PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D3

PROVIDER –
Diversicare 05-06 Medicare Bad Debts Group

Provider Nos.: Various (see Attached Appendix I)

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ National Government Services, Inc.

DATE OF HEARING -
September 2, 2009

Cost Reporting Periods Ended -
Various (See Attached Appendix I)

CASE NO.: 08-0298G

INDEX

ISSUE:

Whether the Intermediary's adjustments to the Providers' Medicare bad debts were proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due providers 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 under interpretive guidelines published by CMS. See, 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. §§405.1835-1837.

The Medicare program reimburses providers for bad debts resulting from deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. 42 C.F.R. §413.89(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, §308 restates these requirements, while CMS Pub. 15-1, §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.)

CMS Pub. 15-1, §312 states 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 CMS Pub. 15-1, §310.

This section goes on to reference CMS Pub. 15-1, §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 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.

CMS Pub. 15-2, §1102.3L offers implementing guidance for debt collection activities and specifically addressed crossover bad debts (bad debts relating to beneficiaries dually eligible for both Medicare and Medicaid). It states in relevant part:

> [e]vidence of a debt arising from Medicare/Medicaid crossovers may include a copy of the Medicaid remittance showing the crossover claim and resulting Medicaid payment or non-payment. However, it may not be necessary for a provider to actually bill the Medicaid program to establish a Medicare crossover bad debt where the provider can establish that Medicaid is not responsible for payment. In lieu of billing the Medicaid

program, the provider must furnish documentation of:

- Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number), and

- Nonpayment would have occurred if the crossover claim had actually been filed with Medicaid.

The dispute in this case involves the Intermediary's application of the "must bill" policy stated in a Joint Signature Memorandum issued by CMS on August 10, 2004, and which the Intermediary interprets as requiring a Medicaid remittance advice prior to reimbursement of any bad debts for crossover claims.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Advocat, Inc., through its subsidiary, Diversicare Leasing Corporation, operates several skilled nursing facilities (the Providers) located in Tennessee.[1] The Providers participate in the State of Tennessee's Medicaid program, referred to as TennCare. During the cost reporting periods at issue, the Providers claimed Medicare bad debts on their cost reports for uncollected coinsurance and deductible amounts related to the care of Medicare beneficiaries who were also eligible for Medicaid (i.e. dual eligible beneficiaries). Such bad debts are referred to as "crossover bad debts." [2] National Government Services ("Intermediary") disallowed certain bad debts based upon the CMS "must-bill" policy, which requires the Providers to bill the state Medicaid program and obtain remittance advices (RA).

The Providers filed a timely appeal with the Provider Reimbursement Review Board ("Board") and have met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Providers were represented by Tracy M. Lujan, Esq. Harwell Howard Hyne Gabbert & Manner, P.C. The Intermediary was represented by Bernard M. Talbert, Esq. of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Providers contend that CMS' "must-bill" policy, requiring a Medicaid RA from the state Medicaid program before writing off the crossover bad debts, is beyond the scope of the regulations and manual sections, and is barred by the Medicare bad debt moratorium. In addition, the Providers contend that they have complied with all the required criteria of 42 C.F.R. §413.89(e) and with CMS Pub. 15-1 §§310, 312 and 322.

The Providers assert that the crossover bad debt claims at issue fully meet the regulatory criteria as allowable bad debts.[3] Specifically, it is undisputed that the debts at issue related to covered services and are derived from deductible and coinsurance amounts. Next, the Providers contend that reasonable collection efforts were made in seeking payment for the crossover claims from

[1] See Appendix 1 for the schedule of Providers in this group appeal.
[2] CMS Pub 15-2 §1102.3L
[3] Providers' Final Position Paper at 11-13; Provider's Post-hearing brief at 13-18.

TennCare, the state Medicaid program. The Providers claim they timely submitted bills for all Medicaid eligible patients to TennCare; however, at the time the bills were submitted, TennCare converted to an electronic claim processing system, which caused numerous delays and extensive backlogs in the processing of the Providers' crossover claims.[4] The Providers contend that they worked diligently and dedicated significant time, effort and resources, including re-submissions, hand delivery of claims, and numerous telephone calls and email messages to TennCare in an attempt to get them to process their claims and issue the RAs.[5] The Providers claim that the Intermediary should have accepted alternative proof of billing and nonpayment by TennCare, because it was not the Providers' failure to bill Medicaid, but rather TennCare's inability to process the claims and issue the RAs.

