PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D36

PROVIDER -
Extendicare 99 Uncollect Co-In
Dual Elig Group

Provider Nos.: See Attached Inventory

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC - WI

DATE OF HEARING -
February 3, 2005

Cost Reporting Period Ended -
December 31, 1999

CASE NO.: 02-2110G

INDEX

ISSUE:

Whether the Intermediary properly determined that bad debts claimed related to uncollectible deductibles and coinsurance for services rendered to patients that were dually eligible for Medicare and Medicaid, also known as qualified Medicare beneficiaries (QMB), that were paid under the Medicare Part B fee screen do not constitute bad debts under applicable Medicare law and regulations.

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 its 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.

The Balanced Budget Act of 1997[1] (BBA) provides that outpatient rehabilitation services covered under Part B and furnished by skilled nursing facilities on or after January 1, 1999, are to be paid 80 percent of the lower of cost or charges for the service or a fee schedule payment as determined under the physicians' fee schedule. The issue in this appeal involves the propriety of claiming uncollectible deductibles and coinsurance arising from therapy services covered and paid under the Medicare Part B fee schedule.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Extendicare Health Services, Inc is a health service company that owned and/or operated all of the 24 Medicare-certified skilled nursing facilities (SNFs) that comprise the Providers participating in this group appeal. On their cost reports for the fiscal year ended 12/31/99, the

[1] P.L. 105-33.

Providers claimed an amount for bad debts for uncollected Medicare deductibles and coinsurance for therapy services rendered to Qualified Medicare Beneficiaries (QMB), i.e., patients who were dually eligible for Medicare and Medical Assistance (MA). During the fiscal year ended 12/31/99, therapy services provided to QMBs were payable under the Medicare Part B fee schedule. Statutes in some of the states where the participating facilities are located (Pennsylvania and Washington) prohibited their respective MA programs from paying the Medicare deductibles and coinsurance for which QMBs were responsible. United Government Services, LLC (Intermediary) audited the cost reports under appeal and challenged the propriety of bad debt reimbursement under the fee-based system. Accordingly, the Intermediary disallowed the Provider's Medicare bad debts related to uncollected deductibles & coinsurance. At issue is whether current regulations implementing the Part B fee schedule preclude the Providers from claiming reimbursement for uncollectible deductibles and coinsurance.

PARTIES' CONTENTIONS:

The Providers dispute the Intermediary's adjustments and argue that when the BBA of 1997 adopted Medicare Part B fee schedules, it also required that deductibles and coinsurance continue to apply. The amount of that coinsurance (20% of the Medicare allowed charge) was determined in accordance with the Part B fee schedule.

The Providers argue further that 42 C.F.R. §413.80[2] establishes the requirements for claiming allowable bad debts. The BBA of 1997 did not alter this section, its definitions, or procedures, and it remains controlling on the issue of bad debts. The Providers contend that the amounts claimed for QMB bad debts met all the requirements set forth in 42 C.F.R. §413.80 and are properly reimbursable under its provisions.

The Providers also contend that the Intermediary supported its adjustment by using instructions and regulatory cites that were specific to durable medical equipment (DME) suppliers. The Providers respond that this position is unsupported by legislative, regulatory or court precedent in-so-far as its application to SNFs and, consequently, cannot supersede or suspend the application of 42 C.F.R. §413.80.

The Intermediary argues that it properly applied the regulations at 42 C.F.R. §413.80 and contends that CMS clarified the treatment of deductibles and coinsurance at the time it converted the reimbursement of home health agency DME from a reasonable cost basis to a fee-based payment methodology. In a Medicare Memo dated February 8, 1996, CMS stated that Medicare payment of beneficiary deductible and coinsurance bad debts applies only to the reasonable cost payment system. In a subsequent memorandum dated May 23, 1996, CMS' Bureau of Policy Development stated that the bad debt policy at 42 C.F.R. §413.80 does not apply to services for which Medicare payment is based on charges or a fee schedule. The Intermediary contends that these CMS instructions make clear CMS policy that bad debts arising from deductibles and

[2] Redesignated as 42 C.F.R $413.89

coinsurance related to fee-based payments cannot be reimbursed through the Medicare cost report.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, 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 Providers' uncollectible deductibles and coinsurance arising from therapy services paid under the Part B fee schedule was improper.

