PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2017-D13

PROVIDER–
La Cheim Schools, Inc.

Provider Nos.: Various

vs.

MEDICARE CONTRACTOR –
Noridian Healthcare Solutions

DATE OF HEARING -
August 4, 2016

Cost Reporting Periods Ended –
June 30, 2008; June 30, 2009 and
June 30, 2010

CASE NO.: 10-1018GC

INDEX

ISSUE:

Whether the Providers can claim Medicare and Medicaid crossover bad debts for reimbursement without billing the appropriate state agency.[1]

DECISION:

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Provider Reimbursement Review Board ("Board") concludes that the Providers have met the requirement in 42 C.F.R. § 413.89 for a reasonable collection effort related to dual eligible non-QMB beneficiaries. Accordingly, the Board remands this matter back to the Medicare Contractor to pay the Providers' for their bad debts related to dual eligible non-QMB beneficiaries for the three fiscal years ending June 30, 2008, June 30, 2009, and June 30, 2010 ("FYs 2008, 2009, and 2010").

INTRODUCTION:

This group appeal involves two California Community Mental Health Centers ("CMHCs ") operating free-standing Partial Hospitalization Programs ("PHPs") that are owned and operated by La Cheim School Inc. (referred to collectively as "La Cheim" or "Providers").[2] The appeal period at issue is FYs 2008 to 2010.[3] The Medicare contractor assigned to this group appeal is Noridian Healthcare Solutions, LLC ("Medicare Contractor").

The Medicare Contractor disallowed the Providers' bad debts for FYs 2008 to 2010 for individuals who are eligible for both Medicare and Medicaid (referred to as "dual eligibles") based on the Centers for Medicare & Medicaid Services' ("CMS'") "must bill" policy. This policy requires providers to bill the relevant state Medicaid program for Medicare deductibles and copayments and receive a remittance advice ('RA") denying payment (in whole or in part) before the uncollectable amount can be reimbursed as a Medicare bad debt.[4]

La Cheim requested a hearing before the Board[5] and met all of the jurisdictional requirements.

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[1] Stipulations at ¶ 1 ((Nov. 9, 2015) ("Stipulations").

[2] Stipulations at ¶ 2.2.

[3] *See* Medicare Contractor Exhibit I-1 (Schedule of Providers).

[4] Provider's Final Position Paper at 3. On August 10, 2004, CMS issued the Joint Signature Memorandum ("JSM"), JSM-370, (copy included at Provider Exhibit P-10) to Medicare contractors to clarify and explain CMS' "must bill" policy. Specifically, JSM 370 states:

> The must bill policy states that if a patient is determined by the provider to be indigent or medically indigent, the provider does not need to attempt to collect from the patient. However, the provider must make certain that "no source other than the patient would be legally responsible for the patient's medical bill; e.g. title XIX, local welfare agency . . . ." prior to claiming the bad debts from Medicare.
>
> . . . in those instances where the state owes none or only a portion of the dual eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State Remittance Advice).

(citations omitted.)

[5] Request for Hearing Letter dated May 4, 2010.

Accordingly, the Board held a record hearing on August 4, 2016. Le Cheim was represented by William J. Petzel, Esq. and the Medicare Contractor was represented by Jerrod Olszewski, Esq. of Federal Specialized Services.

STATEMENT OF FACTS:

A. MEDICARE'S BAD DEBT POLICY

Federal regulations at 42 C.F.R. § 413.89 (e) (2009) specify the criteria that must be met for a provider to claim bad debt reimbursement on its Medicare cost report. Specifically, § 413.89 (e) states:

> (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.[6]

CMS has provided extensive guidance on its bad debt policy in the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), §§ 308, 310, 312 and 322.[7] PRM 15-1 § 308 requires that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM 15-1 § 310 states that a "reasonable collection effort" involves sending a bill on or shortly after discharge or death. However, this section by its own terms is not applicable to indigent patients and specifically refers to § 312 which allows providers to "deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined to be eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." While this language absolves the providers from taking further steps to prove the dual eligible patient indigent, subsection C of § 312 nonetheless requires providers to "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."

