PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D12

PROVIDER –
Various Genesis Health Care Corporation Providers
Kennett Square, PA

Provider Nos.: See Attachment A

vs.

INTERMEDIARY -
BlueCross BlueShield Association/ Highmark Medicare Services

DATE OF HEARING -
July 29, 2009

Cost Reporting Period Ended -
December 31, 2004

CASE NOs.: 06-2376; 06-2377; 06-2378; 06-2379; 06-2381; 06-2383; 06-2385; 06-2410

INDEX

ISSUE:

Whether the Fiscal Intermediary properly adjusted the Providers' bad debts for the fiscal year ended December 31, 2004.

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 or Medicare Administrative Contractors (MAC). 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 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 - 1837.

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)(2004) 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 little likelihood of recovery at any time in the future

The procedures constituting "reasonable collection efforts" are outlined in CMS Pub. 15-1, section 310. The section incorporates CMS Pub. 15-1, section 312 for the determination of indigent 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, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:
>
> A. The patient's indigence must be determined by the provider, not by 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 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.
>
> Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures.

CMS Pub. 15-2, section 1102.3L (2003), offers implementing guidance for debt collection activities and states:

> Evidence 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 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
>
> - that nonpayment would have occurred if the crossover claim had actually been filed with Medicaid.

The dispute in this case involves the Providers' debt collection and write-off policies for its patient population including Medicaid eligible patients.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Genesis Health Care Corporation operates skilled nursing facilities (Providers) in the states of New Jersey and Pennsylvania. In fiscal 2004, Highmark Medicare Services (Intermediary)[1] disallowed the amounts claimed by the Providers' New Jersey facilities for bad debts. The Intermediary made the adjustment based upon two issues:

Issue 1: Reasonable Collection Efforts

The Providers' New Jersey facilities claimed Medicare bad debts for deductible and coinsurance amounts pursuant to the application of their collection policy. The policy states in pertinent part:

When delinquent accounts are identified:

1.3.1 Contact the responsible party….

1.3.1.1 As often as possible and, in particular, if this is the first late payment, the Administrator should make a personal or telephone contact…

1.3.1.2 A verbal commitment to pay by a certain date should be obtained from the responsible party. Results of the phone conversation should be documented on the customer's Collection Activity Log (*Forms*).

1.4 Telephone contact should be followed by a letter to the responsible party contacted to confirm the center's expectations.

1.5 When a telephone contact is not possible the Administrator should send a letter with a copy of the bill ….[2]

The Providers did not document all phone contacts and the Intermediary challenged the propriety of writing off those amounts since there was no documentation to support collection efforts. There is no dispute that 42 C.F.R. §413.89 and CMS Pub. 15-1, sections 308, 310, 312 and 322 are the controlling guidance for bad debts. The dispute centers on the application of the guidance to determine uncollectibility.

Issue 2: "Must Bill" Requirement

The Providers' New Jersey facilities also claimed Medicare bad debts for deductible and coinsurance amounts not paid by a state Medicaid program with a crossover payment prohibition

[1] The Medicare Administrative Contractor (MAC) for the states of New Jersey and Pennsylvania is now Highmark Medicare Services. During 2004, Veritus Medicare Services was the Intermediary of record for the Providers' Pennsylvania facilities and Riverbend Government Benefits Administrator serviced the Providers' New Jersey facilities.

[2] Exhibit I-20; *see also*, Provider Position Paper for PRRB Case Number 06-2385, p. 4 and Exhibit P-9. The Parties agreed that the Providers' position paper for Case Number 06-2385 was representative of the Providers' appeal position and would be used at the hearing to support the Providers' presentation. References hereinafter will be to the "Providers' Position Paper."

for patients with service dates prior to January 1, 2004. The Providers established that the patients were eligible for Medicaid at the time of service and that Medicaid would not have made a payment had the crossover claim been billed. The Providers never billed the state for the deductible and coinsurance amounts related to these patients. During the period, CMS and the Intermediary issued several notices addressing the proper treatment of crossover debts.

