PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D11

PROVIDER -
Foothill Presbyterian Hospital
Glendora, California

Provider No.: 05-0597

vs.

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

DATE OF HEARING -
September 20, 2006

Cost Reporting Period Ended -
September 30, 1995

CASE NO.: 97-2446

INDEX

ISSUE:

Whether the Intermediary's determination of reimbursable Medicare bad debts for beneficiaries without Medicaid eligibility (non-crossover beneficiaries) 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. §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 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 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. In order to qualify for reimbursement, the provider must show that the unpaid deductible and coinsurance amounts meet the following criteria:

(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.

42 C.F.R. §413.80(e).

In §4008 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), Pub. L. No. 100-203, Congress prohibited intermediaries from requiring providers to change their bad debt policies if they had previously allowed them prior to August 1, 1987 (Moratorium). In §6023 of OBRA 1989, Pub. L. No. 101-239, Congress reiterated the prohibition and stated that:

> 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.

This appeal involves the Intermediary's denial of the Provider's bad debt claims.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Foothill Presbyterian Hospital (the Provider) is a 106-bed acute care hospital located in Glendora, California. On its fiscal year ended (FYE) September 30, 1995 cost report, the Provider claimed bad debts for Medicare beneficiaries.[1] United Government Services (the Intermediary) disallowed the bad debts in an NPR dated December 16, 1996. The Provider filed a timely appeal with the Board and met the jurisdictional requirement of the regulations at 42 C.F.R. §405.1835-405.1841. The amount of Medicare reimbursement in controversy is approximately $60,993.

The Provider was represented by Derek F. Petrak, of Petrak and Associates, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross Blue Shield Association.

FACTS:

The undisputed facts establish that the Provider's bad debt collection policies and procedures included both in-house collection efforts and referral of the accounts to an outside collection agency. If the Provider determined that the account was uncollectible after completion of its in-house collection efforts, the Provider wrote off the uncollected amount as a bad debt, but it still referred the debt to the outside collection agency. This

[1] This appeal involves denial of bad debts for Medicare beneficiaries who were not dually eligible for Medicaid, also referred to as "crossover" debts. The character of the debt is not germane to the issue in this case, however.

procedure applied to all of the Provider's bad debts; no distinction was made between Medicare and non-Medicare patients.

The Intermediary disallowed $26,730 and $34,930 claimed for Part A and Part B Medicare bad debts based on its determination that sending the accounts to an outside collection agency extended the collection effort; therefore, the accounts could not be considered worthless or unlikely to be collected in the future as required by 42 C.F.R. §413.80(e)(3) and (4). The Intermediary has not challenged the Provider's compliance with the first two criteria for claiming the bad debts.

PARTIES' CONTENTIONS:

The Provider offers two independent theories in support of its position:

1. It has met all the regulatory criteria for allowable bad debts and
2. The Intermediary's disallowance violates the statutory moratorium on imposition of a different policy than the one applied prior to August 1, 1987.

Regardless of whether accounts written off as bad debts were subsequently referred to collection agencies, the Provider argues that the bad debts at issue nevertheless met the regulatory requirements of 42 C.F.R. §413.80 in that: (1) The bad debts relate to deductible and coinsurance amounts. (2) Reasonable collection efforts were made in accordance with the Provider's collection policy prior to write-off as a bad debt. (3) In the Provider's business judgment, the debts were uncollectible when claimed as worthless. (4) The collection efforts expensed by its in-house staff constituted reasonable efforts as required by the Provider Reimbursement Manual, CMS Pub. 15-1, (PRM) 15-1 §308.

The Provider further asserts that the mere fact that the accounts remained with the outside collection agencies in order to keep the possibility of recoveries open does not support the Intermediary's finding that the accounts were collectible when claimed as worthless. The Provider cites Medicare guidelines as authority that referral to a collection agency does not negate collection efforts that otherwise meet the regulatory criteria.

> 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.

PRM, CMS Pub. 15-1 §310.2.

This provision allows for the presumption of uncollectability after 120 days, but the Provider points out that there is no requirement that any and all collection efforts must be abandoned.

The Provider also notes that PRM 15-1 §316 requires recoveries of previously reimbursed bad debts to be applied as reductions to reimbursable costs and reasons that

such recoveries would not be possible without further collection efforts after the bad debts were claimed and allowed.

