PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2002-D35

PROVIDER –
Metro Physical Therapy and Rehabilitation, Inc.
Taylor, Michigan

Provider No. 23-6554

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/United Government Services

DATE OF HEARING-
July 2, 2002

Cost Reporting Periods Ended
December 31, 1996
December 31, 1997

CASE Nos. 00-3147
00-3150

INDEX

ISSUE:

Did the Intermediary properly adjust the provider's bad debt expense?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Metro Physical Therapy and Rehabilitation, Inc. ("Provider") is a Medicare certified rehabilitation agency located in Taylor, Michigan. United Government Services ("Intermediary") reviewed the Provider's claimed bad debts for the periods ended December 31, 1996 and December 31, 1997. The Intermediary reviewed a sample of the bad debt claims and determined that they were not reimbursable under the Medicare criteria for allowable bad debts. The Intermediary determined that the Provider's documentation was not sufficient to substantiate the bad debts.

The Provider appealed the Intermediary's determination to the Provider Reimbursement Review Board ("Board"). The Provider met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The amount of reimbursement in contention is approximately $11,184 for the fiscal year ended December 31, 1996 and $14,426 for the fiscal year ended December 31, 1997.

The Provider was represented by Mohammad Rafig, Associate Administrator of the Provider. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it met all of the criteria of CMS Pub. 15-1 §§ 308 and 310 for writing off bad debts. It argues that it met the requirement that: "[t]he bad debt must be related to covered services and derived from deductible and coinsurance amounts," and that: "[t]he provider must be able to establish that reasonable collection efforts were made." The Provider points out that it billed the deductible and coinsurance amounts to each patient. Where a patient had supplementary insurance, the insurance was billed first for the deductible and coinsurance, and only the amount not paid by the supplementary insurance was billed to the patient.

The Provider maintains that after sending the patient an initial bill, the patient was sent at least three other demand letters, approximately one month apart. These letters were labeled as "Over Due," or "Delinquent," or "Legal Demand." The Provider contends that it was following the practice of sending bills on a monthly basis.

The Provider argues that its collection policy was the same for both Medicare and non-Medicare patients. If a bill remained unpaid for at least four months, the collection efforts were continued only if the account appeared collectible; otherwise the Provider considered the account a bad debt.

The Provider contends that its procedures were in accordance with the Medicare regulations and policy. If the bill was unpaid for at least 120 days from the date the first bill was sent to the patient, the administrator reviewed the patient chart to determine if at least three follow up letters were sent to the patient, and that there was no likelihood of recovery. The Provider, using sound business judgment then wrote off the account. The Provider at the request of the Intermediary wrote review notes to support its decision to write off an account.

The Provider points out that an account was uncollectible when it was claimed as worthless, in accordance with CMS Pub. 15-1 § 310 which states that:

> [i]f after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

The Provider argues that the Intermediary's requirement that the Provider should have documented that the debts were actually uncollectible or determine the indigence of the patients is not supported by the applicable regulations.

The Provider contends that it wrote off the bad debts in accordance with CMS Pub. 15-1 §§308 and 310. The Provider argues that it was not required to determine a beneficiary's indigence under the above mentioned sections of the CMS Pub. 15-1.

The Provider contends that the Intermediary audited its cost report for the period ended December 31, 1993. In the bad debt portion of that audit, only one bad debt claim was disallowed, as it was written off prior to 120 days. The Provider argues that it utilized the same procedures for the FYE December 31, 1993 as in the present years under contention.

