PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D6

PROVIDER –
Mountain States Health Alliance 05 Bad Debt – Passive Collection CIRP Group

Provider Nos.: 44-0176 and 44-0063

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ Cahaba Government Benefits Administrators, LLC

DATE OF HEARING -
August 1, 2011

Cost Reporting Periods Ended - June 30, 2004; June 30, 2005

CASE NO.: 08-0105GC

INDEX

ISSUE:

Whether the Intermediary's adjustments to remove Medicare bad debts from the Providers' cost reports were proper?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. The Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & 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 ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payments due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Each Provider is required to submit a cost report annually, with the reporting period based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[3] Each 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").[4] 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 receipt of the NPR.[5]

Pursuant to 42 C.F.R. § 413.89(a) (2004),[6] bad debts are deductions from revenue and are not to be included in allowable costs. In order to ensure that costs attributable to covered services furnished to Medicare beneficiaries are not borne by individuals who are not covered by the Medicare program, § 413.89(d) specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs. To be considered allowable, § 413.89(e) specifies that bad debts must meet the following criteria:

(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.

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835-1839.
[6] 42 C.F.R. § 413.89 (*see* Exhibit I-2) was redesignated from 42 C.F.R. § 413.80 pursuant to the final rule published at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

The Medicare bad debt requirements are also described in Chapter 3 of the Provider Reimbursement Manual, CMS Pub. 15, Part 1 ("PRM 15-1" or "Manual"). PRM 15-1 § 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four criteria that must be satisfied for bad debts to be reimbursable by Medicare. PRM 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.)
>
> A. Collection Agencies. —A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.
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> B. Documentation Required. —The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

PRM 15-1 § 310.2 sets forth the "Presumption of Noncollectibility." Specifically, § 310.2 states that: "[i]f after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."

The proper accounting period for recording bad debts and bad debt recoveries is addressed in 42 C.F.R. § 413.89(f):

> The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.[7]

In § 4008(c) of the Omnibus Budget Reconciliation Act of 1987,[8] Congress enacted the following noncodified statutory provision that became known as the "Bad Debt Moratorium":

> (c) CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.— In making payments to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort).

In 1988, in § 8402 of the Technical and Miscellaneous Revenue Act of 1988, Congress retroactively amended the Bad Debt Moratorium as follows:

> SEC. 8402. MAINTENANCE OF BAD DEBT COLLECTION POLICY. Effective as of the date of the enactment of the Omnibus Budget Reconciliation Act of 1987, section 4008(c) of such Act is amended by inserting after "reasonable collection effort" the following: ", including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency"[9]

In 1989, in § 6023 of the Omnibus Budget Reconciliation Act of 1989, Congress again retroactively amended the Bad Debt Moratorium as follows:

> SEC. 6023. CLARIFICATION OF CONTINUATION OF AUGUST 1987 HOSPITAL BAD DEBT RECOGNITION POLICY. (a) IN GENERAL.— Section 4008(c) of the Omnibus Budget Reconciliation Act of 1987 is amended by adding at the end the following: "The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and

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[7] *See also* PRM 15-1 §§ 314 and 316.
[8] Pub. L. No. 100-203, 101 Stat. 1330, 1330-55 (1987) (reprinted in 42 U.S.C. § 1395f note).
[9] Pub. L. No. 100-647, 102 Stat. 3342, 3798 (1988) (reprinted in 42 U.S.C. § 1395f note).

> determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.".
> (b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987.[10]

The dispute in this case involves the Intermediary's denial of bad debt claims, specifically related to the finding by the Intermediary that the Providers did not treat Medicare and non-Medicare debt collection similarly, in violation of Medicare regulations and policy located at 42 C.F.R. § 413.89(e) and PRM 15-1 § 310.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This group appeal involves Johnson City Medical Center and Indian Path Medical Center ("Providers"). Johnson City Medical Center is an acute care hospital located in Johnson City, Tennessee. Indian Path Medical Center is an acute care hospital located in Kingsport, Tennessee. Both Providers are owned by the same parent company, Mountain States Health Alliance.