Section 1861(v)(1)(A)(i) of the Social Security Act articulates the principle against cross - subsidization and states that the cost for individuals covered by the Medicare program must not be borne by individuals not covered by the program and the costs for individuals not covered by the program must not be borne by the program. In 1966, the Health Insurance Benefits Advisory Committee (HIBAC) initially recommended that Medicare cover the unpaid deductible and coinsurance amounts that arose in connection with the provision of covered services to beneficiaries in an effort to avoid the cross-subsidization that might occur if hospitals or other entities tried to recoup Medicare bad debts form other payors. The Secretary, by regulation, adopted the bad debt policy and incorporated it in the anti cross subsidization principle that is part of the definition of reasonable cost contained in section 1861(v) of the Act.

Prior to enactment of the BBA of 1997, SNFs obtained reimbursement under a reasonable cost-based system for the services that they provided to residents eligible for Medicare. The regulations at 42 C.F.R. §413.80 addressed bad debts under reasonable cost-based reimbursement. The section applied the prohibition against cross-subsidization and set the standards under which bad debts would be reimbursed by the Medicare program. Beginning with cost reporting periods commencing on or after July 1, 1998, the BBA mandated that the Medicare program shift its reimbursement system for SNF Part A covered services from a cost-based system to a prospective payment system. The BBA further provided that SNF therapy services would be reimbursed under the Medicare Part B fee schedule where the Medicare eligible patient was not in a covered Part A stay at the time of their delivery. Fee schedules evolved parallel to the cost-based system as the reimbursement mechanism for physician services. With regards to physician fees, CMS asserted that the fee schedule mechanism included all costs, including bad debts, and traditionally did not allow the recovery of bad debts for those services covered by physician fee schedules.

While the BBA of 1997 effectively shifted the basis of payment for SNF outpatient rehabilitation services from reasonable cost to fee-based, it made no mention of their related bad debts, nor did the Secretary make any change to 42 C.F.R. §413.80. The Board majority considers this omission significant. Congress was fully aware of the distinctions between cost-based and fee schedule reimbursement at the time that it made the shift. Congress understood that the bad debt regulation was derived from the policy against cross-subsidization articulated in Section 1861(v) and that there were no concomitant regulatory provisions addressing bad debts for Part B services. The Board majority believes that if Congress had intended to address Part B

bad debts it would have done so in the statutes as it did for physician assistants[3], DME[4] and CRNA[5] services. The Board majority considers Congress' silence on bad debts demonstrative of its intent that existent SNF bad debt policy remain unchanged.

Further, the Board majority's examination disclosed the existence of a Proposed Rule[6] which eliminated bad debts arising from any service provided under a fee schedule. Although the rule was never finalized, its existence offers substantive evidence that CMS was aware that existent regulations allowed bad debts for some fee based services. If CMS believed that the bad debt policy articulated in 42 C.F.R. §413.80 applied only to cost reimbursed services, the change articulated in the Proposed Rule would be unnecessary.

SNF bad debt policy was established by operation of regulation and, when Congress changed the statute, it gave no indication that regulations should be modified. Absent a change in that regulation, the Board majority cannot modify or eliminate its mandate and must conclude that 42 C.F.R. §413.80 remains the controlling authority for the payment of bad debts. The Board majority must further conclude that the Intermediary's adjustment eliminating the application of 42 C.F.R. §413.80 and disallowing the Providers bad debts arising from therapy services paid under the Part B fee schedule was improper.