April 16, 2004 – Veritus Medicare Services issued Provider Notice 04-066 which stated:

> If you are a Skilled Nursing Facility and are not currently billing the state [for Medicaid patients], you should change your billing practices for discharges no later than 60 days of the date of this bulletin.[3]

July 19, 2004 – Veritus Medicare Services subsequently issued Provider Notice 04-116 which changed the implementation date to July 1, 2004.[4]

August 10, 2004 – CMS issued JSM 370 which directed that its "must bill" policy should be implemented for all cost reports beginning on or after January 1, 2004.[5]

November, 2004 – Riverbend Government Benefits Administrator issued Flash No. 04-08 in which it advised providers that for cost reporting periods covering January 1, 2004 and thereafter, Riverbend would require Medicaid remittance advices prior to allowing Medicare crossover bad debts for Medicaid patients.[6] Flash No. 04-08 indicated that Riverbend would weigh availability issues with providers who were unable to obtain the advices due to lapsed time.

Citing the above guidance, the Intermediary challenged the propriety of the Providers' write offs in the absence of proof of billing the state for each patient and the receipt of contemporaneous documentation of a payment or denial. There is no dispute that 42 C.F.R. §413.89 and CMS Pub. 15-1, sections 308, 310, 312 and 322 are the controlling guidance for bad debts. The dispute centers on the application of the guidance to determine uncollectibility.

The Providers appealed both disputes to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 -1841. The Providers were represented by W. Craig Knaup, Esquire, of W. Craig Knaup, P.C. The Intermediary was represented by Arthur E. Peabody, Esquire, of BlueCross BlueShield Association.

PARTIES' CONTENTIONS:

Issue 1: Reasonable Collection Efforts

The Providers acknowledge that they did not document all of the phone calls placed to secure debt recovery. However, the Providers argue that their policy does not require that phone calls

[3] Exhibit I-27.
[4] Exhibit I-28.
[5] Exhibit I-24.
[6] Exhibit I-25.

be documented and argues further that, in some cases, a phone call is not always possible. Further, the Providers contend that section 310 does not mandate telephone calls but, rather, states that a provider is permitted to use a collection agency in lieu of subsequent billings, follow-up letters, telephone and personal contacts. The Providers argue that they made reasonable collection efforts through their billings and the use of a collection agency consistent with section 310 and therefore satisfied the requirements of 42 C.F.R. §413.89.

The Intermediary argues that the plain language of the Providers' collection policy makes telephone calls a central part of their collection efforts and further, that the Provider's failure to make or document those calls constitutes a deviation from the reasonable collection efforts that they established for themselves. The Intermediary contends that absent such documentation, it cannot establish that reasonable collection efforts were made.

The Intermediary also contends that portions of the bad debts were written off while the accounts were pending at a collection agency. The Intermediary argues that bad debts sent to a collection agency for collection activity may not be written off and claimed as Medicare bad debts until the collection agency has concluded its activities and returned the accounts to the provider.[7]

Issue 2: "Must Bill" Requirement

The Providers contend that they had no official notice that New Jersey facilities would be subject to the "must bill" policy until Riverbend Government Benefits Administrator (Riverbend) issued Flash No. 04-08. The Providers argue that prior to the flash, only Veritus Medical Services (Veritus) gave clear instructions on the treatment of Medicare crossover bad debts with service dates prior to January 1, 2004. In its Provider Notice 04-066, Veritus advised skilled nursing facilities that were not billing the state of Pennsylvania for Medicaid patients to "change their billing practices for discharges no later than 60 days of the date of this bulletin."[8] Veritus subsequently issued Provider Notice 04-116 which set July 1, 2004 as the implementation date.[9] The Providers contend that the Veritus notices made no reference to any states other than Pennsylvania and gave no indication that the policy would apply to New Jersey. The Providers sought additional guidance from Veritus and were advised that the "must bill" policy applied to all states but that no state Medicaid program would have to be billed for any bad debts with service dates prior to July 1, 2004.[10] Nevertheless, Riverbend subsequently issued Flash No. 04-08 which announced a "must bill" policy for services provided on or after January 1, 2004. The Providers assert that they implemented Riverbend's policy and billed New Jersey Medicaid for all Medicare crossover bad debts with service dates beginning January 1, 2004. However, the New Jersey Consolidated Statutes at NJAC 10:49-7.2(d)2 mandate that patients must be billed within one year of the date that services were provided.[11] Absent a timely billing, the State will neither make the payment nor provide a remittance advice. Accordingly, the Providers contend that due to Riverbend's late notice, they could not secure the remittance advices required by the Intermediary for services provided prior to January 1, 2004.