In October 2007, Mountain States Health Alliance filed a request for a Common-Issue Related Party ("CIRP") appeal for each of the Providers in connection with bad debt issues for FYE 2005 and then requested a transfer of these bad debt issues from the individual appeals to the CIRP appeal.[11] The Board approved the request to establish a CIRP group appeal and the transfer of the individual appeals to this group appeal. In April, 2008, the Providers requested to transfer an additional individual appeal filed by Johnson City Medical Center for its fiscal year ("FY") 2004[12] to the CIRP appeal on the basis that the appeal presented the same bad debt issue and, therefore, such transfer was appropriate. The Board approved the request to transfer this individual appeal to the group appeal.

The Providers timely appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 – 405.1840. The Providers were represented by Gregory N. Etzel, Esq. and Krista Barnes, Esq. of King & Spalding LLP. The Intermediary was represented by James R. Grimes, Esq. of the BlueCross BlueShield Association.

PARTIES' CONTENTIONS:

The Providers contend that they satisfied all of the regulatory requirements for claiming bad debts contained in 42 C.F.R. § 413.89(e). The Providers argue that they demonstrated reasonable collection efforts through six months of in-house collection activities followed by a referral of all debts to a primary collection agency for an additional six months without regard to

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[10] Pub. L. No. 101-239, 103 Stat. 2106, 2167 (1989) (reprinted in 42 U.S.C. § 1395f note).
[11] Johnson City Medical Center – PRRB Case No. 07-2223; Indian Path Medical Center – PRRB Case No. 07-1659.
[12] PRRB Case No. 07-1583.

payor (*i.e.*, a total of 360 days of collection efforts for all Medicare and non-Medicare debts, far in excess of the CMS 120-day threshold for presuming debts are uncollectible). At the expiration of the primary collection agency period, if it was determined that there was potential for future collection, those claims were referred to a secondary collection agency (all others were returned to the provider). Therefore, the Providers contend their collection efforts went above and beyond CMS requirements.[13]

The Providers assert that the Intermediary interpretation relies solely on an isolated sentence taken from informal agency guidance (PRM 15-1 § 310) and impermissibly holds Providers to a standard of "identical" collection efforts for every stage of a provider's collection activities, rather than the "reasonable" collection efforts required by the regulations and case law interpreting those regulations. The Providers contend that they have provided ample evidence in support of their sound business judgment decision not to pursue certain bad debts (*i.e.*, all Medicare bad debts and certain non-Medicare bad debts which are not referred after applying similar criteria) at the secondary collection agency level. The Providers state that, in exercising their business judgment, they considered multiple factors, including: average account value, attributes of the Medicare population, limitations on collection/wage garnishment activities, expenses associated with pursuing debts relative to the potential recovery and comparable low collection rates.[14]

The Providers also assert that the Intermediary's interpretation is contrary to the expressed language of PRM 15-1 § 310 because the PRM specifically requires that efforts be "similar," rather than "identical." The Providers argue that the Intermediary's interpretation effectively forces collection agencies to pursue Medicare bad debts, whether or not they believe they are worthless or lack any potential for future collection. Such an interpretation exceeds the requirements of the PRM. The Providers further argue that the Intermediary's rigid interpretation requiring identical collection efforts at every stage of collection renders the third ("uncollectible") and fourth ("no likelihood of recovery") prongs of the bad debt criteria in 42 C.F.R. § 413.89(e) meaningless and also conflicts with the second ("reasonable collection efforts") prong by requiring collection efforts even when sound business judgment has established that there is no likelihood of recovery at any time in the future.[15]

