PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2010-D21

PROVIDER -
Reflections Wellness Center, Inc.

Provider No.: 10-1472

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
First Coast Service Options, Inc.

DATE OF HEARING -
October 26, 2009

Cost Reporting Period Ended -
December 31, 2005

CASE NO.: 07-2829

INDEX

ISSUE:

Was the Intermediary's adjustment disallowing bad debts arising from coinsurance and deductibles for dual eligible Medicare and Medicaid beneficiaries 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 to organizations known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. 42 U.S.C. §1395h; 42 C.F.R. §§413.20 and 413.24.

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.

Qualified Medicare Beneficiaries (QMBs) are individuals who are entitled to Medicare Part A, whose family incomes do not exceed 100 percent of the federal poverty line (FPL), and whose resources do not exceed twice the resource-eligibility standard for Supplemental Security Income (SSI). 42 U.S.C. §1396d(p). QMBs may be eligible for full Medicaid benefits or states may limit Medicaid eligibility to payment of Medicare Part B (supplementary medical insurance) premiums and Medicare Part A and Part B cost sharing (deductibles and coinsurance) for Medicare services provided by Medicare providers. 42 U.S.C. §1396d(p)(3).

"[A] State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost-sharing to the extent that payment under subchapter XVIII of this chapter for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a Medicare beneficiary." 42 U.S.C. §1396a(n)(2). In the case in which a State's payment for Medicare cost-sharing for a qualified Medicare beneficiary with respect to an item or

service is reduced or eliminated, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service, and the beneficiary shall not have any legal liability to make payment for the service. 42 U.S.C. §1396a(n)(3).

The Medicare program reimburses providers for bad debts resulting from deductibles and coinsurance amounts which are uncollectible from Medicare beneficiaries. 42 C.F.R. §413.89(e)[1] requires that to be allowable, bad debts must meet the following criteria:

(1) The debt must be related to covered services and derived from deductible and co-insurance 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, Provider Reimbursement Manual, Part I ("PRM-I") §308 restates these requirements, while PRM-I §310 addresses the concept of "reasonable collection effort" as follows:

> To 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. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)

PRM-I §312 interprets the regulation to allow a hospital to forego collection activity where it can establish that the patient was indigent and indicates that, "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." For such beneficiaries, the debt may be deemed uncollectible without applying the collection procedures outlined in §310.

This section goes on to reference PRM-I §322 to address Medicare bad debts under State Welfare Programs. Section 322, states in pertinent part:

> Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. For

[1] Redesignated from 42 C.F.R. §413.80 at 69 FR 49254, Aug. 11, 2004.

> example, a State which covers hospital care for only 30 days for Medicaid recipients is not obligated (unless made part of the State title XIX plan) to pay all or part of the Medicare coinsurance from the 61st day on. For services that are within the scope of the title XIX plan, States continue to be obligated to pay the full deductible and coinsurance for categorically needy persons for most services, but can impose some cost sharing under the plan on medically needy persons as long as the amount paid is related to the individual's income or resources.
>
> Where the State is obligated 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 or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of §312 or, if applicable, §310 are met.

The dispute in this case involves the reasonableness of Provider's collection effort and the determination that the debts of Medicare/Medicaid dual eligible patients were uncollectible.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Reflections Wellness Center, Inc. (Provider) is an outpatient rehabilitation facility located in Miami, Florida. First Coast Service Options, Inc. (Intermediary) is the Provider's fiscal Intermediary.

In its Medicare Cost Report for the fiscal period beginning November 17, 2004 and ending December 31, 2005, the Provider claimed $312,924 as Medicare reimbursable bad debts for co-insurance and deductibles for its dual eligible patients. The Intermediary reviewed the Provider's Medicare cost report and issued an NPR on May 25, 2007.[2] The NPR included an adjustment reducing the amount of allowable bad debt expense. The Provider appealed the Intermediary's determination to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841.

The Provider was represented by Christopher A. Parrella, Esquire, of The Health Law Offices of Anthony C. Vitale, P.A. The Intermediary was represented by Lisa M. Sarris-Cowhey, C.P.A., of the Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider argues it has met the requirements listed at 42 C.F.R. §413.89(e) and PRM-I §308. The Provider contends that there is no dispute that the clinical services in this matter were Medicare covered Partial Hospitalization Program (PHP) services rendered to dual enrollees and the bad debts are derived from related deductible and coinsurance amounts. The Provider argues that "reasonable collection efforts" as described in PRM §310 are not required since pursuant to PRM-I §312, these beneficiaries are deemed

[2] See Provider Exhibit P-1.

indigent and the debt is "de facto" uncollectible. In addition, the Provider argues that PHP services are non-covered in the State of Florida, so in accordance with PRM-I §322, Florida Medicaid has no obligation to make payment for deductibles and coinsurance amounts for the dual enrollees.

The Provider was disenrolled from Medicaid effective July 1, 1998.[3] Therefore, there is no legal mechanism to obtain a Medicaid number or to pursue a remittance advice or denial from the State of Florida. As such, the Provider concludes that sound business judgment would dictate that the bad debt was uncollectible when claimed.