The Providers further argue that the debts were actually uncollectible when claimed as worthless. Using Medicaid formulary obtained from TennCare to determine the amount that TennCare would have paid if it processed the claims,[6] the Providers state that TennCare would have paid only $8,477.[7] Considering the amount TennCare would have reimbursed at most, the Providers assert that this confirms that their sound business judgment rightly established there was no likelihood of recovery at any time in the future. This is because the Providers are prohibited from collecting the unpaid amounts from the dual eligible beneficiaries and instead are limited to payments from Medicaid and Medicare.[8]

The Providers acknowledge that the applicable regulations and manual provisions requires them to bill the state Medicaid program for crossover claims; however, neither the regulations at 42 C.F.R. 413.89(e) nor the manual provisions at CMS Pub. 15-1 §§ 308, 310 and 312 contain an absolute requirement that the Providers must obtain a Medicaid RA as proof of billing.[9] Instead, the regulations require a case by case analysis taking into consideration the particular circumstances in evaluating whether "reasonable collection efforts" were made and "sound business judgment" established no likelihood of recovery prior to claiming the bad debt.

The Providers also acknowledge that CMS' must-bill policy was upheld in the 9th Circuit decision *Community Hospital of the Monterey Peninsula v. Thompson,* 323 F.3d 782 (9th Cir. 2003) ("*Monterey Peninsula*")[10] The Providers argue that the issue in *Monterey Peninsula* was whether providers could request crossover bad debt reimbursement *without billing Medicaid at all*, but instead showing what amounts Medicaid would have paid, if any, and requesting reimbursement for the remainder. Consequently, *Monterey Peninsula* stands only for the proposition that a provider must bill Medicaid. Whether intermediaries may rightfully insist on

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[4] TennCare electronic claim processing was limited to the payment for 'standard' claims (referred to as Level 1 and Level 2). The crossover claims continued to be processed manually. *See,* Providers' Final Position Paper at 3-6; Transcript (Tr.) at 9-10; Providers' Exhibit P-9.

[5] Tr. at 132-140; Providers' Post hearing Brief at 3-12; Providers' Exhibit P-7.

[6] Providers' Final Position Paper at 12; Tr. at 42-43; Providers' Exhibits P-3 and P-4.

[7] Providers' Exhibits P-4 and P-5. The Providers advised that subsequent to the Intermediary's denial of its bad debt claims at issue in this appeal, the Providers did receive paid "0" remittance advices from TennCare relating to $101,557 in crossover claims, of which the Providers were reimbursed in a subsequent cost report. The Providers are now claiming $173,289.34[276,026 - 101,557 - 1,179.661 = 173,289.34]. *See,* Providers' Final Position Paper at 3, fn.1.

[8] Providers' Final Position Paper at 13.

[9] Providers' Final Position Paper at 10.

[10] Providers' Final Position Paper at 10.

receiving a paid remittance advice as the only adequate proof of billing was not the issue before the Court. Thus, the Providers argue *Monterey Peninsula* does not provide any support to the Intermediary's argument that a "paid" remittance advice is properly required by Medicare law and policy.

Finally, the Providers contend that CMS's "must bill" policy is barred by the bad debt moratorium.[11] Providers assert that in issuing the bad debt moratorium, Congress prohibited the enactment of any new rules or regulations regarding bad debt policies, or the changing of the agency's interpretation of, and practice of, enforcement of the rules and regulations as they existed on August 1, 1987.[12] Providers argue that CMS's "must bill" policy was issued on August 10, 2004,[13] obviously after the moratorium, and imposes new requirements for bad debt reimbursement claims that were not contained within the rules, regulations and other policy statements as they existed on August 1, 1987. Because the "must-bill" policy violates the bad debt moratorium, the Providers claim the Intermediary's application of the policy was improper, and the Providers' bad debt claims should be allowed and reimbursed.

