PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2008-D5

PROVIDER -
Summer Hill Nursing Home
Old Bridge, New Jersey

Provider No.: 31-5381

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING -
August 17, 2007

Cost Reporting Period Ended -
December 31, 2004

CASE NO.: 06-1478

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ISSUE:

Whether the Intermediary properly adjusted Medicare bad debts.

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 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Summer Hill Nursing Home (Provider) is a 120-bed skilled nursing facility located in Old Bridge New Jersey. In its cost report for FYE 12/31/04, the Provider claimed $170, 537 in Medicare bad debts of which $135,106 was disallowed by Mutual of Omaha, its fiscal intermediary (Intermediary). The Intermediary reviewed the Provider's collection and bad debt write-off policies and found that the Provider applied the New Jersey Medicaid payment formula to determine the State's liability for any portion of the coinsurance due from patients who were dually eligible for both Medicare and Medicaid. The Provider billed the State only in those instances where it determined that a liability existed. Where the calculations determined no liability, the Provider considered the outstanding coinsurance amount uncollectible and claimed a Medicare bad debt in that amount. The Intermediary disputed the propriety of writing off those amounts without billing the State for each patient and receiving contemporaneous documentation of a payment or a denial. There is no dispute that 42 C.F.R. §413.80 and CMS 15-1, Sections 308, 310 and 312 are controlling for the reimbursement of bad debts. The dispute centers on the application of the guidance to determine uncollectibility.

PARTIES' CONTENTIONS:

The Provider asserts that it has established the "uncollectible" nature of the amounts that it claimed as bad debts in accordance with the "must bill" policy of Section 1102.3L of the Provider Reimbursement Manual (PRM)-II. The Provider claims that the Medicaid Remittance Advice[1] demonstrates that the Provider has billed Medicaid for each of the bad debts claimed and that Medicaid determined that, because the Medicare payment exceeded the Medicaid allowable payment ceiling, no Medicaid payment was due. The Provider acknowledges that the billing occurred after the bad debt was written off but argues that no statute or regulation requires that Medicaid be billed and the bill be denied by Medicaid prior to the Provider claiming dual eligible bad debts. Rather, 42 C.F.R. §413.80(e) requires that reasonable collection efforts be made and that the amount be actually "uncollectible when claimed." The Provider contends that its bad debt policy of applying the New Jersey Medicaid payment formula to determine if the State was liable and then billing the State only if there was liability constitutes a reasonable collection effort. The Medicaid remittance advice affirmed the Provider's determination and, the Provider argues that no source other than the patient would be legally responsible for the patient's medical bill.

In the alternative, the Provider argues that denying bad debts pursuant to the "must bill" policy: 1) goes beyond existing statutory requirements and regulations 2) is arbitrary, capricious and unreasonable in violation of APA, 5 U.S.C. §706(2)(A) and 42 U.S.C. §405; 3) violates the statutory prohibition on cost shifting set forth in 42 U.S.C. §1395x(v)(1)(A); and 4) contravenes the requirements of 42 U.S.C. §1395f(b)(1) that Medicare reimburse providers for expenses actually incurred to serve Medicare beneficiaries.

The Intermediary contends that the Provider's method for writing off bad debts of dually eligible patients without billing the State does not constitute a reasonable collection effort as contemplated by the regulations at 42 C.F.R. §413.89(e) or the manual provisions at CMS Pub. 15-1 §308. The Provider's policy of calculating what the State would pay rather than submitting a bill for each patient fails to establish the fact that "no source other than the patient would be legally responsible for the patient's medical bill. . . . ."[2] The Intermediary argues further that the "must bill" policy is a reasonable reading of the regulations that has been upheld by the CMS Administrator[3] and the courts.[4]

The Intermediary also contends that the Provider received notification of the "must bill" policy on September 12, 2003 when CMS issued Change Request 2796.[5] This Request changed the language in CMS Pub. 15-2, Section 1102.3L to revert back to the pre-1995 language that

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[1] Exhibit P-3.
[2] CMS Pub. 15-1 §312C.
[3] See, California Hospitals 90-91 Outpatient Crossover Bad Debts Group v. Blue Cross and Blue Shield of Association/ Blue Cross of California/Mutual of Omaha/Aetna Life Insurance Company. CMS Adm. Dec., October 31, 2000 reversing PRRB Dec. No. 2000-D80. Intermediary Exhibit I-4.
[4] See, Community Hospital of Monterey Peninsula v. Thompson, U.S. Court of Appeals, Ninth Circuit, 02-15115, (March 18, 2003). Intermediary Exhibit I-5.
[5] See, Intermediary Exhibit I-6.

required providers to bill the individual states for dual eligible beneficiary co-payments before claiming a Medicare bad debt. The Intermediary communicated this change to all providers in its Medicare Newsletter dated October 15, 2003.[6] The newsletter required that bad debts for dual eligible patients' deductibles and coinsurance must be documented by a billing to the welfare agency for each amount and receipt of a partial or total denial of the claim. The newsletter stated further:

> We cannot accept other forms of documentation such as a provider's calculations of the agency's liability for the debt or an affidavit from the provider's employee that they were instructed not to bill by the agency.

