rules, constitutes retroactive rulemaking, and improperly shifts Medicare costs onto non-Medicare patients.[7]

[7] See Provider's position paper at 6.

The Provider asserts that Medicare regulations and HCFA interpretive guidelines specify that a provider is entitled to claim QMB coinsurance and deductible amounts on its Medicare cost report when the state is obligated to pay all or part of the QMB copayment amount, but either does not pay anything or pays only part of the amount due to a payment ceiling, as in accordance with HCFA Pub. 15-1, § 322.[8] The state's AHCCCS program was obligated to pay the QMB copayment amounts, but did not pay anything due to the contractor-imposed payment ceiling. As a result, the Provider was entitled to claim these amounts as bad debts, as long as the Provider put forth a "reasonable collection effort." The issue in this appeal is whether the Provider made such a reasonable collection effort.

The Provider cites HCFA Pub. 15-1, § 310 which 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 after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations.

The Provider contends that it applied similar collection efforts for all payor types, including Medicare and non-Medicare patients covered by third party payors. The Provider did not file any coinsurance claims when third party payor contracts prohibited it from doing so.

In addition, the Provider states that a "reasonable collection effort" means billing the responsible party for the claim and referring the case to a collection agency. The Provider believes that this rule is not applicable in this situation.

The Provider emphasizes that HCFA Pub. 15-1, § 310 contemplates collection efforts against individuals, not third party payors that contract with a provider. First, the provision uses terms like "issuance of a bill," not payor terminology, such as "filing of a claim." Second, the provision requires the issuance of a bill and contemplates the use of a collection agency, without regard to written contracts with payor entities. In many cases, such as the Provider's, third party payors prohibit the provider from filing claims for certain services. Further, providers generally do not use collection agencies to obtain payment from third party payors. Since HCFA Pub. 15-1 § 310 does not address these "payor contract" issues, it could not have been intended to apply to these types of situations and does not govern the outcome of this appeal.

The instructions for completing the HCFA-339, given the limited nature of HCFA Pub. 15-1 §310, does take payor contract issues into consideration. It states:

> [a]ny portion of the deductible/coinsurance not paid by Medicare

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[8] See Provider's position paper at 7.

> under (the criteria stated in HCFA Pub. 15-1 §§ 312 and 322) is a Medicare bad debt and may be claimed on the provider's cost report.

This provision does not mention HCFA Pub. 15-1 § 310 and further states that while evidence of the bad debt "may include" a copy of the Medicaid remittance denying the claim:[9]

> [i]t 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, and
- Non-payment that would have occurred if the crossover claim had actually been filed with Medicaid.

HCFA-339 Form Instructions (L).

Thus, HCFA does not require providers to file claims with the Medicaid program if doing so would be futile (the "futility exception"). In other words, HCFA has made a determination that, in certain circumstances, a "reasonable collection effort" may require the provider to make no collection efforts.

The Provider claims that in this case, they clearly meet the criteria of the futility exception. For the Intermediary to deny the Provider's claims without regard to HCFA's own instruction on this subject, exceeds the scope of the Intermediary's authority. HCFA's failure to comply with its own instructions constitutes retroactive rulemaking in violation of federal law.

There is no dispute of the claimed beneficiaries' Medicaid eligibility at the time the services were rendered, since they were AHCCCS plan enrollees. Furthermore, the Provider's contract with PHS clearly demonstrated that the Provider would not have been paid if it had actually filed the claim with the AHCCCS contractor, PHS.

The Provider contends that it was not required to wait 120 days before claiming the uncollected amounts as bad debts. The only requirement is that the debt be actually uncollectible when claimed as worthless in accordance with the HCFA-339 Form Instructions.

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[9] See Provider's position paper at 8.

As stated above, when the Provider claimed its bad debts on the cost report, the outstanding debt was considered to be worthless. The HCFA-339 Form Instructions further clarify that the 120 day waiting period is used to prove that the debt is actually uncollectible. The 120 day waiting period is not required when the provider can demonstrates that the debt is uncollectible:[10]

> [w]hen a provider claims Medicare bad debts in 120 days or less from the first bill, the provider must be prepared to demonstrate that the debts were "actually worthless."

