PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D12

PROVIDER –
Baptist Regional Medical Center
Corbin, Kentucky

Provider No.: 18-0080

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services - Kentucky

DATE OF HEARING –
June 20, 2007

Cost Reporting Periods Ended -
August 31, 1999; August 31, 2000
and August 31, 2001

CASE NOs.: 04-1491**;** 04-1495
and 04-1496

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ISSUE:

1. Whether the Intermediary properly adjusted Medicare bad debts accounts considered indigent by the Provider.

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 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.

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

CMS Pub. 15-1, §312 interprets the regulation to allow a hospital to forego collection activity where it can establish that the patient was indigent and provides the following guidelines for establishing indigence:

A. The patient's indigence must be determined by the provider, not the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of his indigence;
B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;
C. The provider must determine that no other source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and
D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

The dispute in this case involves the application of CMS Pub. 15-1, §312 to the Provider's bad debt collection and write-off policies.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Baptist Regional Medical Center (Provider) is a voluntary nonprofit short-term hospital located in Corbin, Kentucky that offers hospital inpatient/outpatient, psychiatric, and rehabilitation services. The Provider is a member of the Baptist Healthcare System. National Government Services – Kentucky (formerly AdminaStar Federal) (Intermediary) reviewed the Provider's collection and write-off policies and found that the Provider had established a charitable care policy for indigent patients. For an account with a balance due from the patient under $800, the Provider's policy allowed the patient to disclose information regarding income without further supporting documentation. The policy considered the patient indigent and granted full or 100% charity if the patient's income was less than 125% of the federal poverty level. For account balances due from the patient of $800 or greater, the policy required patients to disclose information regarding both income and assets, and the Provider determined the amount of debt forgiveness based on both. The Intermediary considered the Provider's charity care write-off practices inconsistent with the requirements of CMS Pub. 15-1, §312 that determinations of indigence include consideration of the patients' total resources (i.e., assets, liabilities and income and expenses) and, accordingly, disallowed all bad debt claims for which the Provider's records did not evidence an asset test. There is no dispute that 42 C.F.R. §413.80 and CMS Pub. 15-1, §312 are the controlling guidance for bad debts. The central question for the Board is whether the asset test guideline in CMS Pub. 15-1, §312(B) must be applied to determine a Medicare beneficiary's indigence.

The Provider appealed the Intermediary's disallowances to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Neal A. Cooper, Esquire, of Hall, Render, Killian, Heath & Lyman, P.C.

The Intermediary was represented by James R. Grimes, Esquire, Associate Counsel, Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that the Intermediary's adjustment is based upon an improper reading of CMS Pub. 15-1, §312(B). The Provider argues that no Medicare law, rule or guideline requires that asset test be performed prior to write-off of a patient's account as uncollectible. Although, the Provider acknowledges that the language of CMS Pub. 15-1, §312(B) uses the word "should," the Board previously addressed the use of the term "should" in *Parkland Memorial Hospital v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Texas* (hereinafter *Parkland).*[1] There, the Board concluded that §312 is an interpretive rule that does not have the effect of law. The term "should" indicates that the provision is permissive, not mandatory. Further, the regulation at 42 C.F.R. §413.80 sets forth the requirement for bad debts to be allowable. Nothing in §413.80 requires an asset test. The District Court in *Harris County Hospital District v. Shalala*[2] also concluded that CMS Pub. 15-1, §312 did not require an asset test.

The Intermediary contends that the methodology used by the Provider to determine indigence is not consistent with the requirements of 42 C.F.R. §413.80. The regulation requires that reasonable collection efforts be made and sound business judgment be used. Furthermore, CMS Pub. 15-1, §312 requires that indigence must be proved by the provider and that the statements of a patient are not proof of indigence. Further, CMS Pub. 15-1, §312(B), requires that the determination of indigence take into account a patient's total resources including an analysis of assets, liabilities, income and expenses. The Intermediary relies on the decision of the CMS Administrator reversing the findings of the Board in *Harris*.[3] There, the Administrator concluded:

> Pursuant to 42 C.F.R. §413.80 (e)(2) and (3), PRM section 312 establishes that, except in the case where the patient has been determined eligible for Medicaid, providers are required to follow certain procedures in making indigency determinations. Those procedures include: not relying on patient declarations of inability to pay as proof of indigency; the application of an asset test – taking into account patient assets, as well as liabilities, income and expenses, to determine indigency; and ensuring after an initial determination that a patient is indigent, that the beneficiary's financial condition has not improved. That Providers must strictly comply with theses procedures flows from mandatory language of section 312…[4]

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[1] PRRB Dec 93-D106 (Case No. 90-1410, Sept. 30, 1993), reversed by HCFA Administrator (Nov. 29, 1993).