In its Joint Signature Memorandum 370 (JSM-370) dated August 10, 2004, CMS reiterated its "must bill" policy and issued a directive to all fiscal intermediaries to hold harmless providers that could demonstrate that they followed the instructions previously laid out at PRM-II Section 1102.3L for open cost reporting periods beginning prior to January 1, 2004.[7]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence included in the record, the Board finds and concludes as follows:

The primary issue before the Board is whether a finding of uncollectibility on a debt owed by a patient who is dually eligible for Medicare and Medicaid must be supported by an individual billing to the state. The Board examined the regulations at 42 C.F.R. §413.80 and the program guidance at CMS Pub. 15-1, Sections 308, 310, 312, and 322 that govern the recognition of Medicare bad debts as well as the newsletters and agency alerts cited by the parties in their respective position papers.

Based on the Board's examination of the regulation at 42 C.F.R. §413.80 and the program guidance at CMS Pub. 15-1, Section 308, it finds that neither contained a requirement to bill. Rather, the sections require that a provider make reasonable collection efforts and apply sound business judgment to determine if the debt was actually uncollectible. CMS Pub. 15-1, Section 310 sets the parameters for establishing reasonable collection efforts. However, the section specifically refers to Section 312 for indigent and/or medically indigent patients and, by its own terms, is inapplicable in determining reasonable collection efforts for indigent patients.

It states in pertinent part:

> Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the

[6] See, Intermediary Exhibit I-7.
[7] See, Intermediary Exhibit I-8.

> indigence of patients to the case of the Medicare beneficiary under the following guidelines: … (emphasis added)

CMS Pub. 15-1 Sections 312.

The plain language of this paragraph establishes that Medicaid-eligible beneficiaries are indigent and that a provider does not have to apply additional steps to prove their indigency. Immediately following the quoted paragraph, subsections A through D set forth specific requirements regarding how and by whom indigence is to be determined and how that determination is to be documented by a provider. Subsection C states:

> The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; . . .

The subsection C language imposes a universal requirement to collect the debt from responsible third parties. However, the Board finds that the use of the word "otherwise" in the first paragraph effectively makes sub-sections A-D applicable to non-Medicaid eligible beneficiaries only. Further, the duty imposed by subsection C to collect from responsible third parties still does not rise to a specific billing requirement. Nowhere does the language of this section support the conclusion that uncollectibility must be established by a billing and denial of payment.

CMS Pub. 15-1, Section 322, Medicare Bad Debts under State Welfare programs, provides that deductible and coinsurance amounts not covered by state title XIX plans may be claimed as Medicare bad debts if they meet the requirements of sections 312 or 310. Section 322 states in pertinent part:

> Where the State is obligated to either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible and coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided the requirements of §312 or, if applicable, §310 are met.

The Board finds no billing requirement in Sections 310 or 312. Accordingly, the Board concludes that no billing requirement is imposed by either the bad debt regulations or the manual provisions.

The Intermediary relies on its Newsletter dated October 15, 2003,[8] as evidence of a "must bill" requirement. At its page 3, the Newsletter states:

[8] See, Intermediary Exhibit I-7.

> A provider must demonstrate that a debt was uncollectible when claimed as worthless. With respect to a dual eligible, this can only be done by billing the welfare agency for each deductible and coinsurance amount and receiving a partial or total denial of the claim.

The Newsletter is the only evidence in the record that such a billing is required. However, the Board finds the Newsletter, while explicit, is unsupported by a statute or regulation and is, therefore, insufficient to impose an additional major requirement for bad debt reimbursement. The Newsletter goes well beyond the requirements of the regulation and manual provisions because it clearly requires that such billings be made even when they are futile, a provider can otherwise demonstrate that there is no reasonable expectation of payment, and the debt was worthless when it was claimed. Accordingly, the Board concludes that the application of the "must bill" policy to outstanding deductible and coinsurance amounts due from dually eligible beneficiaries is improper.

DECISION AND ORDER:

The Intermediary's "must bill" policy has no foundation in law in that it is beyond the requirements of the regulations and manual. Application of the "must bill" policy to outstanding deductibles and coinsurance amounts due from dually eligible beneficiaries is improper. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West, C.P.A.
Yvette C. Hayes

DATE: November 1, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson