PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D21

PROVIDER -
El Centro Regional Medical Center
El Centro, California

Provider No.: 05-0045

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/
United Government Services, LLC-CA
(n/k/a National Government Services,
LLC-CA)

DATE OF HEARING -
December 13, 2005

Cost Reporting Periods Ended -
June 30, 1999 and June 30, 2000

CASE NOS.: 03-0268 and 03-0269

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ISSUE:

Whether the Intermediary's adjustments disallowing the Provider's regular Medicare bad debts were proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a health care provider.

The Medicare program provides health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare & 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 the program's administration. 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 providers under Medicare law and interpretative 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 portion 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 NPR. 42 U.S.C. §1395oo; 42 C.F.R. §405.1835.

Medicare reimbursement is governed by section 42 U.S.C §1395x(v)(1)(A) of the Social Security Act. In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation at 42 C.F.R. §413.9 provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services.

With respect to Medicare reimbursable costs, 42 C.F.R. §413.80(a) states that bad debts are reductions in revenues and are not included in allowable costs. However, the regulation also provides that bad debts attributable to 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.

In order for a provider to be reimbursed for its Medicare bad debts, 42 C.F.R. §413.80(e) states:

> (e*) Criteria for allowable bad debt*. A bad debt must meet the following criteria to be allowable:
>
> (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.
>
> (Emphasis added).

Program instructions contained in the Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §310 describe "reasonable collection effort" as follows:

> [t]o 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.

Further, program instructions at HCFA Pub. 15-1 §310. A. Collection Agencies state in pertinent part:

> [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.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

El Centro Regional Medical Center (Provider) is a short-term, acute care hospital located in El Centro, California. During its cost reporting periods ended June 30, 1999 and June 30, 2000, the Provider claimed reimbursement for bad debts attributable to Medicare

beneficiaries' deductibles and coinsurance. United Government Services (Intermediary) reviewed the Provider's cost reports and disallowed the Provider's regular[1] bad debt claims. The Intermediary concluded that the Provider had not made a "reasonable effort" to collect the debts pursuant to Medicare's Provider Reimbursement Manual, Part I (HCFA Pub. 15-1) §310.

The Provider appealed the Intermediary's adjustments to the Board pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $275,691 ($171,132 in 1999 and $104,559 in 2000).[2]

The Provider was represented by David L. Volk, Esq., of Sonnenschein Nath & Rosenthall LLP. The Intermediary was represented by James R. Grimes, Esq., Associate Counsel, Blue Cross Blue Shield association.

PARTIES' CONTENTIONS:

The Intermediary contends that the procedures used by the Provider's collection agency to recover Medicare accounts receivable were not similar to the procedures used to recover non-Medicare accounts receivable as required by HCFA Pub. 15-1 §310.[3] The Intermediary cites to page 3 of Exhibit I-11[4] (Collection Procedures for Medicare Accounts) which shows that the Provider's collection agency would attempt to collect Medicare accounts for 60 days before returning them to the Provider to be written off as uncollectible, and to page 4 of Exhibit I-11, which shows that the collection period was reduced to 30 days beginning April 1999. In contrast, the Intermediary cites to page 5 of Exhibit I-11 (Standard Collection Process), which detailed a collection process that continued long past the 60-day and 30-day periods for "non-Medicare" accounts and included certain other actions such as skip tracing. The Intermediary cites to the Administrator's decision in Hemet Valley Medical Center v. Blue Cross Blue Shield Assoc./Blue Cross of California, PRRB Dec. No. 2001-D5, December 4, 2000, modif'd., CMS Administrator, January 19, 2001, where a collection agency's use of different steps to collect non-Medicare accounts than were used to collect Medicare accounts did not meet the requirements of HCFA Pub. 15-1 §310 (Hemet Valley).[5]

The Provider contends that the Intermediary's own audit workpapers show that similar collection efforts were applied to its Medicare and non-Medicare patient accounts. Exhibit I-2 of the Intermediary's Supplemental Position Paper shows that Medicare accounts underwent active collection efforts at the collection agency for more than 100 days for fiscal year 1999 and for more than 60 days for fiscal year 2000.[6] In addition, the

[1] The word "regular" is used in this instance to distinguish the bad debts at issue from "cross-over" bad debts which are paid to a provider by the Medicaid State Agency when eligible beneficiaries are unable/or otherwise fail to pay their Medicare deductibles and coinsurance.
[2] Intermediary's Supplemental Position Papers at 5.
[3] Transcript (Tr.) at 14.
[4] Intermediary's Supplemental Position Paper for case number 03-0268.
[5] Tr. at 28-29. Exhibit I-13.

Intermediary misinterpreted the 60-day and 30-day return policies; these were minimum, not maximum periods to be expended on the recoupment of Medicare accounts.

Finally, the Provider contends that the Intermediary misinterpreted the collection agency's "Standard Collection Process" described at Exhibit I-11 at 5. The Intermediary concludes, based upon the exhibit's timeline, that Medicare claims are returned to the Provider before the agency takes such actions as skip tracing and legal action. However, collection efforts performed during days 1-30 of the timeline are performed under the Provider's name and not the name of the collection agency, consistent with the Fair Debt Collection Practices Act. Thereafter, beginning on the 31st day, all collection activities were performed for all available accounts.[7]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes that the Intermediary's disallowances were improper.