Finally, PRM-I § 322 states that a provider may not declare Medicare bad debt for that portion of the deductible and copayment amounts that "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" but may include the "portion of deductible or coinsurance amounts that the State is not obligated to pay" provided that the requirements of § 312 or, if applicable § 310 are met.

On August 10, 2004, CMS issued the Joint Signature Memorandum ("JSM") JSM-370 to Medicare contractors to clarify and explain its "must bill" policy that the provider must bill and obtain an RA from the relevant state Medicaid program whenever a bad debt involves a dual

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[6] *See* Medicare Contractor Exhibit I-2. Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 308 restates these requirements.
[7] For copies of the PRM sections, *see* Medicare Contractor Exhibit I-3.

eligible regardless of whether that program may owe nothing or only a portion of the dual eligible's Medicare deductible or co-payment. The Ninth Circuit in *Community Hosp. of the Monterey Peninsula v. Thompson* ("*Monterey*")[8], found CMS' must-bill policy to be a reasonable implementation of the bad debt reimbursement system and not inconsistent with the statute and regulations governing fiscal years 1989 through 1995.[9] In 2012, the federal district court in the District of Columbia upheld the agency's must bill policy but noted that a provider that was unable to bill the state Medicaid program because it could not be enrolled as a Medicaid provider was in a "Catch-22" and remanded the case back to the agency to determine whether the providers were justified in relying on CMS' prior failure to enforce the must-bill policy with respect to dual-eligible reimbursement claims from non-participating Medicaid providers.[10]

B. MEDICARE BAD DEBTS ASSOCIATED WITH STATE COST SHARING OBLIGATIONS FOR DUAL ELIGIBLES

State Medicaid agencies have a legal obligation to reimburse providers for any Medicare cost-sharing (Medicare deductibles and copayments) on behalf of poor and low-income Medicare-eligible individuals. While a state may limit payment of cost sharing amounts for most dual eligible patients,[11] a state may be obligated to pay full cost sharing amounts for patients who qualify for Medicaid as Qualified Medicare Beneficiaries ("QMBs").[12] In general, to receive Medicaid reimbursement, a provider must enroll as a Medicaid provider. Some state Medicaid agencies do not allow enrollment of certain providers (*e.g.*, CMCHs, long term care hospitals, inpatient rehabilitation facilities) and, in those situations, the providers are unable to bill the state Medicaid program for Medicare cost sharing amounts.

In the present case, La Cheim was one of those providers who could not enroll in the Medi-Cal (California's Medicaid program) because Medi-Cal did not cover PHP services provided in a CMHC and, therefore would not enroll and give La Cheim a Medi-Cal provider number.[13] As a result, La Cheim could not bill Medi-Cal for its dual eligible crossover claims and, therefore, did not receive RAs from Medi-Cal.[14] La Cheim claimed some of these deductible and co-insurance amounts on their cost reports for FYs 2008 to 2010 as "bad debts." The Medicare Contractor disallowed these dual eligible bad debts based on the CMS' "must bill" policy.[15]

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[8] 323 F.3d 782, 785 (9th Cir. 2003).

[9] However, with respect to the time under review, the Court declined to apply § 1102.3L which was added to PRM 15-2 in 1995 to allow for certain documentation as an alternative to RAs. In CMS Memorandum, JSM-370, CMS withdrew § 1102.3L and reverted back to the pre-1995 language which required providers to bill state Medicaid programs before claiming Medicare bad debt. *See* Provider Exhibit P-10.

[10] *Cove Associates Joint Venture v. Sebelius, 848 F.Supp.2d 13, 30 (D.D.C. 2012).*

[11] 42 U.S.C. § 1396a(n)(2) allows states to limit the cost-sharing amount to the Medicaid rate and "essentially pay nothing toward the dual eligibles' cost sharing if the Medicaid rate is lower than what Medicare would pay for the service."

