PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2006-D57

PROVIDER –
Glenwood Park, Inc.
Princeton, West Virginia

Provider No.: 51-5028

vs.

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

DATE OF HEARING -
June 8, 2006

Cost Reporting Period Ended -
December 31, 2002

CASE NO. 05-0051

INDEX

ISSUE:

1. Whether the Intermediary properly disallowed bad debts claimed for uncollectible deductibles and coinsurance related to therapy services furnished to Medicare beneficiaries dually eligible for Medicare and Medicaid, and paid under the Part B fee schedule.

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. §1395h, 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.

The Balanced Budget Act of 1997[1] (BBA) provides that outpatient rehabilitation services furnished by skilled nursing facilities on or after January 1, 1999 are to be paid 80 percent of the Medicare allowed charge (which is the lower of actual charge or the Medicare physician fee schedule amount) after the Part B deductible is met. The issue in this appeal involves the proper treatment of bad debts arising from the uncollectible deductibles and coinsurance amounts for therapy services provided to Medicare beneficiaries and billed under a fee-based reimbursement system.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Glenwood Park, Inc. (Provider) is a non-profit, freestanding, continuing care retirement community located in Princeton, West Virginia. The community includes a 147 bed skilled nursing/ assisted living facility. During the period ended 12/31/02, the Provider

[1] P.L. 105-33.

rendered therapy services to patients who were dually eligible for Medicare and Medicaid and received payment for those services under the Medicare Part B fee schedule. On its cost report for the period, the Provider claimed crossover bad debts for uncollected coinsurance and deductibles arising from the therapy services rendered to its dually eligible patients. United Government Services (Intermediary) disallowed the entire amount of Medicare Part B bad debts claimed on the cost report because the therapy services were paid based on a fee schedule. At issue is whether regulations implementing the Part B fee schedule preclude the Provider from claiming reimbursement for uncollectible deductibles and coinsurance amounts.

PARTIES' CONTENTIONS:

The Provider argues that the Intermediary's adjustment was not supported by Medicare statute or regulation. This is evidenced by the fact that the Intermediary's adjustment did not specifically cite a regulatory reference, and, therefore, there is no basis for the adjustment and it should not have been made.

The Provider states that 42 C.F.R. §413.80 requires the reimbursement of Medicare bad debts. Neither the BBA nor subsequent CMS implementing guidance altered this section, its definitions, or procedures. Therefore, it remains controlling on the issue of bad debts. The Provider contends that the amounts that it claimed for bad debts met all the requirements set forth in 42 C.F.R. §413.80 and are properly reimbursable under its provisions.

The Provider also contends that the most direct reference to the disallowance of Part B bad debts for services reimbursed under a fee schedule was found in the Proposed Rules of the Federal Register dated February 10, 2003 (Vol. 68, No. 27). The section stated in pertinent part:

> Exception. Bad debts arising from services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

However, the proposed rule was never finalized; consequently, no change eliminating Medicare payment for bad debts for therapy services reimbursed on a fee schedule was ever incorporated into 42 C.F.R. §413.80. The Provider argues that the Intermediary's position is, therefore, unsupported by legislative, regulatory or court precedent and cannot supersede or suspend the operation of 42 C.F.R. §413.80.

The Intermediary argues that CMS clarified the treatment of Medicare bad debts related to uncollectible deductibles and coinsurance amounts in its Medicare letter dated October 3, 1995. In it, CMS' Bureau of Policy Development stated that Medicare payment to a provider of service for the deductible and coinsurance "bad debts" of Medicare beneficiaries, applies only to the "reasonable cost" payment system. In a subsequent memorandum dated November 7, 2001, CMS 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 a fee

schedule or reasonable charge methodology. The Intermediary contends that these CMS memoranda make it clear that CMS policy is that bad debts related to uncollectible deductibles and coinsurance amounts for services paid based on a fee schedule 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 adjustment to the Provider's 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 from other payors. The Secretary adopted the bad debt policy and included 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 were reimbursed 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 provided for reimbursement of bad debts and expressed as the rationale the statutes prohibition against cross-subsidization. It also established the standards under which bad debts would be reimbursed by the Medicare program. Fee-based schedules evolved parallel to the cost-based system as the reimbursement mechanism for physician services. CMS asserted that the physician fee schedule mechanism included all costs, including bad debt, and traditionally did not allow the recovery of bad debts for those services covered by these fee schedules.

Beginning with cost reporting periods commencing after July 1, 1998, the BBA mandated that the Medicare program shift its reimbursement system for 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.

While the BBA effectively shifted payment for SNF rehabilitation services from reasonable cost to fee-based, it made no mention of their related bad debts, nor did CMS make any change to 42 C.F.R. §413.80. The Board majority considers these omissions significant. Congress addressed the issue of Medicare bad debt in the BBA for a variety of services. These provisions illustrate that Congress was fully aware of the distinctions

between cost-based and fee-based reimbursement at the time that it made the shift. The Congress fully 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 concludes that if Congress had intended to alter treatment of bad debts under established principles, it would have done so in the statutes, as it did for physician assistant,[2] DME[3] and CRNA[4] services. The Board majority considers Congress silence on bad debts demonstrative of its intent that SNF bad debt policy remain unchanged.

Furthermore, the Board majority finds that the existence of a proposed rule,[5] which proposed to eliminate bad debts arising from any service provided under a fee schedule, offers substantive evidence that CMS was aware that existing regulations allowed bad debts for some fee-based services. If CMS had believed that the bad debt policy articulated in 42 C.F.R. §413.80 applied only to cost reimbursed services, such a change would not have been necessary. CMS' failure to finalize its proposed rule suggests that it considered but rejected the policy change.

SNF bad debt policy was established by operation of regulation. Absent a change in that regulation, via either a legislative change or through the rule-making process, the Board cannot modify or eliminate its mandate, and the majority must conclude that 42 C.F.R. §413.80 remains the controlling authority for the payment of bad debts. The Board majority further concludes that the Intermediary's adjustment eliminating the application of 42 C.F.R. §413.80 and disallowing the Provider's bad debts arising from therapy services paid under the Part B fee schedule improper.

DECISION AND ORDER:

The Intermediary's adjustment to the Provider's bad debts for uncollectible deductibles and coinsurance amounts arising from therapy services paid under the Part B fee schedule was improper. The Intermediary's adjustment is reversed.

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

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

FOR THE BOARD:

DATE: September 28, 2006

Suzanne Cochran, Esquire
Chairperson

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 that service. 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 Provider 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 it 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, C.P.A.