The Provider maintains that there was no change in CMS Pub. 15-1, or any instructions received from the Intermediary after the audit of the December 31, 1993 cost report, which required the Provider to change its practice regarding bad debts. By the Intermediary demanding a different set of

standards without informing the Provider, there is a violation of the principles of due process. The Provider points out that in Tri Home Health Care and Services, Inc. (Forest Hill, Md.) v. Independence Blue Cross, PRRB Dec. No. 97-D37, March 24, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,152, the Board held that failure of the intermediary to disseminate to the providers a change in policy violated the principles of due process.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not meet all of the criteria for allowable bad debts as required by CMS Pub. 15-1 § 308. That section defines the criteria for allowable bad debts as follows:

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 Intermediary points out that Section 310 of CMS Pub. 15-1 defines what is considered a reasonable collection effort. That Section states in part: "[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." This section goes on to state that if a collection agency is used "[M]edicare expects the provider to refer all uncollected patients charges of like amount to an agency without regard to class of patient."

The Intermediary argues that the Provider's bad debt policy does not follow the above-mentioned treatment. The Provider's policy states that working patient's files are sent to a collection agency whereas non-working patients are written off as a bad debt. As most Medicare patients are not working, the Provider is clearly in violation of the comparable effort requirement of CMS Pub. 15-1 § 310.

The Intermediary argues that the Provider did not document its files as to whether or not the debt was actually uncollectible. The Provider supplied brief notes on the sampled claims as to why the claims were considered uncollectible. However, these notes were completed after the bad debt was

written off and claimed on the Medicare cost report. The Intermediary contends that prior to writing off a bad debt its worthlessness should be determined. The Intermediary further argues that the Provider did not use sound business judgment that there was no likelihood of recovery at any time in the future before it wrote off its bad debts.

The Intermediary contends that findings in a previous year's audit should not determine the situation in the current year. The Intermediary maintains that the Provider is incorrect in its assertions that because the Intermediary did not make any adjustments in previous years' cost reports, it must be consistent with the current years cost reports. The current year audit should stand on its own merit and adjustments made as found to be necessary. In fact, an error may have been made in a previous year, and such consistent treatment would result in the continuation of the original error.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

   §§ 405.1835-.1841 - Board Jurisdiction

2. Program Instructions - Provider Reimbursement Manual(CMS Pub. 15-1):

   § 308 - Criteria for Allowable Bad Debt

   § 310 - Reasonable Collection Efforts

3. Cases:

   Tri Home Health Care and Services, Inc. (Forest Hill, Md.) v. Independence Blue Cross, PRRB Dec. No. 97-D37, March 24, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,152.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the law, regulations, program instructions, facts, parties' contentions, and evidence submitted on the record finds that the Intermediary properly adjusted the Provider's bad debt expense.

The Board finds that it is undisputed that the Provider sent monthly demand letters to the debtors. However, there was no evidence in the record that there was an analysis that would indicate that the debt was uncollectible. The

Board finds that the Provider's "Policy on Bad Debt" dated January 1, 1994[1] was:

> 4. a) If the patient is working and appears collectible MPT will hand over the bill either to an agency for collection or to our attorney for legal action.
> b) If the patient is not working and likely does not care about his credit rating, MPT will write off the unpaid balance.

Based on this policy, the Board finds that the Provider wrote off Medicare patients bad debts without considering if the debts were collectible. Just because a patient is not working does not mean the debts are uncollectible.

It appears that the Provider did send bad debt cases to either a collection agency or an attorney. However, the Board finds that the Medicare patients were not referred to a collection agency. Section 310 of CMS Pub. 15-1 states in part:

> [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.

Therefore, the Board finds that the Provider was in violation of Section 310 since it did not handle Medicare debts in the same manner as it handled non-Medicare debts.

The Board notes that the Provider contended that in the previous year's audit there was only one bad debt claim disallowed, and that the Provider used the same procedures for that fiscal year as in the present year under contention. The Board finds that this contention has no merit. Each year stands alone. A previous year's audit does not dictate what happens in a current year.

DECISION AND ORDER:

[1] Provider Exhibit P-7.

The Intermediary properly adjusted the Provider's bad debts expense. The Intermediary's adjustment is upheld.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire
Stanley J. Sokolove
Dr. Gary Blodgett
Suzanne Cochran, Esquire

Date of Decision: August 28, 2002

FOR THE BOARD:

Irvin W. Kues
Chairman