PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D40

PROVIDER -
Sierra Nevada Memorial Hospital
Nevada Valley, California

Provider No: 05-0150

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
United Government Services, LLC

DATE OF HEARING -
December 14, 2006

Cost Reporting Period Ended -
December 31, 2000

CASE NO: 04-2269

INDEX

ISSUE:

Whether the Provider's regular Medicare outpatient bad debts are not allowable until all collection efforts including those of a collection agency have ceased.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the 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.

According to Medicare regulations at 42 C.F.R. §413.80, a provider is entitled to claim as a reimbursable cost bad debts attributable to deductibles and coinsurance amounts that remain unpaid by the Medicare beneficiaries it services.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sierra Nevada Memorial Hospital (Provider) is a 104-bed acute care hospital located in Nevada County, California. In its cost report, the Provider claimed regular Medicare Part A bad debts of $150,616 and Part B bad debts of $308,259. The Intermediary disallowed $37,542 and $70,901 of the Part A and Part B bad debts, respectively. Of these amounts, $38,158 consisted of bad debts which the Provider deemed uncollectible even though the accounts were still in the hands of its outside collection agency. The collection agency never issued a formal determination that it had completed its collection efforts. United Government Services, LLC (Intermediary) denied the latter bad debts on the grounds that all collection efforts by the collection agency were not completed.

The Provider appealed this determination to the Board. The Provider's filing met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by John P. Wagner, Esquire, of Nossaman, Gunther, Knox & Elliott, LLP. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the facts, parties' contentions and evidence submitted, the Board finds and concludes that the Provider properly claimed uncollectible Medicare accounts as bad debts even though the accounts were still with its collection agency.

The Intermediary disallowed a portion of the Provider's claimed Medicare bad debts, contending that the Provider had failed to comply with the requirements of 42 C.F.R. §413.80(e) which set forth the criteria that must be met for bad debts to be allowable costs. The Intermediary's sole basis for the disallowance was the Provider's use of an outside collection agency as part of its collection efforts after the bad debt had been deemed worthless and written off by the Provider. The Intermediary concluded that the Provider was not entitled to claim Medicare reimbursement for any bad debts until such time that the collection agency ceased its collection activities and returned the accounts to the Provider.

The Medicare program reimburses providers for bad debts resulting from deductibles and coinsurance amounts which are uncollectible from Medicare beneficiaries. Pursuant to 42 C.F.R. §413.80(e), bad debts 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.

The Intermediary does not dispute that the bad debts claimed by the Provider related to covered services provided to Medicare beneficiaries, nor that they were attributable to deductibles and coinsurance amounts.

The Board is unable to reconcile the Intermediary's position with CMS Pub. 15-1 §310.2, which allows a provider to seek Medicare bad debt reimbursement for accounts that remain uncollected after a provider has engaged in reasonable and customary collection efforts for a period of a least 120 days. The Intermediary claims that the Provider must wait to claim a debt as uncollectible until either the collection agency returns the account

to the Provider or the collection agency makes a determination that the account is worthless.

According to the Provider Reimbursement Manual (PRM) §310.A, a provider's use of a collection agency may be in addition to or in lieu of collection efforts undertaken by the provider itself. That same section allows a presumption of uncollectibility after a provider's reasonable and customary attempts to collect the bill have failed and the debt remains unpaid for more than 120 days. Thus, the Board finds that the Intermediary's argument that the Provider's use of an outside collection agency negates the presumption of uncollectibility even if the debt remains unpaid after 120 days of reasonable collection effort, is without merit. Moreover, the Provider argues and the Board concurs that PRM §316 indicates that when a provider, in a later reporting period, recovers amounts previously claimed as allowable bad debts, the provider's reimbursable costs in the period of recovery are reduced by the amounts recovered. Thus, based on this Medicare program instruction, the Board finds that it is reasonable to infer that the Medicare program anticipates that providers may continue to pursue collection activities with respect to debts that have been deemed uncollectible for Medicare reimbursement purposes.

The Board also concurs with the Provider's contention that the Medicare regulations and program instructions do not support the Intermediary's decision to disallow the Provider's Medicare bad debts. The only CMS publication that addresses the denial of a bad debt while a Medicare account is still at the collection agency after the 120-day collection activity period has ended is the Medicare Intermediary Manual (MIM). The MIM addresses the audit procedures and steps which intermediaries must use in performing their audits. However, this instruction, directed to intermediaries, goes beyond the requirements of the Medicare regulations and program instructions applicable to providers.[1]

The Board finds that "uncollectible," within the meaning of the regulation, means that no payments have been received or are expected to be made on an account based on the provider's experience and sound business judgment.

The Board finds that the CMS Administrator's interpretation of the regulation requires undue efforts by providers in attempting to collect their bad debts, and such requirements do not foster program efficiency. Substituting CMS' requirements regarding bad debt collection policy for a provider's judgment based on its own operational experience and the nature of its bad debts, subjects providers to counter-productive burdens that are not required by the regulation.

[1] The Board acknowledges that the CMS Administrator reserved the Board's decision in Battle Creek Health System v. Blue Cross Blue Shield Association/United Government Services, LLC, PRRB Dec. 2004-D40, 9/16/04, Medicare & Medicaid Guide §81,193 (Battle Creek). The Administrator stated, "Until 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."

The Board finds that the Provider's practice of writing off uncollected Medicare accounts after 120 days as allowed by HCFA Pub. 15-1 §310.2 and then sending them to a collection agency is consistent with the Medicare regulation and program instructions. Furthermore, CMS is not disadvantaged by this procedure, because if the Provider does recover funds from previously written off bad debts, such recovery will reduce allowable bad debts in a later period. In summary, to follow CMS' prescribed methodology for collecting bad debts by using an audit manual generally unavailable to a provider is arbitrary and can be cost-inefficient.

DECISION AND ORDER:

The Provider properly claimed Medicare bad debts under the presumption of uncollectibility provisions of CMS Pub. 15-1 §310.2 even though the accounts were still with the collection agency. The Intermediary's adjustment is 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

DATE: May 31, 2007

FOR THE BOARD:

Suzanne Cochran
Chairperson