The Providers also contend that the Intermediary's interpretation violates the Bad Debt Moratorium by imposing a new requirement that collection efforts for Medicare and non-Medicare bad debts be identical, without regard to the debts' value or potential for collectability. The Providers contend that an analysis of relevant cases prior to the Moratorium shows that the Secretary's policy on debt collection in place as of August 1, 1987 was to permit providers to refrain from sending Medicare accounts to outside collection agencies if doing so would be contrary to sound business judgment (*i.e.*, collection efforts could be deemed reasonable even if Medicare and non-Medicare accounts were not treated the same at every stage of collection). The Provider cites to the following four PRRB decisions to support its position on the nature of the bad debt policy that was in place prior to the Moratorium:

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[13] *See* Providers' Post Hearing Brief at 12-14.
[14] *See id.* at 5-6, 14-20; Transcript (Tr.) at 27-32, 88, 117, 130-136.
[15] *See* Providers' Post Hearing Brief at 20-25.

1. Memorial Hospital of Dodge County v. Blue Cross and Blue Shield Association, PRRB Dec. No. 86-D5 (Jan. 23, 1996), *rev'd by Administrator* (March 22, 1986).
2. Reed City Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 86-D67 (Feb. 20, 1986), *Administrator declined review* (March 31, 1986).
3. Cincinnati General Hospital v. Blue Cross Association, PRRB Dec. No. 81-D52 (May 28, 1981).
4. St. Francis Hospital and Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. 86-D21 (Nov. 12, 1985), *aff'd by Administrator* (Jan. 8, 1986).

Thus, the Providers contend that the Agency's position in 1987 was that differences in collection efforts were not determinative when a provider had otherwise performed reasonable collection efforts and sound business judgment indicated that Medicare debts should not be pursued further.[16]

The Providers claim that the case relied upon by the Intermediary, *El Centro Regional Medical Center v. Leavitt*, Case No. 07cv1182 WQH (PCL), 2008 WL5046057 (S.D. Cal. 2008)(*El Centro*), is not controlling in this matter because it is factually and legally distinguishable. The Providers state that their collection efforts are much more rigorous than those in *El Centro.* Also, the Providers contend that the record evidence, statistics, and testimony presented in this matter show that the Providers' accounts were uncollectible when claimed as worthless and that sound business judgment established that there was no likelihood of recovery in the future. Also, the Providers note that *El Centro* did not address the Bad Debt Moratorium at all. In this case, the Bad Debt Moratorium is an independent basis for reversal of the Intermediary's adjustment.[17]

Finally, the Providers contend that the Intermediary's interpretation could potentially lead to providers eliminating their outside collection activities and/or writing off bad debts at an earlier point in time and expending less effort on collection. The Intermediary's position would potentially discourage providers from utilizing outside collection agencies to potentially reduce the Medicare program's bad debt liability. That is clearly not in the interest of the Medicare program.[18]

The Intermediary contends that the adjustments that eliminated the bad debts were reasonable because, the referral of bad debts to a secondary collection agency did not result in similar collection efforts for the Medicare and non-Medicare bad debts. The non-Medicare accounts were automatically transferred from the primary collection agency to the secondary collection agency, while all the Medicare accounts were returned from the primary collection agency to the Providers and written off as Medicare bad debts. The Intermediary contends that when a collection agency is used, CMS requires providers to refer all uncollected patient charges of "like amount" to the collection agency without regard to the class of the patient.

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[16] *See id.* at 28-32.
[17] *See id.* at 32-34.
[18] *See id.* at 35.

The Intermediary also asserts that there was nothing in the record to show that similar collection efforts applied to the Medicare accounts would not result in a similar recovery. Thus, it was reasonable to expect the Providers to pursue outside collection before claiming these debts were worthless. The Intermediary argues that the Providers conceded during testimony at the hearing that, not only would the recovery rate for collection efforts at the secondary collection agency be similar for Medicare accounts, they may even be better than the recovery rate for non-Medicare accounts. Therefore, the Providers should be expected to pursue collection of the Medicare accounts as vigorously as they pursue the non-Medicare accounts.[19]

Finally, the Intermediary asserts that the evidence in this matter shows that, despite the Providers' assertions, the Providers' decision not to send Medicare accounts to the secondary collection agency had nothing to do with whether or not the accounts were worthless with no likelihood of recovery. The testimony from the Providers' witnesses at the hearing demonstrates that the real reason for the decision not to forward the Medicare accounts on to the secondary collection agency was that those Medicare accounts were not profitable for the collection agency.[20]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare laws, regulations, program instructions, the evidence presented and the parties' contentions, the Board finds the Intermediary's adjustments to remove Medicare bad debts from the Providers' cost reports were proper.