The Intermediary contends that the adjustments to the Providers' bad debts were in accordance with CMS' must-bill policy, as articulated in the JSM 370,[14] dated August 10, 2004 and based on the holding in *Monterey Peninsula.* [15] The Intermediary advises that the must-bill policy integrates the reasonable collection standard as articulated in the regulation and the supporting manual provisions. The Intermediary asserts that billing the state Medicaid program and obtaining the remittance advice (RA) is important for two reasons.[16] First, it verifies that a qualified Medicare beneficiary (QMB) patient has Medicaid eligibility. Second, it determines what liability, if any, the state has for the patient's deductible and coinsurance amounts.

The Intermediary acknowledges that while there were some problems with the TennCare payment process, the Providers received remittance advices on a substantial number of claims.[17] The Intermediary contends that while the Providers timely billed TennCare there was a lack of follow-up on the claims that were not paid and that, under JSM 370, the burden falls on the Providers. [18]

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[11] Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203 (OBRA), as amended by OBRA of 1989, Pub. L. No. 101-239, 103 Stat. 2106 (reprinted in 42 U.S.C. §1395f note).

[12] Providers' Final Position Paper at 15, citing to *Detroit Receiving Hospital v. Shalala*, 1999 WL 970277 at 12 (contained at Providers' Exhibit P-12); *Hennepin County Medical Center v. Shalala* 81 F.3d 743, 751 (1996) (contained at Providers' Exhibit P-14).

[13] Joint Signature Memorandum (JSM) 370, 08-03-04 issued to Fiscal Intermediaries by CMS Director Chronic Care Policy Group, Center for Medicare Management (August 10, 2004) (contained at Providers' Exhibit P-17).

[14] In the Intermediary's post-hearing response to the Board's inquiry on the definition and authority of a JSM, the Intermediary advised that a JSM is not to be used to convey new instructions. In this case, JSM 370 addressed the must-bill policy as upheld in the *Monterey Peninsula.* The Intermediary stated that JSM is classified as interpretive rules, general statements of policy and rules of agency organization, procedure, or practice, and as prescribed by 42 C.F.R. §405.1867 shall be afforded great weight. *See*, Letter from Bernard Talbert, Esq. Blue Cross Blue Shield Association, (November 2, 2009).

[15] Intermediary's Final Position Paper at 8; Tr. at 18-19.

[16] Tr. at 20.

[17] Tr. at 23 – 25.

[18] Tr. at 24.

Consequently, the Intermediary asserts that the Providers failed to establish that reasonable collection efforts were employed as required under 42 C.F.R. §413.89(e), and that the debts were actually uncollectible when claimed as worthless.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The primary issue before the Board is whether there was an absolute requirement that the Providers bill the state Medicaid program and receive a Medicaid remittance advice (RA) prior to claiming unpaid deductible and coinsurance amounts as bad debts for dual eligible beneficiaries. The Board reviewed the regulations at 42 C.F.R. §413.89(e) and the program guidance at CMS Pub. 15-1 §§308, 310, 312 and 322 that govern the recognition of Medicare bad debts. Based on its analysis of the regulations and manual instructions, the Board 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 that the debt was actually uncollectible when claimed.

CMS Pub. 15-1, §310 provides guidance on establishing reasonable collection efforts. However, the section by its own terms, is inapplicable to the determination of reasonable collection efforts for indigent patients and specifically refers to §312 for guidance as to indigent and or medically indigent patients. Section 312 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, (emphasis added) the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines. . .

The plain language of the above section establishes that Medicaid eligible beneficiaries are deemed indigent and that a provider is not required to take further steps to prove indigence. However, the language of subsections A through D of §312 is convoluted. 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 . . .

A common sense reading of this guideline suggests that it imposes a universal requirement to collect the debt from responsible third parties. That requirement appears applicable except for the use of the term "otherwise" used in the first paragraph which effectively makes subsections A through D applicable to situations other than Medicare/Medicaid dual eligible beneficiaries. Further, the duty demanded by subsection C to collect from responsible third parties still does not rise to a specific billing requirement. Nowhere does the language of the section support the

conclusion that the requirement to collect can only be established by submission of a bill and receipt of a remittance advice.