The Provider further contends that there is a CMS internal memorandum dated March 27, 2006 that addresses the situation in Florida and instructs the intermediaries to suspend the prior "must bill" instructions in JSM-370, and continue to reimburse for bad debts for PHP dual enrollees. Specifically, JSM-06345, 03-24-06,[4] states:

> On August 10, 2004, the Centers for Medicare & Medicaid Services (CMS) issued a directive regarding Medicare's policy for reimbursement of bad debts for dual eligible beneficiaries (Joint Signature Memorandum (JSM)-370), requiring a provider to bill the State and receive a remittance advice before allowing a bad debt.
>
> The CMS recently became aware of instances in which the Florida Medicaid Agency disenrolled freestanding psychiatric hospitals as Medicaid providers and indicated that it will not accept claims filed by such hospitals (or issue Remittance Advices) because of the facilities' disenrollment as Medicaid providers. The CMS is currently investigating the extent to which disenrollment in the Medicaid Program affected these hospitals and other Medicare providers in Florida.
>
> Until further notice, the CMS is instructing fiscal intermediaries not to reduce tentative settlements to the affected freestanding psychiatric hospitals for bad debts not billed to the State of Florida. If a tentative settlement made since August 10, 2004, reduced bad debts because the State of Florida was not billed, you must issue a revised tentative settlement to temporarily pay these bad debts. In addition, interim payments to the affected freestanding psychiatric hospitals in Florida should be immediately reviewed and adjusted, if necessary, to reflect bad debts not billed to the State of Florida. Until we provide further guidance, do not final settle cost reports for the affected hospitals or reopen any cost reports for this issue.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends it properly adjusted the bad debts due to the "must bill" policy that was issued by CMS on August 10, 2004 (see Exhibit I-1). "The 'must bill' policy states that if a patient is determined by a provider to be indigent or medically indigent,

[3] Exhibit P-21.
[4] Exhibit P-5.

the provider does not need to attempt to collect from the patient. However, the provider must make certain that 'no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency…' prior to claiming the bad debt from Medicare." The memorandum goes on to state that, "in those instances where the states owes none or only a portion of the dual-eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State Remittance Advice)." Therefore, it is the Intermediary's position that the Provider must document that it billed the State. Since the Provider has not provided documentation for this case, the Intermediary believes that the adjustment should stand.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions and the evidence contained in the record, the Board finds and concludes that the provider has met the requirement for a reasonable collection effort related to the dual eligible beneficiaries as required by 42 C.F.R. §413.89 and PRM-I §308.

The Intermediary alleges that the reasonable collection effort requirement was not satisfied because JSM-370 makes the act of billing and the receipt of a remittance advice the exclusive evidence that will be used to prove the state's obligation, or lack of obligation, to pay. The Board finds that while a remittance advice is one type of documentary evidence to support a reasonable collection effort, it is not the only source and the Provider in this case cannot be held to the "must bill" requirement as laid out in JSM-370.

First, the Board finds that a JSM is an inappropriate vehicle to formulate policy and is therefore entitled to far less deference than regulations and manual instructions. The CMS website for Division of Change and Operations[5] describes a Joint Signature Memorandum (JSM) as a memorandum/letter communicated to all or a select group of Medicare fee-for-service Fiscal Intermediaries and Carriers that must be signed by at least two group directors. Relevant here is what CMS says a JSM is not to be used for--the conveying of new instructions or providing clarification of existing requirements that affect contractor operations. In those situations, Manual instructions should be submitted through the formal Change Management/Change Request process.

Second, JSM-06345, 03-2406 instructs the Florida intermediaries to suspend the prior "must bill" instructions in JSM-370, 08-03-04. The Board notes that the two signatories on the original JSM are also on the subsequent JSM.[6] The NPR dated May 25, 2007 was issued subsequent to the March 27, 2006 JSM-06345 modification. This modification shows CMS' recognition that the JSM-370 "must bill" requirements may not be reasonable in some circumstances. No further evidence was offered to show that the directive was withdrawn or modified. Contrary to Community Hospital of the Monterey

[5] http://www.cms.hhs.gov
[6] See Provider Exhibits P-5 and P-6.

Peninsula v Thompson, the authorization of an alternative to billing is relevant in this case because it was not possible for the Provider was to bill Florida's Medicaid program.

Third, as evidenced in a previous PRRB case, Florida statute regarding Medicaid Provider Fraud at §409.920(2)(b) states that it is unlawful to "[k]nowingly make, cause to be made, or aid and abet in the making of a claim for items or services that are not authorized to be reimbursed by the Medicaid program. . . A person who violates this subsection commits a felony of the third degree." [7] Coupled with the fact that Florida's Medicaid State Plan was amended to eliminate any coverage responsibility for QMB co-insurance and deductibles for the type of services furnished by the Provider. The Board finds it would be unreasonable to place the Provider in legal jeopardy to bill in accordance with JSM-370 to collect Medicare bad debts.

Fourth, the Board finds that the Medicare requirement to bill and obtain a remittance advice was a matter of impossibility for the Provider. The impossibility is made more compelling because CMS participated in the "errors" that created the impossibility by initially approving the amendment to the State Plan and then requiring modifications to be made only prospectively.

Based on the above, the Board finds that the Intermediary improperly disallowed the dual eligible Medicare bad debts based upon the "must bill" policy. The Provider's assertions that absent the "must bill" policy it has fulfilled all other regulation and manual requirements to be reimbursed for the bad debts at issue has not been contested by the Intermediary.[8] In addition, given the unique circumstances in the State of Florida, the Board also finds that the associated bad debts were actually uncollectible when the Provider claimed them as worthless and that sound business judgment established that there was no likelihood of recovery at any time in the future.

DECISION AND ORDER:

The Intermediary improperly disallowed the bad debts arising from coinsurance and deductibles for dual eligible Medicare and Medicaid beneficiaries. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

[7] Royal Coast Rehabilitation Center vs. Blue Cross Blue Shield Association, PRRB Decision 2010-D13, January 29, 2010.
[8] Provider Position Paper pp.8-10, and 13.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: March 19, 2010