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[7] Transcript, pp. 13-14. *See also, Battle Creek Health System v. Leavitt*, 498 F.3d 401 (6th Cir. 2007).
[8] Exhibit P-17, p. 3 and Exhibit I-27.
[9] Exhibit P-17, p. 4 and Exhibit I-28.
[10] Exhibit P-17, pp. 5, 6 and Exhibit I-29.
[11] Exhibit P-14.

The Providers argue that the amounts in dispute meet the criteria established at 42 C.F.R. §413.89 and should be reimbursed as Medicare bad debts. The Providers argue further that they verified the beneficiaries' eligibility under the New Jersey program and that under the plan the amounts outstanding would not be paid. Furthermore, their verification efforts constituted reasonable collection efforts that established no likelihood of recovery and, given that low likelihood, sound business judgment precluded further pursuit of costly, additional collection efforts.

The Providers also argue that their write-off methodology is in full compliance with the procedures constituting "reasonable collection efforts" that are presented in CMS Pub.15-1, section 312. Section 312 states: "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." Section 312(C) further 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 section concludes "once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures." The Providers contend that their individual examination of each patient's Medicaid status was a reasonable collection effort that established that Medicaid had no liability and the patient was indigent. Once indigency was determined, the Providers contend that they properly wrote off coinsurance amounts.

The Intermediary contends that the Providers' method for writing off dually eligible patients' bad debts does not constitute reasonable collections efforts as contemplated by the regulations at 42 C.F.R. §413.89(e) or the manual provisions at CMS Pub. 15-1 §308. The Providers' calculation of what the state would pay rather than submitting a bill for each patient fails to validate the requirement that "no source other than the patient would be legally responsible for the patient's medical bill."[12] The Intermediary argues further that the "must bill" policy is a reasonable reading of the regulations that has been upheld by the CMS Administrator[13] and the courts.

The Intermediary relies on the 9th Circuit's decision in *Community Hospital of Monterey Peninsula v. Thompson*, 323 F.3d 782 (9th Cir. 2003) which it asserts outlines the relevant rules of administrative law by which CMS' "must bill" policy should be analyzed. The Medicare statute authorizes the Secretary to reimburse "both direct and indirect costs of providers of services" and to promulgate regulations as to how it will be done. 42 U.S.C. § 1395x(v)(1)(A); 42 U.S.C. § 1395g(a). Utilizing this authority, the Secretary has issued a regulation setting forth criteria for the collection of bad debts. 42 C.F.R. §413.89(e). In addition, 42 C.F.R. §413.20(a) sets forth documentation requirements – a regulation requiring "sufficient financial records and statistical data for proper determination of costs payable under the program."

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[12] CMS Pub. 15-1 §312

[13] *See*, *Port Huron Hospital v. Blue Cross Blue Shield Association/ National Government Services*, CMS Administrator Decision, Oct. 14, 2008, PRRB Dec. No. 2008-D32.

The Court observed that the Secretary may fill "gaps" where authorized and such policies or procedures will be upheld unless arbitrary, capricious, or contrary to law. The Court found that CMS' "must bill" policy filled such a gap. More specifically, the Court observed that:

> When [the Secretary] makes a determination through adjudication, we will defer to that interpretation if it is not inconsistent with the statute and regulations, and is a reasonable interpretation thereof. Given that billing the state is the most straightforward and reliable way of determining whether, and, if so, how much the state will pay, we are unable to say that the "must bill" policy is inconsistent with the statute or regulations or is an unreasonable implementation of them.[14]

The Court held further that the gap CMS policy fills is fully consistent with long standing documentation requirements found in applicable regulations. 42 C.F.R. §§413.20 and 413.24.