It is undisputed that the Provider's in-house collection policies comply with all program requirements. The disallowances at issue are based upon the Intermediary's finding that the Provider's contracted outside collection agency did not use similar efforts to recover Medicare patient accounts as those used to recover non-Medicare patient accounts. The Intermediary bases its finding on the Provider's collection policies depicted in Exhibit I-11. From this information, the Intermediary concludes that the Provider's collection agency returned Medicare accounts to the Provider after 60 days of recovery effort (after 30 days beginning in April 1999) to be written off as uncollectible, while non-Medicare accounts would remain at the agency for an indefinite period and be subjected to additional recovery measures such as skip tracing and legal action.[8]

However, the Board finds that HCFA Pub. 15-1 §310, which requires similar collection efforts be applied to Medicare accounts as those applied to non-Medicare accounts, does not apply to an outside collection agency's efforts. In the instant case, the Provider met this requirement by treating all patient accounts receivable of like amounts the same; such that when in-house efforts failed to collect on a patient account it was reviewed and forwarded to the outside collection agency when deemed appropriate. Contrary to the Intermediary's contention that collection efforts must be similar to the very end and in all phases of the collection process, the Board finds nothing in HCFA Pub. 15-1 §310.A that attempts to dictate to collection professionals how they must conduct their business. Furthermore, the Board finds that the only requirement mandated by this manual section is that when a provider uses a collection agency, it must refer all like amounts of Medicare and non-Medicare receivables for outside collection, which the Provider, in this case, did. Clearly, the manual provision is a program guideline that is applicable to

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[6] Provider's Post-Hearing Brief at 5. Tr. at 46-47.
[7] Provider's Post-Hearing Brief at 8. Tr. 46-47, 93-94 and 97-98.
[8] Tr. at 14-15 and 18-22.

Medicare providers, and it cannot be applied to third party/non-provider operations such as contracted collection agencies.[9]

The Board notes that HCFA Pub. 15-1 §310.A, which pertains to a provider's use of an outside collection agency, does not address collection agency practices. Rather, it contains a fundamental requirement that "Medicare expects the provider to refer all uncollectible patient charges of like amount to the agency without regard to class of patient." With respect to the instant case, there is no dispute regarding the Provider's compliance with this requirement.

In addition, the Board finds the evidence compelling that the 60-day, and later 30-day collection periods were minimum periods rather than automatic or maximum periods for the return of Medicare accounts. According to the Provider, these policies were established to help assure that Medicare accounts would be at least 120 days old from the date the Provider first billed a beneficiary so they could be claimed as bad debts pursuant to HCFA Pub. 15-1 §310.2. Exhibits I-2 and I-3, which are copies of Intermediary audit workpapers, confirm that actual collection efforts at the collection agency routinely extended far beyond 60 days.[10]

The Board also finds the evidence compelling that Medicare and non-Medicare accounts were subject to the same collection activities, such as skip tracing, as non-Medicare accounts. The Intermediary's argument regarding this matter is based upon Exhibit I-11 at 5. The exhibit shows that collection efforts such as skip tracing not beginning until a claim had been at the collection agency for at least 31 days. When the Intermediary misinterpreted the Provider's policy as requiring return of Medicare accounts after 30 days beginning in April 1999, it also assumed that these collection policies would never be applied to Medicare accounts. However, the Board finds that Medicare accounts were not routinely returned to the Provider after 30 days or 60 days but remained at the agency for as long as collection efforts seemed warranted. Moreover, Provider testimony, which included that of an expert in usual and customary collection practices, explained that the first 30 days of collection effort depicted in Exhibit I-11 at 5 were conducted in the Provider's name rather than in the name of the collection agency. During the first 30 days, a "Precollection letter" is sent to a patient explaining that their debt would be turned over to a collection agency if payment is not made. Essentially, the first day that a patient account is deemed to be assigned to the collection agency is reflected as day 31.[11]

Finally, the Board is convinced that the Provider's bad debt claims are allowable for program reimbursement pursuant to 42 C.F.R. 413.80(e), Criteria for allowable bad debt, which is the controlling authority in this matter. It is undisputed that the bad debts at issue are related to covered services and derived from Medicare patient deductible and coinsurance amounts. Also, as discussed above, the Provider established that reasonable

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[9] The Board distinguishes the instant case from Hemet Valley where an outside collection agency was contractually obligated by the provider to suspend recovery efforts on Medicare accounts after certain specific actions were taken. Exhibit I-13 at 9.

[10] Tr. at 46 and 49. Declaration of Lawrence J. Winslow, P-12 at 1, Point 3.

[11] Tr. at 102 and 110. See also, Declaration of Lawrence J. Winslow, P-12 at 2, Point 7.

collection efforts were made and that the debts were actually uncollectible when claimed as worthless. Notably, the Provider's own in-house collection activity, as shown in Exhibit I-2 (Case No. 03-0268), often continued for extensive periods of time and included the issuance of several collection letters.

DECISION AND ORDER:

The Intermediary's adjustments disallowing the Provider's regular Medicare bad debt claims were improper. The Intermediary's adjustments are reversed.

Board Members Participating:

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

DATE: February 23, 2007

FOR THE BOARD:

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