In an attempt to collect unpaid accounts, the Providers used an in-house collection process along with primary and secondary collection agencies. It is undisputed that the Providers treated Medicare accounts and non-Medicare accounts in a similar manner during in-house and primary collection agency efforts. The in-house collection efforts were expended for a period of six months and primary collection agency efforts were expended for at least another six months before being eligible for referral to the secondary collection agency. After the in-house and primary outside collection agency efforts were expended, the Providers then differentiated in their treatment of Medicare and non-Medicare accounts by not pursuing collection efforts on Medicare accounts and certain non-Medicare accounts.[21] A decision was made on a global basis not to refer Medicare accounts to a secondary collection agency because these accounts were viewed as a whole as difficult to collect. This decision was not based upon specific attributes of each individual Medicare account, as was the decision to not refer certain non-Medicare accounts to the secondary collection agency.

CMS promulgated regulations at 42 C.F.R. § 413.89(e) to specify the Medicare criteria for allowable bad debts. The criterion at issue in the case is requirement in § 413.89(e)(2) that "[t]he provider must be able to establish that reasonable collection efforts were made." In particular,

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[19] The Intermediary also argues that the CMS "like amount" language contained in PRM 15-1 § 310 relating to collection agency procedures has been unchanged since at least 1978 and, as a result, the Intermediary's interpretation is not contrary to the Bad Debt Moratorium

[20] *See* Intermediary's Post Hearing Summary at 3.

[21] The non-Medicare accounts that were not referred were described as involving bankruptcies, deceased individuals, those lacking financial ability to pay their accounts, and those deemed as charity.

this case involves the issue of how the use of collection agencies affects the reasonableness of a provider's collection efforts.

In PRM 15-1 § 310, CMS provides guidance on when collection efforts are "reasonable" and addresses the use of collections agencies. Specifically, § 310 states, in pertinent part:

> *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.)
>
> A. Collection agencies.—A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. *Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient.* The 'like amount' requirement may include uncollected charges above a specified minimum amount. *Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency.* Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.[22]

The key principle then for determining whether a provider's efforts to collect Medicare deductible and coinsurance amounts is "reasonable" is that such efforts are "similar" to the provider's efforts to collect "comparable" amounts from non-Medicare patients. As a result, the focus is on whether the provider expends "similar" efforts on "comparable amounts" regardless of patient type. In connection with the use of collection agencies, § 310 specifies that, if a provider uses a collection agency, a provider must refer all uncollected patient charges of "like amount" to the agency without regard to whether the patient is Medicare or non-Medicare.

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[22] (Emphasis added.)

During the hearing, the Providers' representative described the Providers' collection policy as follows:

1. Medicare and non-Medicare patient accounts go through an in-house collection process for the first 180 days.
2. After 180 days of in-house collection, both Medicare and non-Medicare accounts that are active (*i.e.*, uncollected and not written off) are sent to an outside collection agency and the outside collection agency pursues these debts for an additional 180 days, making follow up phone calls, letter campaigns, etc.
3. After approximately 360 days, the outside collection agency sends the active Medicare and non-Medicare patient accounts back to the Provider. The Provider writes off these Medicare patient accounts and certain categories of non-Medicare patient accounts (*e.g.*, those involving bankrupt or deceased patients). The remaining active non-Medicare patient accounts are sent to a second collection agency for additional collection efforts that primarily involve resolution through litigation.[23]

Under the Providers' collection policy, the Providers' collection efforts on Medicare and non-Medicare patient accounts are similar up until the point when only certain active non-Medicare patient accounts are referred to a second collection agency.[24] The Providers' collection policy is silent regarding the impact of the dollar value of accounts on the decision to refer debts to collection agencies.[25] The Board agrees with the Intermediary's contention that, when a collection agency is used for collection efforts, CMS requires providers to refer all uncollected patient charges of "like amount" to the collection agency without regard to class of patient.

