PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D16

PROVIDER –
Dameron Hospital
Stockton, CA

Provider No.: 05-0122

vs.

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

DATE OF HEARING -
April 14, 2005

Cost Reporting Period Ended -
December 31, 1999

CASE NO.: 04-0426

INDEX

ISSUE:

Whether the Intermediary's disallowance of the Provider's inpatient and outpatient Medicare bad debts was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment 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 Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

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 proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider 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 issuance 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. This appeal involves the Intermediary's denial of the Provider's bad debt claim.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Dameron Hospital (Provider) is a 195 bed, general short-term hospital located in Stockton, California. The Provider was certified to participate in the Medicare program on July 1, 1966.

For fiscal year ended (FYE) 12/31/99 the Provider claimed $64,000 in bad debts on its cost report based upon its debt collection polices and its actual collection activities throughout the fiscal year. The Provider's collection and write-off policies had been reviewed and accepted by its Intermediaries during audits of prior periods. In 1999, United Government Services (Intermediary) became the Provider's intermediary and

conducted its first audit of the Provider's debt collection policies/activities. The audit indicated that the Provider deemed its accounts uncollectible when it exhausted its in-house attempts to collect them. Subsequent to those write-offs, the Provider sent its uncollectible accounts to an outside agency for a last effort to effect collection. The Intermediary disputed the propriety of identifying those accounts forwarded to the outside agency as uncollectible and disallowed the amount of the write-off in total. There is no dispute that 42 C.F.R. §413.80 and Provider Reimbursement Manual (PRM) 15-1, sections 308 and 310 are the controlling guidance for bad debts. The dispute centers on the appropriate time to identify an account as uncollectible and write it off as a bad debt.

The Provider timely appealed to the Board pursuant to 42 C.F.R. §§405.1835-.1841 and has met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is $38,000. The Provider was represented by Gregory M. Hatton, Esquire. The Intermediary was represented by James Grimes, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

For FYE 1999 the Intermediary audited 58 of 142 accounts that the Provider submitted to Medicare for bad debt reimbursement. Based on the audit of the 58 accounts, the Intermediary denied all 142 bad debt submissions on the FYE 1999 cost report. The Provider argues that the Intermediary's denial must be reversed in its entirety for the following reasons:

1.) The Intermediary misinterprets applicable law and regulation. As to each of the audited accounts, the Provider's sound business judgment establishes that, at the time the account was written off to bad debt, there was no likelihood of recovery at any time in the future.

2.) The Intermediary fails to comprehend the collection policies and procedures followed by the Provider that are relevant here. The Provider exhausts extensive collection efforts before concluding that any Medicare patient account is actually uncollectible and worthless.

3.) The Intermediary evidently failed to comprehend the Provider's detailed documentation of relevant collection efforts on the 58 audited accounts. These collection efforts provide the basis for the Provider's sound business judgment that there was no likelihood of recovery at any time in the future.

4.) Neither of the competing presumptions regarding collectibility in the Program Instructions apply here. The PRM, section 310.2, permits a debt unpaid for more than 120 days from the first billing of the beneficiary to be deemed *uncollectible*. A countervailing presumption is found in the Medicare Intermediary Manual (MIM). Part IB, 13-2 of the MIM includes the presumption that any account that remains on "active" or "open" status with the Provider's outside collection agency has "value" and is therefore

collectible. Neither the presumption of *collectibility* in the PRM, nor the presumption of *uncollectibility* in the MIM are conclusive. And where, as here, the provider satisfies all four of the criteria in C.F.R. §413.80(e), *neither* presumption applies.[1]

5.) The Provider's documentation of its activity is detailed and adequate. As to each of the 58 accounts, the Provider's documentation supports the conclusion that: (a) "Sound business judgment establishes that there was no likelihood of recovery at any time in the future;" and (b) The debts were "actually uncollectible when claimed as worthless." Failure to reimburse the bad debts violates the prohibition on cross-subsidization; Social Security Act Section 1861(v)(1)(A); and bad debt reimbursement regulations. C.F.R. §413.80(d) and (e).