HCFA-339 Form Instructions (L).

The Provider contends that it has ample evidence that its debts were worthless.

Despite the fact the Provider insists it's entitled to bad debt reimbursement, the Intermediary contends that the Provider is not so entitled, citing several AHCCCS documents and a HCFA Administrative Decision[11] in support of its position. These documents and case citations, however, are not relevant to this appeal.

First, the AHCCCS Fee-for-Service Manual ("Manual") cited by the Intermediary does not apply to the Provider. The Manual only governs payments to providers that do not contract with program contractors:[12]

> [t]his manual is only for fee-for-service claims, it is not a substitute or replacement for a health plan's or program contractor's manual. If you contract with one or more of the AHCCCS health plans or program contractors, please continue to follow their instructions when providing and billing for services rendered to a recipient enrolled in the plan.

Id.

During the fiscal year at issue, AHCCCS deferred billing and payment decisions to the AHCCCS contractors. Thus, the Provider was prohibited through its PHS contract and AHCCCS instructions from billing PHS for the coinsurance and deductible amounts.

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[10] See Provider's position paper at 9.
[11] See Intermediary's position paper at 6.
[12] See Provider's position paper at 10 and Exhibit 3.

Second, the Provider asserts that AHCCCS correspondence has no bearing on this appeal. The letters that the Intermediary refers to in its position paper were written in 1997,[13] well after the Provider's fiscal year at issue, and directly conflict the AHCCCS rules implemented by the program contractors in effect at the time. The letters, which are dated well after the Provider's deadline for filing claims had passed, do not give providers any extension of the claims filing deadline or otherwise advise providers of their right to obtain any coinsurance and deductible payments for past years. Indeed, the letters suggest that providers are not entitled to either Medicare or AHCCCS reimbursement for the coinsurance amounts they have to incur. This governmental "finger pointing" was not the intent of the principles behind Medicare bad debt reimbursement.

Third, the Provider contends that the HCFA Administrative Decision cited by the Intermediary, in its position paper, is distinguishable from this case in many respects. For example, the state in that case did not establish a payment ceiling. Here, as explained above, AHCCCS did establish a payment ceiling as evidenced by the PHS contract. Furthermore, that case did not address the bad debt billing instructions, which explicitly allow the providers to not file claims, when filing such claims would be futile. The provider in that case also did not have explicit instructions from the Medicaid program not to bill for coinsurance and deductible claims, as did the provider in this case. Finally, in that case, the provider could not substantiate its claims for coinsurance and deductible amounts. Here, the Intermediary acknowledges that had the Provider followed policy and properly billed the AHCCCS program; the bad debts should have been reimbursed.[14]

The Provider claims 42 U.S.C. § 1395x(v) and 42 C.F.R. § 413.80 make clear that the purpose of bad debt reimbursement is to ensure that the costs of services furnished to Medicare beneficiaries are not borne by persons not covered by that program.[15] If a provider does not collect revenue related to its services, then the provider has not recovered the cost of its services, and these costs must then be borne by non-Medicare patients. Here, the Provider has not received any reimbursement for its coinsurance and deductible amounts attributable to its QMB's for the fiscal year in question, thus illegally shifting the burden for these costs onto non-Medicare patients.

After the fact, AHCCCS implied that it should have paid these coinsurance and deductible amounts, but the time for filing such claims has long since past; and AHCCCS has not given providers any opportunity to obtain reimbursement for what it now views as contractors' violation of state policy.[16]

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[13] See Intermediary's position paper at Exhibit I-3.

[14] See Intermediary's position paper at 6.

[15] See Provider's position paper at 12.

[16] See Intermediary's position paper at Exhibit I-3.

In conclusion, the Provider respectfully requests that the Intermediary reimburse the Provider for its QMB/PHS bad debts. However, if the Board concludes that AHCCCS is responsible for such payments, the Provider requests the Board take whatever action is necessary to require the AHCCCS program to reimburse the Provider for these coinsurance and deductible amounts.

