PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2004-D42

PROVIDER –
Mesa Vista Hospital
San Diego, CA

Provider No.: 05-4012

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
United Government Services, LLC--CA

DATE OF HEARING –
May 18, 2004

Cost Reporting Period Ended -
February 28, 1998

CASE NO.: 01-2416

INDEX

ISSUE:

Did the Intermediary properly eliminate the Provider's Medicare bad debts due to the Provider allowing discounts to only non-Medicare patients?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This dispute arises out of United Government Services' (Intermediary) failure to reimburse Mesa Vista Hospital (Provider) the amount that the Provider claims is due under the Medicare program of the Social Security Act, 42 U.S.C. §§ 1395 et seq. The amount in contention relates to whether Medicare is responsible for reimbursing the Provider for uncollected coinsurance and deductible amounts when a provider offers discounts on outstanding balances for non-Medicare patients but not for Medicare patients.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395 – 1395cc. The Health Care Financing Administration, (HCFA) now the Centers for Medicare and Medicaid Services (CMS), is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

The Secretary's payment review and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS. Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs that is to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement (NPR). 42 C.F.R §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Under the Medicare statute, a provider is entitled to claim as a reimbursable cost "bad debts" attributable to amounts unpaid by beneficiaries for Medicare deductibles and coinsurance for the Medicare patients it services. 42 C.F.R. §413.80. The relevant program instruction relating to the dispute is HCFA Pub. 15-1 §310: Reasonable Collection Effort. It requires a consistent effort to collect outstanding bills from all patients.

The Provider is a hospital located in San Diego, California, and participated in the Medicare program until February 28, 1998. On its terminating cost report, which covered the period from January 1, 1998 to February 28, 1998, the Provider claimed Medicare bad debts of $63,500.

The Intermediary disallowed all of the bad debts claimed for 1998 based upon its audit of the Provider's bad debt claims for the prior cost reporting period (FYE 12/31/97). The Intermediary concluded that the Provider's collection efforts for Medicare and non-Medicare patients were inconsistent because four non-Medicare patients were offered discounts of between 10% and 25% if they paid their balances by a certain date. No Medicare patients were offered such discounts.

The Intermediary's 1997 bad debt audit workpaper, included in its Position Paper as Exhibit I-3, indicates that it identified four non-Medicare patients who were offered discounts. However, the work-papers at I-6 (collectively Intermediary workpaper 15-G) contain a copy of three letters offering such discounts. Furthermore, when the Provider requested a copy of all of the documents that made up workpaper 15-G, the Intermediary provided a copy of just two such letters.[1] The Provider points out that all of the letters that offered the discounts were dated months after the Provider was sold, and that they represented a last-ditch effort to collect outstanding balances. Finally, the Provider maintains that the offering of discounts was not typical of the hospital's day-to-day operations and furthermore, none of the patients offered the discounts paid their outstanding balances.[2]

The Provider appealed the Intermediary adjustments to the Board and met all of the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Mr. Reid Fujinaga of Getner and Company. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the facts, parties' contentions and evidence submitted, finds and concludes that the Intermediary improperly denied the Provider's claimed Medicare bad debts for the cost reporting of January 1, 1998 – February 28, 1998.

Based on the facts that the Provider ceased operations two months into the cost reporting period and offered discounts to non-Medicare patients considerably after the close of its final period, the Board finds that the Provider's offer of discounts to non-Medicare patients was an unusual procedure which was not part of the Provider's normal collection effort.

The Board further finds that there was no evidence in the record to indicate any difference in collection effort between Medicare and non-Medicare patients prior to the offering of discounts to non-Medicare patients. The Board concurs with the Provider's contention that all bad debts were referred to a collection agency but only after an appropriate in-house collection was completed. The Board finds that this activity meets the reasonable collection effort as stated in HCFA Pub. 15-1 §310.

---

[1] See Provider's position paper, pg. 8

[2] Id. @ pg. 9

The Board concurs with the Provider's contention that HCFA Pub. 15-1 §310's collection effort requirement for Medicare and non-Medicare bad debts does not mean that the collection effort has to be identical. Appropriate business conditions and factual situations may call for different collection efforts that may culminate in a similar result. Finally, the Board concurs with the Provider's contention that the Intermediary improperly applied the audit results of the Provider's 1997 Medicare bad debts summarily to the 1998 Medicare bad debts. Appropriate audit effort should have been applied to the 1998 bad debts to determine their propriety.

DECISION AND ORDER:

The Medicare bad debts for 1998 are allowable. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA

DATE: September 17, 2004

FOR THE BOARD:

Suzanne Cochran
Chairperson