CMS Pub. 15-1, §322 addresses "Medicare Bad Debts Under State Welfare Programs." This section requires 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 §312. CMS Pub. 15-1 §322 states in pertinent part:

> 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 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 that §322 is consistent with the regulations in that it describes what constitutes a "reasonable collection effort" as that phrase is used in 42 C.F.R. §413.89(e)(2). Where a provider can bill and the state is obligated to pay, the provider must implement reasonable collection efforts to obtain payment from the state under CMS Pub. 15-1, §322. However, to read §322 as an absolute bar, regardless of the collection effort, would conflict with the statute and regulation allowing payments for Medicare bad debts. In addition, the Intermediary's standard is inconsistent with the requirements for all other payors and is inconsistent with the concept of reimbursement for bad debts, which is premised on the inability to collect, despite reasonable collection efforts, from a payor with a legal obligation.

The Intermediary argues that the requirement for a "reasonable collection effort" was not satisfied because the Joint Signature Memorandum (JSM) 370 issued following the *Monterey Peninsula* decision makes the act of billing and the receipt of a remittance advice the exclusive evidence to prove the state's obligation, or lack of obligation to pay. The Board notes that CMS' "must bill" policy as issued to intermediaries through JSM-370 dated August 10, 2004 is not an appropriate vehicle to set policy and therefore is given little weight.[19] Consequently, the Board finds the Intermediary's disallowance of bad debts based upon the JSM is inappropriate. The JSM should not be used as a means to convey new instructions or provide clarification of existing requirements to intermediaries. In those situations, changes to the manual instructions should be submitted through the formal Change Management/Change Request process.

The record shows the Providers made a concerted effort to obtain the RAs from TennCare.[20] The Providers repeatedly billed TennCare for the crossover claims. However, due to multiple problems with TennCare's electronic billing system coupled with the manual processing of crossover claims by its Intermediary, TennCare was unable to issue RAs for all the crossover

[19] The Board recognizes that a JSM is not issued to the general public. CMS states it is used by CMS to communicate internally with its contractors. It is used for the purpose of announcing a contract award; emergency alert, and/or a one-time request for information. A JSM is not to be used to convey new instructions or provide clarification of existing requirements that impact contractor operations. *See*, CMS Division of Change & Operations Management CMS/CMM/Medicare Contractor Management Group, *About Joint Signature Memorandums (JSMs) and Technical Direction Letters (TDLs)*, only available on CMS' Intranet.

[20] Providers' Exhibits P-7 and P-8; Tr. 120-236.

claims in dispute.[21] Indeed, the Intermediary acknowledged that the Providers had timely billed TennCare and that "there was a breakdown in the billing system" and the "process was not successful every time."[22] The Board finds that due to circumstances beyond the Providers' control, they were unable to obtain the RAs. The Board also finds that while a remittance advice is one source of documentary evidence used to support reasonable collection efforts, it is not the only reliable source.

As to the Providers' assertions that the "must bill" policy violates the bad debt moratorium, the Board finds no evidence that the Intermediary changed its policy. The Providers were able to obtain RAs until November 2004 when TennCare implemented a new electronic claims processing system. While there was no violation of the bad debt moratorium, the Providers had actively pursued obtaining RAs and demonstrated reasonable collection efforts in their attempt to recover the bad debts.

Given the unique circumstances in this case, the Board finds that the Providers met the requirements for a reasonable collection effort related to the dual eligible beneficiaries as required by 42 C.F.R. §413.89 and the manual instructions. The Board finds that the bad debts were actually uncollectible when the Providers 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 adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: October 22, 2010

[21] In some instances, TennCare was able to process and issue remittance advices to the Providers (*See supra* note 8).
[22] Tr. at 21, 23-25.

APPENDIX 1

Provider Name	Provider Number	FYE
Manor House of Dover Dover TN.	44-5155	12/31/2005
Laurel Manor Health Care New Tazewell, TN	44-5156	12/31/2005
Mayfield Nursing and Rehab Center Smyrna TN	44-5160	12/31/2005
Martin Health Care Facility Martin, TN	44-5249	01/31/2006
Briarcliff Health Care Center Oak Ridge, TN	44-5260	02/28/2006
Briarcliff Health Care Center Oak Ridge, TN	44-5260	08/31/2005