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.[17] HCFA Pub. 15-1 § 308 and 42 C.F.R. § 413.80(e) state:

> (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 an 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:

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[17] See Intermediary's position paper at 3 and Exhibit I-2.

> [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.[18]

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:[19]

> [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

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[18] See Intermediary's position paper at 4.

[19] See Intermediary position paper at 4 and Exhibit I-3.

> 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,[20] explains that in accordance with the Arizona State Plan 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 contractors 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

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[20] See Intermediary position paper at 5 and Exhibit I-3.

AHCCCS program, these bad 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 bad 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,[21] 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 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 as 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 C.F.R. § 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. Law – 42 U.S.C.:

   § 1395x(v) et seq. - Reasonable Costs

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

   §§ 405.1835-.1841 - Right to Board Hearing - Time Place, Form and Content of Request for Board Hearing

   § 413.80 et seq - Bad Debts

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

   § 308 - Criteria for Allowable Bad Debts

   § 310 - Reasonable Collection Effort

   § 310.2 - Presumption of Noncollectibility

   § 312 et seq. - Indigent or Medically Indigent Patients

[21] See Intermediary's position paper at 6.

§ 322 - Medicare Bad Debts Under State Welfare Programs

4. 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, rev'd, HCFA Administrator, March 31, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,231.

Community Hospital of Monterey Peninsula v Tommy G. Thompson, 259 F.3d 1071 (9th Cir. 2001).

5. Other:

HCFA-339 Form Instructions

AHCCCS Policy and Procedure Manual § 300

AHCCCS Fee-for-Service-Manual

ASPA 96-013

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

The Board finds that the Provider followed the steps available to it in pursuing the claims for Medicare coinsurance and deductibles from the State Medicaid program in which it participated.

The Board notes that the record contains evidence that the State Medicaid program's policy[22] was to pay the full Medicare coinsurance and deductibles for AHCCCS and Medicare covered services provided to eligible recipients; however, the State did not implement the necessary procedures to allow providers to recover these amounts. In addition, neither the State of Arizona nor the program contractor, PHS, 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.

[22] See Intermediary's position paper Exhibit I-2.

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. The express language of the Provider's contract with PHS prohibited the Provider from billing any amounts that exceeded the PHS contract rate.[23] Since the Medicare paid amounts exceeded the PHS contract rates, PHS would have denied the Provider's additional claims. Therefore, if the Provider had filed these coinsurance and deductible claims with PHS, it would have risked losing payment for the entire service and, more importantly, termination of its AHCCCS contract.

The Board notes that the record indicates that program contractors on behalf of AHCCCS were liable for the coinsurance and deductible amounts.[24] The record contains considerable correspondence from the HCFA Regional Office, the Intermediary, and the AHCCCS administration, directed at clarifying the responsibility of the state to pay for coinsurance and deductible amounts and ensuring that the policy be implemented.[25] 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.[26]

The Board finds 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.

In support of its findings the Board refers to Community Hospital of Monterey Peninsula v Tommy G. Thompson, 259 F.3d 1071 (9th Cir. 2001), where the court held that the Secretary's insistence on a must bill requirement does not have a basis in the text of the regulations and is contradicted by manual provisions. The court concluded that a per se must bill requirement pursuant to a crossover payment ceiling is arbitrary and capricious because this requirement violates Congress' prohibition of cost-shifting in Medicare, as expressed in 42 U.S.C. § 1395 x(v)(1)(A) and 42 C.F.R. § 413.80(d).

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[23] See Provider's position paper at 9 and Exhibit 2.

[24] See Intermediary's position paper Exhibit I-2.

[25] See Intermediary's position paper Exhibit I-3 and Provider's position paper Exhibit 1.

[26] See Intermediary's position paper Exhibit I-3.

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 not made 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
Stanley J. Sokolove
Dr. Gary Blodgett

Date of Decision: January 10, 2002

FOR THE BOARD

Irvin W. Kues
Chairman