[12] However, 42 U.S.C. §1396d(p)(3), at least for a time, required state Medicaid programs to pay cost-sharing amounts for QMBs. *See* Stipulations at ¶ 2.5.

[13] Stipulations at ¶¶ 2.3, 2.4. *see also* Provider Exhibit P-2.

[14] Stipulations at ¶¶ 2.6, 2.7.

[15] Providers' Final Position Paper at 3.

Previously HCFA[16] Region IX allowed La Cheim to claim, and be paid for dual eligible bad debts without billing the state as long as other documentary evidence could be provided.[17] This approach was outlined in a September 4, 1998 letter and was followed by La Cheim and the Medicare Contractors[18] for costs reports through FY 2007. During this period La Cheim documented its bad debts using Medi-Cal's Eligibility Verification System ("EVS") to determine both Medi-Cal eligibility and identify those individuals who may be "QMBs."[19] La Cheim removed QMBs from the list of bad debts it submitted to the Medicare Contractor.[20] Le Cheim received bad debt reimbursement through this process. Beginning in 2008, La Cheim was assigned a new Medicare Contractor. The new Medicare Contractor ignored the exception created by the September 1998 letter and simply denied all dual eligible Medicare bad debts because they were not billed to Medi-Cal.[21]

DISCUSSION, FINDINGS OF FACT AND CONCLUSION OF LAW:

The Medicare Contractor maintains the Le Cheim Providers' collection efforts do not meet the reasonable collection effort criteria for allowable bad debts stated in PRM-I §§ 308, 310 and 312(C); and 42 C.F.R. § 413.89.[22] The Medicare Contractor argues that La Cheim did not properly bill Medi-Cal and did not obtain a state RA prior to claiming the bad debt reimbursement from Medicare.[23] The Medicare Contractor argues that the state agency's refusal to issue La Cheim Medi-Cal billing numbers does not relieve La Cheim of the obligation to submit claims to Medi-Cal in order to claim bad debt reimbursement.[24] The Medicare Contractor asserts that, unless La Cheim files the related claims, Medi-Cal has no basis to determine its payment obligation under the state's approved plan and La Cheim has not met its obligation to determine third party liability.[25]

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[16] Health Care Financing Administration ("HCFA") changed its name to CMS in June 2001.

[17] *See* Providers' Exhibit P-7 (copy of the September 4, 1998 letter from HCFA (CMS) to Professional Medical Adjusters, Inc. c/o La Cheim Schools, Inc.).

CMS stated:

> [W]e believe it is reasonable to conclude that La Cheim has no means of obtaining a provider number to bill the State for the coinsurance and deductible amounts related to dually eligible patients. We will instruct the intermediary to allow the related bad debts without your billing the State. However, the following conditions apply:
> All allowed bad debts must otherwise meet the criteria as defined in Chapter 3 of the Provider Reimbursement Manual.
> For unpaid coinsurance/deductible related to dually eligible patients, the provider must fully document the Medicaid eligibility of the patients to the intermediary's satisfaction. If the provider is unable to do this, the intermediary will expect collection efforts as described in Section 310 of the Provider Reimbursement Manual.

[18] **Si**nce 1994 four different sets of Medicare Contractors including Aetna, Blue Cross, United Government Services and National Government Services allowed La Cheim dual eligible bad debts without a Medi-Cal RA as there was no mechanism to obtain such RA. *See* Providers' Appeal Request Tab 2.

[19] Providers' Final Position Paper at 2-3.

[20] *Id.* at 3.

[21] *Id.*

[22] Medicare Contractor's Supplemental Final Position Paper at 4.

[23] *Id.* at 7 -8.

[24] *Id* at 7.