Consistent with the Providers' policy, the record reflects that, at the end of 360 days, all active non-Medicare patient accounts were referred to the second collection agency except for accounts having certain attributes not related to the class of the patient such as bankruptcy status or death of the patient.[26] The Provider has described these excluded categories of non-Medicare accounts as "having no likelihood of future recovery."[27] The record also reflects that the Providers generally excluded all Medicare patient accounts from referral to the second collection agency.[28] The Providers justify this decision based on their global findings on Medicare accounts as a whole that: (1) the Medicare accounts in this last stage on average were considerably less than those for non-Medicare debts[29]; (2) the amounts to be collected for Medicare accounts were on

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[23] *See* Tr. at 27-32; 64-70.122-126; 131.
[24] Tr. at 64-68; Providers' Post Hearing Brief at 4-6.
[25] Upon being referred to the secondary collection agency, the agency then considered the dollar amount of the account as it "prefers to spend its time and money on high value accounts." Providers Post Hearing Brief at 18.
[26] *See* Tr. at 66-67; Intermediary Exhibit I-1.
[27] *See* Tr. at 67.
[28] *See* Tr. at 66-67; Intermediary Exhibit I-1.
[29] *See* Tr. at 88, 92-95, 117, 130-136 .

average considerably smaller than those for non-Medicare accounts[30]; and (3) the collection agency in this last phase utilized litigation techniques (*e.g.*, wage garnishments and liens on property) which tended to be difficult to use with Medicare beneficiaries.[31] Further, the Providers maintain that collection agencies generally do not want to conduct similar collection efforts on Medicare accounts.[32]

Thus, in connection with the Providers' decisions on whether to refer to the secondary collection agency, the record reflects that: (1) for delinquent non-Medicare patient accounts, the Providers made collection effort decisions based on individual attributes of the account in question (*e.g.*, bankrupt, deceased, presence of property); and (2) for delinquent Medicare accounts, the Providers made a single global decision not to refer such accounts to the secondary collection agency based on attributes believed by the Providers to generally exist across Medicare accounts as a whole. The decision not to refer Medicare accounts was based upon the Providers' conclusions that the Medicare population *on average* is retired and not gainfully employed, is not necessarily going to borrow money, is living off retirement and social security income, presents difficulty with regards to pursuing property liens and wage garnishments, and has no regard for a lower credit score.[33] The Providers' decisions not to refer Medicare accounts to the secondary collection agency resulted in collection efforts that differed based on the insurance status of payor accounts (*i.e.*, non-Medicare versus Medicare). The decision was not based on the actual documented collectability of the individual account (*e.g.*, bankrupt or deceased patient) or on a global threshold amount by which Medicare and non-Medicare accounts were referred alike (*e.g.*, referring only open Medicare and non-Medicare accounts with balances greater than $500).

While the Providers argue that the Intermediary's interpretation of reasonable collection efforts violates the Bad Debt Moratorium by imposing a new requirement that collection efforts for Medicare and non-Medicare bad debts be identical, without regard to the debts' value or potential for collectability, the Board disagrees. The Secretary's policy regarding reasonable collection efforts as outlined in the PRM 15-1 § 310 was in effect when the Bad Debt Moratorium was enacted in 1987, and has remained the same. The requirements at issue in this appeal regarding reasonable collection efforts are clearly not new law or policy.