Analyzing Manual Provisions §§ 310, 312, and 322, the Court found the Secretary's interpretation to be reasonable; namely, the provisions require reasonable collection efforts, including billing.[15] More specifically, the Court found the provisions "ambiguous" at best and, as a result, deferred to them, thereby upholding the "must bill" policy.[16]

The Intermediary also contends that the Providers received notification of the "must bill" policy in CMS' Change Request 2796, Transmittal 5, which was published on September 12, 2003.[17] The transmittal, applicable to CMS Pub. 15-2, section 1102.3L, became effective October 1, 2003. The transmittal changed the instructions to complete Exhibit 5 (Bad Debt Listing) to state the following:

> Column 4 – Indigency/Welfare Recipient – If the patient included in column 1 has been deemed indigent, place a check in this column. If the patient in column has a valid Medicaid number, also include this number in this column. See the criteria in Provider Reimbursement Manual – I sections 312 and 322 and 42 C.F.R. §413.80 for guidance on the billing requirements for indigent and welfare recipients.

Id. at 3.

Section 312 of CMS Pub. 15-1[18] 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.

Section 322 of CMS Pub. 15-1[19] states:

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[14] *Community Hospital* at 782.
[15] *Id.* at 795.
[16] *Id.* at 796.
[17] Exhibit I-21.
[18] Exhibit I-22.

> Where the State is obligated . . . 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 section 312 or, if applicable, section 310 are met.

The Intermediary contends further that Veritus' Provider Notices 04-066 and 04-116 gave adequate notice of the "must bill" policy to the Providers and cites the Providers' August 2004 request to Veritus for clarification of the policy's application to all states as evidence that the Providers knew of the policy.[20] In addition, the Intermediary argues that the Providers received further notice in August, 2004, when CMS issued JSM 370 which directed that its "must bill" policy should be implemented for all cost reports beginning on or after January 1, 2004.[21] Riverbend subsequently issued Flash No. 04-08 in November, 2004, which advised providers that for cost reporting periods covering January 1, 2004, and forward, Riverbend would require Medicaid remittance advices prior to allowing Medicare crossover bad debts.[22] Flash No. 04-08 also indicated that Riverbend would weigh availability issues with providers who were unable to obtain the advices due to lapsed time. The Providers failed to contact Riverbend with timeliness issues or alleged inability to obtain remittance advices because some of the claims contained service dates older than one year. The Intermediary argues that had the Providers acted promptly upon the receipt of any of the notices, they would have been able to secure a substantial number of the remittance advices that were necessary to substantiate their claims for bad debts.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Issue 1: Reasonable Collection Efforts

The language of the Providers' collection policy requires that telephone calls be made "as often as possible" and recognizes that there are times "when a phone call is not possible ..." The language does not impose an absolute requirement that telephone calls be made. Rather the policy requires that an attempt be made to contact the debtor. Accordingly, the Board does not consider the absence of documentation to support telephone calls fatal to the Providers' collection efforts. It is undisputed that the Providers had extensive in-house procedures in place to effect collection and that the Providers referred those debts that they could not collect through their own efforts to collection agencies. The Board considers such efforts demonstrative of reasonable collection efforts and concludes that the Intermediary's adjustments improperly eliminated those debts on the sole basis that no telephone contact documentation was available.

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[19] Exhibit I-23.
[20] Exhibit I-29.
[21] Exhibit I-24.
[22] Exhibit I-25.