[25] *Id.*

La Cheim contends that it could not bill Medi-Cal as the state did not enroll CHMCs and did not cover their PHP services.[26] In addition, La Cheim points out that it did not claim any Medi-Cal Aid Code 80 QMB patient accounts or any unmet SOC [share of costs] amounts.[27] La Cheim contends that the Medi-Cal Eligibility Verification System provides all the needed information on dual eligible patients except the amount of the state's liability on a QMB patient.[28] However, La Cheim asserts that it has omitted QMB patients in the bad debt listings so "any such remittance advice information would only be academic."[29]

The Board's review of the record shows that Medi-Cal did not allow the La Cheim Providers to enroll in the Medicaid program for the time period at issue.[30] Based on its review of similar cases, the Board is aware that La Cheim's inability to obtain RAs is similar to the two exceptions to the "must bill" policy that the Secretary recognized in a brief that she filed in connection with *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142 (N.D. Cal. Oct. 11, 2001) ("*Monterey")*. Specifically, the following excerpts from that brief describes "two unique instances where ***the Secretary*** permits providers to claim Medicare crossover bad debt without billing the State Medicaid agency"[31]

1. Community mental health centers ("CMHCs").—CMHCs "are allowed to claim Medicare crossover bad debts without billing the State agency because CMHCs cannot bill the State agency given that they are not licensed by the State and, therefore, have no Medi-Cal provider numbers."[32]

2. Institutions for mental diseases ("IMDs").—IMDs "are permitted to claim Medicare crossover bad debts without billing the State agency where the services are provided to patients aged 22-64. This is because the Medicaid statute and regulations categorically preclude payment for services provided to patient aged 22-64 in IMDs, and the state accordingly has absolutely no responsibility for the coinsurance/deductibles associated with those particular services."[33]

Accordingly, consistent with the Secretary-recognized exceptions to the "must bill" policy, the Board concludes that La Cheim's inability to obtain RAs from the Medi-Cal Program qualifies as an exception to the "must bill" policy.

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[26] Providers' Final Position Paper at 2; Stipulations at ¶¶ 2.3, 2.4.
[27] Providers' Final Position Paper at 3.
[28] *See* Providers' Final Position Paper at 1-3: Provider Exhibit P-9. La Cheim obtains key information from California's Eligibility Verification System ("EVS") related to the status of a dual eligible beneficiary including share of costs ("SOC") and special aid code 80 QMB status. The only data the provider cannot obtain is the specific amount of the State's QMB share of cost.
[29] *See* Provider's Final Position Paper at 4.
[30] *Id.* and Provider Exhibit P-2.
[31] Defendant's Memorandum in Reply to Plaintiffs' Opposition to Defendant's Motion for Summary Judgment at 9n.5, *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2001) (emphasis added). An example of prior Board decisions referencing these exceptions is *LifeCare Hosps v. Novitas Solutions, Inc.*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016), *modified by*, CMS Adm'r Dec. (Nov. 28, 2016).
[32] *Id.* (citations omitted).
[33] *Id.* (citations omitted).

In further support of this conclusion, the Board notes that La Cheim clearly was caught in the same "Catch-22" described by the D.C. District Court in *Cove Assocs. Jt. Venture v. Sebelius* ("*Cove*").[34] Like the long term care hospitals in *Cove*, La Cheim was unable to enroll in the Medi-Cal program and, accordingly, could not bill the program and obtain Medicaid RAs in compliance with Medicare's "must bill" policy. As the *Cove* Court stated, in these situations providers "are left in the untenable position of either refusing to treat dual-eligible patients or absorbing the bad debts associated with those patients."[35]