Further, contrary to the Providers' assertions, the Board finds that the Board cases that the Providers cite to support their interpretation of the bad debt policy in effect as of August 1, 1987 are not relevant to the Bad Debt Moratorium issue. First, the *Cincinnati General Hospital, Reed City Hospital*, and *St. Francis Hospital* cases are not relevant to the Bad Debt Moratorium issue because the bad debt policy that was in effect as of August 1, 1987 was issued in January 1983[34] and these cases dealt with CMS policy that was in effect prior to this January 1983 change. In particular, these cases dealt with the pre-January 1983 CMS policy that required Medicare and non-Medicare bad debts to be treated differently once sent to a collection agency because of a prohibition against using or threatening court action to collect Medicare bad debts.[35] Second, in

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[30] *See* Tr. at 141-145; Providers' Exhibits P-17 and P-18.
[31] *See* Tr. at 131-133; Providers' Post Hearing Brief at 17.
[32] *See* Tr. at 27-29.
[33] *See* Tr. at 131-133.
[34] PRM 15-1, Transmittal No. 278 (Jan. 1983).
[35] *See also Dodge City*, Administrator decision at n.11.

connection with *Dodge County*, the Board also finds that it is not relevant because the decision was rendered in 1996 which is well after August 1, 1987 and because it is based on the *Cincinnati General Hospital, Reed City Hospital*, and *St. Francis Hospital* cases which the Board finds are not relevant.

The Board finds that the Providers' decision to treat these accounts differently did not comply with the regulatory requirement that reasonable collection efforts were made. Reasonable collection efforts of Medicare accounts are required by the PRM 15-1 § 310 to be "similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients." Further, in defining "reasonable collection effort," § 310 does not place a time limit (*e.g.*, 360 days) on the requirement for expending "similar" efforts on "comparable" amounts to the extent a provider makes a business decision to continue collection efforts.[36] There is no requirement that a collection agency be utilized to collect bad debts; however, it is required that, when a collection agency is used, the provider must refer "like amount[s] to the agency without regard to class of patient." Here, the Providers did not comply with this requirement when referring to the secondary collection agency only certain non-Medicare accounts that were outstanding 360 days or more and excluding all Medicare accounts on a global basis.

DECISION AND ORDER:

The Intermediary properly disallowed the Providers' claimed Medicare bad debts on the grounds that collections efforts were not similar for Medicare and non-Medicare debts. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Keith E. Braganza, C.P.A
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

[36] The Board recognizes that PRM 15-1 § 310.2 describes a "presumption of noncollectibility" for debts unpaid for more than 120 days. Significantly, § 310.2 is a subsection to § 310 entitled "Reasonable Collection Effort." As a result, the § 310.2 presumption must be read in the context of the second ("reasonable collection effort") prong of the bad debt criteria in 42 C.F.R. § 413.89(e). In this regard, the Board does not applied the § 310.2 presumption when the provider continues collection efforts. *See, e.g., Davie County Hosp. v. Blue Cross and Blue Shield Assoc.*, PRRB Dec. No. 84-D89 (Mar. 22, 1984) (available at CCH ¶ 33,939), *Administrator declined review* (Apr. 18, 1984).

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: MAR 04 2013

Form G: Schedule of Providers in Group

Group Name: Mountain States Health Alliance 2005 Bad Debt-Passive Collection CIRP Group

Representative: Gregory N. Etzel

Date Prepared: 11/9/10[1]

Case No. 08-0105G

Issue: Bad Debt

#	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determ.	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amt. of Reimburse-ment	F Original Case No.	G Date(s) of Add/ Transfer
1	44-0176	Indian Path Medical Center, Kingsport, Sullivan County, Tennessee	6/30/05	Riverbend GBA	9/25/06	3/20/07	176	33, 38, 53, 56	$87,404	07-1659	10/22/07
2	44-0063	Johnson City Medical Center, Johnson City, Washington County, Tennessee	6/30/04	Riverbend GBA	9/29/06	3/20/07	172	40, 44, 51, 52	$332,419	07-1583	4/7/08
3	44-0063	Johnson City Medical Center, Johnson City, Washington County, Tennessee	6/30/05	Riverbend GBA	12/11/06	6/6/07	177	23	$294,279	07-2223	10/22/07

[1] This is an amended Schedule. The original Schedule was prepared and submitted on July 30, 2008.