6.) Finally, the Provider contends that the Intermediary violated section 6023 of the Omnibus Budget Reconciliation Act of 1989 (OBRA). The Intermediary disallowed the Provider's bad debt claims because the accounts were still listed as "active" by the Provider's outside collection agency years after the Provider assigned the accounts. Prior to August 1987, and until the FYE 1999 audit, the Intermediary had accepted the Provider's collection policy and procedure, whereby the Provider wrote off patient accounts as bad debts at or about the time that the accounts were assigned to an outside agency. Under OBRA, the Intermediary must continue to accept this policy.

INTERMEDIARY'S CONTENTIONS:

The Intermediary selected a sample of 58 regular Medicare bad debt accounts to review for compliance with PRM 15-1 sections 308 and 310. The following were the auditor's findings:

1.) "The FI requested the Provider to furnish documentation to support that all regular bad debts claimed were deemed worthless/uncollectible in FY 1999. The Provider furnished a report, which was generated by the collection agency. Based on the review of sampled accounts' collection history, the FI found that all of them were still active in 1999. Medicare accounts at a collection agency are not deemed worthless/uncollectible until the collection agency stopped active

[1] Methodist Hospital of Dyesburg v. Blue Cross and Blue Shield, PRRB Case No. 96-1215, Decision No. 00-D56; : Lourdes Hospital v. AdminaStar of Kentucky, PRRB Dec. Nos. 95-D58, 95- D59, 95-D60, Medicare and Medicaid Guide (CCH) ¶43,585 (1995); King's Daughters' Hospital v. Blue Cross and Blue Shield of Kentucky, PRRB Dec. No. 91-D5, Medicare and Medicaid Guide (CCH) ¶38,950 (1990); St. Francis Hospital and Medical Center v. Kansas Hospital Service Assn., PRRB Dec. No. 86-D21, Medicare and Medicaid Guide (CCH) ¶35,302(1985), and Scotland Memorial Hospital v. Blue Cross and Blue Shield Association of North Carolina, PRRB Dec. No. 84-D174, Medicare and Medicaid Guide (CCH) ¶34,225 (1984).

collection efforts."

2.) "Collection efforts were not consistent with all payer types."

3.) "The Provider did not follow its own in-house collection policies and producers [sic] [procedures]."

Based on the above findings, the Intermediary disallowed all regular Medicare inpatient and outpatient bad debts. The Intermediary contended that Provider failed to comply with the applicable Medicare regulations and manual sections pertaining to bad debt collections because it was still pursuing collection efforts for its Medicare bad debts by using an external collection agency.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, finds and concludes that the Intermediary's adjustments to the Provider's bad debts were improper. The Provider's bad debts are allowable.

42 C.F.R. §413.80(a) provides that bad debts attributable to the deductible and coinsurance amounts of Medicare beneficiaries are reimbursed under the Medicare program. Bad debts are defined at 42 C.F.R. §413.80(b)(1) as:

> [A]mounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

The regulation at 42 C.F.R. §413.80(d) states that payment for deductibles and coinsurance amounts is the responsibility of the beneficiaries. However, recognizing the reasonable cost principle at Section 1861(v)(1)(A) of the Social Security Act, which prohibits cross-subsidization, the program states that the inability of providers to collect deductibles and coinsurance amounts from Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not beneficiaries. Therefore, to prevent such cross-subsidization, Medicare reimburses providers for allowable bad debts.

Providers may receive reimbursement for Medicare bad debt if they meet all of the criteria set forth in 42 C.F.R. §413.80(e). The criteria require 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.

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

PRM 15-1 Section 310 states:

> To 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.

Section 310.A of the PRM further explains:

> A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. . . .

The evidence establishes that the Provider's collection efforts on Medicare accounts not only meet the Provider's collection efforts on non-Medicare accounts but also exceed those efforts in one critical regard. The Provider, through an agreement with its outside collection agency, forwards Medicare accounts to outside collections when: (1) They are actually uncollectible; and (2) in the sound business judgment of the Provider, there is no likelihood of recovery at any time in the future.

Section 310.2 of the PRM provides:

> 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.