The Intermediary suggested that many of the Providers' bad debts were written off while the accounts were pending at a collection agency and argues that debts sent to a collection agency cannot be written off and claimed as Medicare bad debts until the agency has concluded its collection activities.[23] The Intermediary invited further review of the issue.[24] However, the Board could find nothing in the record that indicated that the write-offs of the accounts at the collection agency were the basis for the Intermediary's adjustments, nor could the Board find any evidence identifying any such accounts. Further, the Board has consistently held that, where the Provider satisfies all four criteria of 42 C.F.R. §413.89(e), any presumptions of collectability or un-collectability are necessarily moot, and the bad debt must be reimbursed.[25] To hold otherwise would violate Medicare's prohibition on cross-subsidization by requiring a non-beneficiary (here, the Providers) to bear the cost of Medicare covered services. [42 U.S.C §1395(x)(v)(1)(A); 42 C.F.R. §413.5]. The Board concludes that the Intermediary may not properly adjust the bad debts on this basis.

Issue 2: Must Bill Requirement

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 a bill being submitted to the state. The Board examined the regulations at 42 C.F.R. §413.89 and the program guidance at CMS Pub. 15-1, sections 308, 310, 312, and 322 that govern the recognition of Medicare bad debts. The Board's examination included the newsletters and agency alerts cited by the parties in their respective presentations.

The Board finds that neither the regulation at 42 C.F.R. §413.89, nor the program guidance at CMS Pub. 15-1, section 308, contain a requirement to bill, but instead require a provider to make reasonable collections efforts and apply sound business judgment to determine if the debt is actually uncollectible. CMS Pub. 15-1, section 310 sets forth the requirements for establishing reasonable collection efforts. However, that section refers specifically to section 312 for indigent and/or medically indigent patients and, by its own terms, is inapplicable to the determination of reasonable collection efforts for indigent patients.

CMS Pub. 15-1, section 312, addresses bad debts for indigent or medically indigent patients. The section's first paragraph 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 indigence of patients to the case of the Medicare beneficiary under the following guidelines … (emphasis added).

The language of the paragraph establishes that Medicaid eligible beneficiaries are indigent and that a provider does not have to apply additional steps to prove their indigency. However, the

[23] Intermediary's Post Hearing brief, p. 4, 17.
[24] Intermediary's Post Hearing brief, p. 4-5.
[25] *See, e.g.*, Provider Reimbursement Review Board Decision 2006-D15, February 3, 2006.

language of the section is convoluted. A further reading of the guidelines included in section 312.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 Board's reading of this guideline suggests that it imposes a universal requirement to collect the debt from responsible third parties except for the use of "Otherwise" in the first paragraph. The use of "Otherwise" effectively makes the application of the guidelines applicable to patients other than dually eligible beneficiaries. Further, the duty demanded by guideline 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 uncollectibity must be established by a billing.

CMS Pub.15-1, section 322 addresses Medicare Bad Debts under State Welfare programs. The section requires that deductible and coinsurance amounts not covered by Medicaid may be claimed as Medicare bad debts if they meet the requirements of section 312. Section 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 could find no billing requirement in sections 310 or 312. Accordingly, the Board concludes that no billing requirement is imposed by either the regulations or the manual.

The Intermediary relies on its collective provider notices and CMS' Joint Signature Memorandum (JSM) 370 dated August 10, 2004, as evidence of a 'must bill" requirement effective for all periods involved in this appeal-even prior to January 1, 2004. The Intermediary did not release the JSM to the provider community until November 2004. These notices and the JSM provide the only evidence in the record that such a billing was required during the fiscal periods under appeal. The requirement, although explicit, is unsupported by an appropriate statutory or regulatory base and is, therefore, insufficient to impose an additional major requirement for reimbursement. Further, the notices and JSM clearly require that such billings be made even where they are futile and the provider can otherwise demonstrate that there is no reasonable expectation of payment. The "must bill" policy goes well beyond the requirements of the regulation and manual provisions and requires the Providers to do something that is futile and, in some cases, impossible. The Board also notes CMS itself does not consider a JSM an appropriate vehicle to set policy and states it should not be used as a means to convey new instructions or provide clarification of existing requirements to intermediaries.[26] Accordingly,

[26] 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

the Board concludes that the application of the "must bill" policy to unpaid deductibles and coinsurance amounts due from dually eligible beneficiaries is improper.