[2] *Harris County Hospital District v. Shalala*, 863 F. Supp. 404 (S.D. Texas, 1994), aff'd 64 F.3d 220 (5th Cir. 1995).

[3] PRRB Dec. 93-D103 (case No. 90-1159, Sept. 29, 1993); Reversed by HCFA Administrator (Nov. 23, 1993).

[4] Id.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and stipulations, and the testimony offered at the hearing, the Board finds and concludes as follows:

The parties in the case sought to frame the question before the Board as a narrow legal issue. To that end, the parties submitted a joint stipulation of facts. The stipulations at paragraph number 2 state:

> . . . the Fiscal Intermediary disallowed a portion of the Provider's bad debts for certain accounts for the sole reason that the Provider allegedly failed to perform and/or document an asset test (and in some cases an income test) in order to determine indigence before writing off those bad debts.

The stipulations continue at paragraph number 4:

> But for the disputed failure to perform and/or document an asset test, (and in some cases an income test), each of the bad debt amounts disallowed as described in paragraph 2, above, would have been a Medicare allowable bad debt.

Taken collectively, the stipulations restrict the issue presented for the Board's consideration to whether the Medicare provisions at CMS Pub. 15-1, §312(B) require that an asset test be conducted on every bad debt to determine indigence.

The Board notes that both parties in this action referenced the *Harris* case in support of their positions. The Intermediary relies on the November 23, 1993 decision of the Administrator that reversed the Board's decision in PRRB Dec. 93-D103 and held that an asset test is mandatory under §312(B). The Provider relies on the District Court's reversal of the Administrator's decision[5] and its subsequent affirmance by the Fifth Circuit Court of Appeals.[6] The District Court found:

> Even if the secretary is correct in asserting that the moratorium does not apply, the court concludes that use of the asset test was not mandatory. The regulations do not contain the asset test, only the manual does. The issuance of the manual was not preceded by the formal rule-making of the administrative procedure act. The rules in the manual do not have the effective of substantive law or regulation, rather they are interpretive rules. Interpretive manuals clarify or explain existing law or regulations; they may set practical processes

[5] 863 F. Supp. 404 (S.D. Texas, 1994).
[6] 64 F.3d 220, (5th Cir., 1995).

> or serve educational goals, but they cannot be substantive. Administering and legislating are different functions.
>
> The manual's provisions for a hospital's determination of indigence relate to the regulatory requirement that the provider must be able to establish that reasonable collection efforts were made. In effect, the manual says that no effort to collect is reasonable when the patient is indigent.
>
> Two of the four guidelines that the manual lists use mandatory language, *must*, and two use precatory language, including the word *should*. The provision suggesting an asset test uses the word *should*.
>
> The secretary goes to heroic efforts to assert that should means must. Her argument fails. *Should* is mandatory only when used as the past tense of *shall*. Otherwise, should is precatory . . . .
>
> There is nothing inconsistent with the regulation in suggesting use of an asset test but not requiring it. The court does not need to decide whether requiring an asset test would be inconsistent with the regulation because the manual does not require one. In fact, the regulations state that the hospital is to use its "sound business judgment" in establishing that there was no likelihood of recovery.[7] (Emphasis in original; citations omitted).

The Board finds the Court's rationale persuasive and, accordingly, concludes that CMS Pub. 15-1, §312 does not create a mandatory asset test. Rather, each determination of indigence must take into consideration each patient's circumstances. In some instances, that will require an asset test while other circumstances may obviate the need for that test.

At the hearing the Intermediary agreed that the completion of the Provider's Financial Disclosure form would have been sufficient documentation of indigence.[8] The Board does not reach that conclusion. The parties did not furnish the documentation upon which indigence was determined. However, the Intermediary acknowledged that the supporting documentation was voluminous and that, absent a requirement for an asset test (in this case interpreted to be a Financial Disclosure form), each of the bad debts in dispute "would have been a Medicare allowable bad debt." The stipulation to this fact, therefore, removes the question of sufficiency of the documentation from the Board's consideration.

DECISION AND ORDER:

CMS Pub. 15-1, §312 does not create a mandatory asset test. The Provider's bad debts should be reimbursed in a manner consistent with the stipulations of the parties.

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[7] 863 F. Supp. 404, supra, at 409-410.
[8] Transcript at 154.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: December 10, 2007