The Provider does not rely on the "120-day presumption" in declaring the accounts worthless. Rather, it relies on its sound business judgment on each individual account.[2] Section 314 of the PRM states that uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the cost reporting period in which such debts are

[2] P35.

determined to be worthless and non-collectible. This instruction also places the burden on the Provider to thoroughly document its claimed bad debts:

> . . . Since bad debts are uncollectible accounts . . . the provider should have the usual accounts receivable records-ledger cards and source documents to support its claim . . . for each account included. Examples of the information that may be retained include . . . date of bills . . . date of write off . . .

Moreover, to ensure that providers receive reimbursement for services they actually furnish, the Secretary has implemented a number of Medicare documentation regulations at 42 C.F.R. §§413.9, 413.20 and 413.24. Consistent with the documentation regulations and relevant to Medicare bad debts, section 310.B of the PRM provides:

> Documentation Required. --The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

The Provider is in compliance here as well. As noted earlier, the Provider's in-house collection department keeps thorough records of every collection letter, telephone contact and all other collection efforts.

Section 310.2 of the PRM permits a debt unpaid for more than 120 days from the date the first bill is mailed to the beneficiary to be deemed uncollectible. However, the Intermediary argues that the language of that section implies discretionary rather than mandatory application of the presumption, i.e., the debt "may" rather than "shall" be deemed uncollectible. The Intermediary also points out that section 310.2 does not suggest that this "presumption" relieves the Provider from meeting the general regulatory documentation requirements or the specific documentation requirements in sections 310.B and 314 of the PRM. Thus, the presumption applies only where the Provider has otherwise demonstrated through appropriate documentation that it engaged in reasonable collection efforts before declaring the debt worthless. In the 58 audited accounts, the amount of time from the first bill to write off varied from a low of 134 days to a high of 1793 days.[3]

The Board is also cognizant of pertinent sections of the MIM and related policy memoranda that appear to include a countervailing presumption --- namely that accounts assigned to an outside collection agency have "value" and are not "worthless" if the accounts have not been returned to the provider as uncollectible by the outside agency. Neither presumption is conclusive. Rather, the four enumerated criteria in C.F.R. §413.80(e) control. And where, as here, the Provider has plainly satisfied those criteria, neither presumption applies.

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[3] P35.

The Secretary issued guidelines for an intermediary to follow when auditing cost reports. The MIM states that since Medicare bad debts for deductible and coinsurance are reimbursed as a pass-through cost, there is an incentive to claim bad debts before they become worthless.[4] This instruction also discusses that reliance on a collection agency may occur and the kind of documentation the Provider should maintain to support a conclusion that a reasonable collection effort has been made. Specifically, the instruction states that:

> If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort.

MIM 13-4, Chapter 2 – Guidelines for Performing Provider Audits, §4198.

The agency also issued policy memoranda, dated June 11, 1990 and April 1, 1992, which discussed the intent of the regulation and the Intermediary Manual. (These memoranda also discuss the effects of the moratorium on the allowance of bad debts. This issue is relevant here, and is discussed infra.) The June 11, 1990, memorandum states that:

> [U]ntil a provider's reasonable collection effort has been completed, including both in-house efforts and the use of a collection agency, a Medicare bad debt may not be reimbursed as uncollectible. This is in accord with the fourth criterion in section 308 which provides that an uncollected Medicare account cannot be considered an allowable Medicare bad debt unless sound business judgment established that there is no likelihood of recovery at any time in the future. We have always believed that, clearly, there is a likelihood of recovery for an account sent to a collection agency and that claiming a Medicare bad debt at the point of sending the account to the agency would be contrary to the bad debt policy in sections 308 and 310. . . .

As cited above, a provider is entitled to bad debts arising from Medicare coinsurance and deductibles. In order to be reimbursed for such bad debts, a provider must meet certain criteria. In demonstrating that the criteria have been met, among other things, a provider must show that the debts are actually uncollectible when claimed as worthless and sound business judgment established no likelihood of recovery in the future.

Contrary to the Intermediary's assertion, the June 11, 1990 policy memorandum does not establish a conclusive presumption that accounts assigned to an outside collection agency have value or are collectible. Nor does the policy memorandum obviate the sound business judgment rule or any of the other bad debt reimbursement criteria set forth in 42

[4] The amount of bad debts treated as allowable costs is reduced by 40% for cost reporting periods beginning during fiscal year 1999 42 C.F.R. §41.85(h).