The Intermediary also relies on the 9th Circuit's decision in *Community Hospital* to argue that Congress granted the Secretary broad authority to enact regulations to implement the Medicare program. Those regulations represent the Secretary's policy, and manual provisions fill in the "gaps." In filling the gaps in a reasonable manner, the Secretary merely developed a means to determine whether, and, if so, how much Medicaid would pay through the development of reasonable requirements for documentation. The Board finds the Intermediary's reliance on *Community Hospital* to be misplaced because the Court did not deal with circumstances existing here that make billing impossible because of the Intermediary's late and misleading notices. *Community Hospital* involved a Medicaid state plan that applied a payment ceiling, which limited the amount of payment or resulted in no payment for coinsurance and deductibles. Because payments were small, the provider sought to use its own calculations showing the payment that would have been received from the state. It argued that the amounts it could potentially receive were so small they did not justify the expense of billing. The Court noted that while the existence of a ceiling might make the payment amount predictable, in many cases it would be unclear whether the state would pay and, if so, how much.[27] The Court found the Secretary was authorized to determine what supporting documentation was required, so long as it was not inconsistent with the statute and regulation, and was a reasonable implementation thereof. Under the circumstances presented in that case, the Court found that billing the state was the most straightforward and reliable way of determining whether, and, if so how much the state would pay. Therefore, it could not say the "must bill" policy was inconsistent with the statute or regulations nor was it an unreasonable implementation of them. [28] The Court was also persuaded by the fact that there was no evidence in that case that the Secretary had ever reimbursed Medicare crossover bad debts without a remittance advice (RA). The provider's requests were consistently denied. It also noted that PRRB cases had consistently denied reimbursement pursuant to the "must bill" policy.[29] There is nothing in *Community Hospital* to indicate the Court considered billing an impossibility. Under the rationale expressed by the Court, the Board is persuaded that, if these circumstances in this case had been presented, the "must bill" requirement would likely have been found not to be a reasonable implementation of the regulation and manual provisions. In addition, the evidence shows, in this case, the Secretary allowed payment for Medicare crossover bad debts without RAs under the regulation and manual provisions prior to issuance of the JSM.

Based on the foregoing, the Board finds the Intermediary's application of the bad debt collection policy to include an absolute requirement that the Providers obtain Medicaid remittance advices (RA) prior to claiming Medicare bad debts is unsupported by the applicable statute, regulations, manual provisions, and case precedent.

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alert, and/or a one-time request for information. According to CMS, 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)*, available at http://cmsnet.cms.hhs.gov/hpages/cmm/dcm/agoutjsm.htm (accessed September 2, 2009).

[27] 323 F.3d at 796.

[28] *Id* at 793.

[29] *Id* at 796.

DECISION AND ORDER:

Issue 1: Reasonable Collection Efforts

The Providers made reasonable collection efforts through their billings and the use of a collection agency consistent with section 310 and satisfy the requirements of 42 C.F.R. §413.89. The Intermediary's adjustments are reversed.

Issue 2: Must Bill Requirement

The Intermediary's absolute "must bill" policy has no foundation in law or regulation and is beyond the requirements of the regulations and manuals. Application of the "must bill" policy to outstanding deductibles and coinsurance amounts due from dually eligible beneficiaries is improper. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: December 2, 2010

Attachment A

Genesis Healthcare Corporation
Schedule of Providers Under Appeal

Case Number	Provider Name	Provider Number	FYE
06-2376	Summit Ridge	31-5038	12/31/04
06-2377	Park Place Care	31-5362	12/31/04
06-2378	Mercerville Center	31-5094	12/31/04
06-2379	Jersey Shore	31-5364	12/31/04
06-2381	Inglemoor	31-5349	12/31/04
06-2383	Holly Manor	31-5143	12/31/04
06-2385	Cranbury Care	31-5353	12/31/04
06-2410	Arbor Glen	31-5036	12/31/04