DECISION AND ORDER:

The Intermediary's adjustment to the Providers' uncollectible deductibles and coinsurance arising from therapy services paid under the Part B fee schedule was improper.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

DATE: July 21, 2006

Suzanne Cochran, Esquire
Chairperson

[3] Social Security Act (P.L. 74-271), Section 1842 (b)
[4] Social Security Act, Section 1834(a)
[5] Social Security Act, Section 1833 (1)(5)(C)
[6] Federal Register dated February 10, 2003 (Vol. 68, No. 27)

INVENTORY OF PROVIDERS IN APPEAL

PROVIDER NUMBER	PROVIDER NAME
45-5872	Dalworth Care Center
10-5193	Oaks Resident and Rehab Center
50-5024	Franklin Hills Health and Rehab Center
50-5207	Southcrest Subacute & Specialty Care
50-5236	Aldercrest Health & Rehab Center
50-5243	Evergreen Nursing & Rehab Center
50-5263	Kittitas Valley
50-5269	Pacific Specialty & Rehab Care
39-5167	Valley Manor Nursing Home
39-5174	Abington Crest Nursing Center
39-5208	Belair Nursing Center
39-5266	Beaver Valley Nursing Center
39-5286	Broad Mountain Nursing Home
39-5331	Mountain Laurel Nursing Center
39-5341	Elk Haven Nursing Home
39-5458	Clairview Nursing & Rehab Center
39-5499	Tremont Health & Rehab Center
39-5509	Dresher Hill Health & Rehab Center
39-5510	Grove Manor Nursing Center

INVENTORY OF PROVIDERS IN APPEAL (CONTINUED)

PROVIDER NUMBER	PROVIDER NAME
39-5633	Haven Crest Nursing Center
39-5698	Meadow Crest Nursing Center
39-5785	Stonebridge Health & Rehab Center
39-5892	Edgewood Nursing Home
39-5959	The Caring Place Nursing Center

Dissenting Opinion of Elaine Crews Powell

The majority found that the Provider is entitled to claim reimbursement for bad debts related to deductible and coinsurance amounts for Part B therapy services paid under a fee schedule. I respectfully dissent.

The Balanced Budged Act of 1997 (BBA) adopted the Medicare Part B fee schedule as the payment system for therapy services provided on or after January 1, 1999 to SNF patients who were not in a covered Part A stay. Reimbursement under the fee schedule was to be 80% of the lesser of the actual charge for the therapy or the fee schedule.

Prior to the changes mandated by the BBA 1997, providers were reimbursed for Part B therapy services on the basis of reasonable cost, subject to certain limits. As such, payment was determined in accordance with the provisions of 42 C. F. R. Chapter 413 entitled: PRINCIPLES OF REASONABLE COST REIMBURSEMENT...." It is, therefore, logical, understandable, and significant that Medicare's bad debt reimbursement policy is found in this section of the regulations.

What I find even more significant, however, is that there is no bad debt reimbursement policy in the chapter of the regulations that governs reimbursement determined under a fee schedule – Chapter 414. The inference that I draw from this fact is that under fee schedule reimbursement Medicare has established the maximum amount it will pay for certain services, and no additional payment will be made for bad debts. When the Program sets a fee schedule as the basis for paying for a given service, it is no longer sharing proportionately in the cost of providing those services. Therefore, the cost reimbursement principles, including the bad debt regulation at §413.80, are not applicable. Congress mandated that Part B therapy services be paid on a fee schedule, and it made no provision for bad debt reimbursement. Therefore, it is clear to me that Congress intended that the fee schedule to be the exclusive payment mechanism for these services.

The Providers found significant CMS' failure to finalize the proposed rule that sought to amend §413.80 to exclude bad debts related to fee-reimbursed services (68 Fed. Reg. 6682-6683, February 10, 2003). Given my understanding of the bad debt regulation, perhaps CMS determined that a revision to this reasonable cost reimbursement regulation was unnecessary. That is certainly what I think.

I also find it necessary to state that is my long-standing, personal understanding that the Program has never reimbursed bad debts associated with fee-reimbursed services. This is because the established fee screens took into account the cost of doing business, including bad debts. Writing this dissent has provided me the opportunity to research the issue and to shore up my "understanding" with a fact-based analysis of the sound reasoning behind CMS' policy.

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Elaine Crews Powell, CPA