C.F.R. §413.80. Rather, as occurred here, it is entirely possible for the Provider to satisfy all four of the criteria in 42 C.F.R. §413.80 as to any collection account that remains on "active" status with an outside collection agency.

The conclusive presumption urged by the Intermediary elevates form over substance. The mere "active" status of an account with an outside collection agency, while suggestive of collectibility, is not in and of itself *proof* of value *or* collectibility, especially in the face of evidence presented here. Further, a conclusive presumption of collectibility arising from an account's "open" or "active" status at an outside collection agency is contrary to both the reality of the collection trade and the regulations that the Board is entrusted to enforce. There is no evidence that providers control the decision making process of their outside collection agencies. Thus, an account that is actually worthless and uncollectible could languish as an "open" or "active" account in an outside collection agency indefinitely. The conclusive presumption proffered by the Intermediary would prohibit the reimbursement of such bad debts as required by 42 C.F.R. §413.80(d) and (e) and violates the prohibition against cross-subsidization at Section 1861(v)(1)(A) of the Social Security Act. Equally important, the conclusive presumption urged by the Intermediary would encourage, if not mandate, that the Provider "prompt" the return of accounts assigned to an outside collection agency. To overcome the Intermediary's conclusive presumption of collectibility, a provider could simply:

1.) Mail a series of automated collection notices to the beneficiary;
2.) Assign the account to an outside collection agency after 120 days; and
3.) Instruct the collection agency to mail its own series of automated collection notices and then promptly return the account to the provider as uncollectible.

The foregoing illustrates why neither the 120-day presumption of uncollectibility in the PRM nor the presumption of collectibilty of collection agency accounts in the Intermediary Manual can operate as conclusive presumptions. In the final analysis, the four criteria in 42 C.F.R. §413.80(e) must control, and to comply with that regulation, the Intermediary must evaluate the collection efforts and the sound business judgment applied by the Provider to each audited account.

The Intermediary also contends that the Provider's documentation is insufficient to establish that the 58 audited accounts were uncollectible when claimed as worthless. This contention is not supported by the evidence. The Intermediary stipulated to the accuracy of the data summarizing the Provider's collection efforts on each of the audited accounts,[5] and the Provider submitted its data printout on all 58 audited accounts.[6] The Provider also maintains a hard copy of correspondence and other collection related documents in each patient's file.[7] All of this documentation was made available to the

[5] P35.
[6] P30, 36.
[7] Tr. 120, 232-235.

Intermediary, as were all collection policies and procedures.[8] The collection efforts documented by the Provider meet the Secretary's requirements, and they were completed *before* the Provider determined the accounts to be uncollectible and worthless. The Intermediary's claim that the Provider should have "done more" to collect on decedents' and indigents' accounts is also difficult to fathom. Considering the amount owed on the decedent and indigent accounts audited by the Intermediary, the Board finds that the collection efforts and investigation by the Provider met or exceeded the efforts mandated by Medicare in every instance. Finally, it must be noted that the Intermediary's conclusive presumption of collectibility (based on outside collection account status) runs afoul of well established precedent, as would any conclusive presumption of uncollectibility (based on the so-called "120-day rule"). *Methodist Hospital of Dyesburg v. Blue Cross and Blue Shield*, PRRB Case No. 96-1215, Decision No. 00-D56 ("Methodist Hospital") is instructive. In *Methodist Hospital*, the Board considered both the 120-day presumption of uncollectibility and the presumption of collectibility urged by the Intermediary here.

The Board has consistently held that where the Provider satisfies all four criteria of 42 C.F.R. §413.80(e), any presumptions of collectibilty or uncollectibility are necessarily moot, and the bad debt must be reimbursed.[9] To hold otherwise would violate Medicare's prohibition on cross-subsidization by requiring a non-beneficiary (here, the Provider) to bear the cost of Medicare covered services. [Section 1861(v)(1)(A) of the Social Security Act; 42 C.F.R. §413.80].