The Provider further asserts that it is illogical and contrary to common industry practice, sound business practice, and to the interests of the Medicare program to cease all collection efforts of any kind and not keep accounts listed with collection agencies for periodic review.

Finally, the Provider contends that the Intermediary's policy of automatically deeming bad debts referred to collection agencies as collectible is not in compliance with the Moratorium's prohibition against the imposition of different policies with respect to what constitutes reasonable collection effort than those applied to the Provider as of August 1, 1987. The Provider points out that it had the same policy for at least the prior five years and was never denied reimbursement, but notes that it does not have any audit workpapers for years prior to 9/30/90 on file.

The Intermediary contends that for a bad debt to be allowable, all collection efforts must have ceased. The Intermediary reasons that if the Provider is still pursuing collection efforts on the account, it is because there is a potential to recoup the amount owed; thus, the account is not worthless and "uncollectible when claimed" as required by PRM 15-1 §308. The Moratorium provides that if the Intermediary had allowed the bad debts in question in the FYE audited in 1987, then it had to allow them in subsequent years. The Intermediary states that this Provider did not claim any bad debts in FYE 1984, which was audited in 1987; therefore, the Moratorium provisions do not apply. Furthermore, if it had allowed bad debts under these circumstances prior to the year in question, it had done so in error.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The facts are undisputed. The Provider attempted to collect accounts through its in-house collection procedures. If those efforts failed, the Provider determined that the debts were uncollectible and had no likelihood of recovery at any time in the future and claimed those Medicare bad debts for reimbursement on its cost report. Despite its determination that the accounts were uncollectible, the Provider forwarded all its bad debts to an outside collection agency where the accounts remained unless collected. The Intermediary does not challenge the reasonableness of the Provider's collection effort or that its policies applied to all bad debts without any distinction being made between Medicare and non-Medicare accounts. However, the Intermediary asserts that the referral to the collection agency is inconsistent with the Provider's determination of worthlessness.

We begin our analysis with PRM 15-1 §310.2 - Presumption of Noncollectibility:

> 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 did not simply rely on the "120-day presumption" in declaring the accounts worthless. Rather, it sent at least three notices requesting payment and attempted to collect the accounts for an average of over 300 days. Exhibits P-4 and P-5.

PRM 15-1 §310.A further explains that:

> 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. . . .

Guidelines in the Medicare Intermediary Manual (MIM) for intermediaries cost repost audits and related policy memoranda appear to create a countervailing presumption to the 120-day 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. It states:

> 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, Exhibit A-11-Medicare Bad Debts.

The agency also issued policy memoranda, dated June 11, 1990 and April 1, 1992, which discussed the intent of the regulation and the Medicare Intermediary Manual. 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. . . .

The Board finds that neither the MIM nor the June 11, 1990 policy memorandum establishes a conclusive presumption that accounts assigned to an outside collection agency have value or are collectible. Nor do these policies obviate the sound business judgment rule or any of the other bad debt reimbursement criteria set forth in 42 C.F.R. §413.80. Rather, as occurred here, it is entirely possible for a 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 June 11, 1990 policy memorandum 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 Medicare 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.

Based upon the Provider's extensive in-house collection efforts that included numerous letters and active pursuit of claims for an average of over 300 days, the Board finds that the collection efforts documented by the Provider met the Secretary's regulatory requirements, and they were completed before the Provider determined the accounts to be uncollectible and worthless. In addition, the Board finds that the 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". This decision follows the Board's recent decision in Dameron Hospital v. Blue Cross Blue Shield, PRRB Dec. No. 2006-D16, Medicare & Medicaid Guide (CCH) ¶81,502 (2006) and other Board decisions that have 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.[2] To hold otherwise would violate Medicare's prohibition on cross-subsidization by requiring a non-beneficiary, 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].

Finally, the Board notes that the record did not contain sufficient information concerning the Provider's bad debt policy in effect prior to 1994. Without this information, the Board cannot determine whether the Moratorium provision applies.

DECISION AND ORDER*:*

The Medicare bad debts for FYE 1995 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
Yvette C. Hayes

[2] 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).

FOR THE BOARD:

DATE: December 19, 2006

Suzanne Cochran, Esquire
Chairperson