The Board also finds that the Intermediary's present rejection of the Provider's bad debt policy, after having repeatedly accepted it for prior years, is statutorily barred. In this case, the Provider established that it writes off worthless and uncollectible Medicare accounts shortly after those accounts are forwarded to an outside collection agency. This is consistent with the Provider's pre-August 1987 policy, wherein the Provider customarily wrote off Medicare accounts as bad debts at or about the time the accounts were assigned to an outside collection agency. But beginning with the FYE 1999 audit, the Intermediary for the first time rejected bad debt submissions on accounts that remained "active" with an outside agency. In §6023 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239 (Dec. 19, 1989), Congress expressly

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[8] Tr. 223-226.

[9] The Board was also presented with a host of other persuasive authorities by the parties in Methodist Hospital, many of which are also presented here, including: Lourdes Hospital v. AdminaStar of Kentucky, PRRB Dec. Nos.95-D58, 95- D59, 95-D60, Medicare and Medicaid Guide (CCH) ¶43,585 (1995); King's Daughters' Hospital v. Blue Cross and Blue Shield of Kentucky, PRRB Dec. No. 91-D5, Medicare and Medicaid Guide (CCH) ¶38,950 (1990); St. Francis Hospital and Medical Center v. Kansas Hospital Service Assn., PRRB Dec. No. 86-D21, Medicare and Medicaid Guide (CCH) ¶35,302 (1985), and Scotland Memorial Hospital v. Blue Cross and Blue Shield Association of North Carolina, PRRB Dec. No. 84-D174, Medicare and Medicaid Guide (CCH) ¶34,225 (1984).

prohibited such conduct. Amending the moratorium it had imposed two years earlier on regulatory changes to the bad debt collection rules, Congress provided:

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigence determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

The above prohibition is directly applicable to this case. The Intermediary, applying program rules in effect on August 1, 1987 with respect to collection agency referrals, accepted the Provider's bad debt collection policy before that date. It cannot now apply the same rules to declare the policy unacceptable.

The Intermediary contends that the Provider's documentation is insufficient proof of the Intermediary's pre-1987 acceptance of the bad debt collection write-off policy described above. The Intermediary posits that the Provider must produce the Intermediary's pre-1988 audits to prove that the Intermediary accepted the Provider's pre-August 1, 1987 policy of writing off accounts as bad debt at or about the time the debts were assigned to an outside collection agency.[10] The Intermediary cites no law or regulation that suggests that the Provider must retain the Intermediary's audit reports or NPRs for over 15 years, or that such reports are the only acceptable documentation of the Intermediary's acceptance of pre-August 1987 collection policies. The certification of the Provider's Chief Financial Officer (CFO) is the only documentation on this issue, and it was presented to the Intermediary in August 2003, 20 months before the hearing.[11] The Intermediary had 20 months to search its files to find records that would rebut the Provider's documentation but failed to do so.

The certification of the Provider's CFO and the testimony at the hearing established that:

1.) The Provider's CFO was employed by the Provider prior to August 1, 1987 through August 2003.

2.) Prior to August 1, 1987, and at all times preceding the Intermediary's FYE 1999 audit, the Intermediary had accepted the Provider's policy and procedure of writing Medicare accounts off as bad debts at or about the time that the accounts were assigned to a collection agency.[12]

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[10] Tr. 214-223.
[11] P36, Tab 5A pp14-15; Tr. 214-216.
[12] Tr. 56-58; P33, 36.

Under section 6023 of OBRA, the Intermediary cannot now require the Provider to change this bad debt collection policy.[13]

DECISION AND ORDER:

The Medicare bad debts for FYE 1999 are allowable. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West

FOR THE BOARD:

DATE: February 17, 2006

Suzanne Cochran, Esquire
Chairperson

[13] The Board notes that its finding here does not enable the Provider to obtain reimbursement in otherwise collectible Medicare accounts. The Provider established that, as to the Medicare accounts at issue in the FYE 1999 audit, sound business judgment established that there was no likelihood of recovery at the time the accounts were turned over to the Provider's outside collection agency. The Intermediary offered no evidence to the contrary, and the Provider's documentation of this is sufficient. Again, no money has been collected by the outside collection agency on *any* of the 58 audited accounts assigned over five years ago.