The Board recognizes that the Administrator has disagreed with the Board on this issue in two similar bad debt reimbursement cases. In both *Life Care Hospitals v. Novitas Solutions Inc.*, PRRB Decision No. 2016-D25 and *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups v. Novitas Solutions Inc.*, PRRB Decision No. 2016-D22,[36] the CMS Administrator specifically rejected the Board's determination that the excerpt from the *Monterrey* brief created an "exception" from billing a state Medicaid program and obtaining an RA for providers that could not be certified as Medicaid providers. Rather, the Administrator took the position that the reference in the *Monterrey* brief was to a very limited settlement agreement and "settlements are not admissible as evidence and would not be properly considered in the case."[37] Further the Administrator noted that, if such an exception existed, it should only be applied to non-Medicaid CMHCs located in California and not to non-Medicaid long term care hospital providers in Pennsylvania and North Carolina.[38]

The Board respectfully disagrees with the Administrator's characterization of the language from the *Monterey* brief and believes that this excerpt reflects the Secretary's policy because the Secretary made this statement in the brief without qualification and, in particular, neither cited to nor referenced any settlement agreement in that statement. Further, the Board points out that the providers in this case ***are*** CMHCs located in California. As a result, the Board finds that the "exception" identified by the Secretary can and should be applied to La Cheim.

Likewise the Administrator rejected the Board's position related to the "catch 22" situation a provider finds itself in when the state will not enroll that provider type. The Administrator in his decision stated:

> In instances where the State does not process a dual eligible claim, a Provider's remedy must be sought with the state. If a state does not have the ability to process a dual eligible beneficiary claims, for all types of Medicare providers, then the State is out of compliance with Federal statute and the state must be forced to comply. Where States are made aware of their duty and still refuse to enroll Providers for the purpose of billing and receiving

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[34] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).
[35] *Id.*
[36] Adm'r Dec. dated November 28, 2016 in *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups*, PRRB Dec. No. 2016-D22 and Adm'r Dec. dated November 28, 2016 in *Life Care Hospitals v. Novitas Solutions Inc.*, PRRB Decision No. 2016-D25.
[37] *LifeCare Hosps. v. Novitas Solutions, Inc.*, CMS Adm'r Dec. at 19 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016).
[38] *Id.* at 19-20.

> remittance advices, or otherwise refuse to process non-enrolled providers' claims, then the appropriate course would be for the Providers to take legal action with their states."[39]

However, the Board is not convinced that requiring an individual provider to take legal action against its State is a viable means for the provider to obtain Medicare bad debt reimbursement. Rather, the Board points to *Cove*, where the agency's counsel conceded "it is in a better position than the providers to ensure that the states comply with the applicable regulations of the Medicaid program."[40] The *Cove* Court was "not willing to place a stamp of judicial approval on a policy that would put non-participating providers in the position of not being paid due to the delinquency of federally-funded state programs."[41]

Finally, the Administrator in his recent decisions also rejected any determination that the Medicare contractors' past practice of allowing bad debt claims for non-Medicaid providers "constitutes an explicit or affirmative agency action on policy" stating that such an allowance could happen only because of the constraints on the Medicare contractors to timely and correctly audit undocumented claims.[42] In this case, however, the exhibits[43] demonstrate that La Cheim had an explicit exception to the "must bill" policy, as long as La Cheim could establish patients' Medicaid eligibility and demonstrate that the debt was related to Medicare deductibles and coinsurance. The Medicare Contractor does not dispute that prior Medicare contractors accepted the documentation established in the 1998 directive. The Board finds that La Cheim had received explicit agency approval and, therefore, was justified in relying on CMS' prior stated policy allowing an exception, specifically an exception to allow La Cheim, to follow its established, long-standing procedure to document patients' Medi-Cal eligibility.[44]

Given the unique circumstances of this case, the Board finds that an exception to the "must bill" policy should be applied to La Cheim. Further, regardless of the application of the exception in this case, the Board concludes that La Cheim's bad debts were uncollectible when claimed as worthless and that sound business judgment established that there was no likelihood of recovery at any time in the future. La Cheim's bad debt claims have met the requirements of the regulation, 42 C.F.R. § 413.89(e).

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[39] *Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups. v. Novitas Solutions, Inc*., CMS Adm'r Dec. at 17 (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D22 (Sept. 27, 2016). *See also LifeCare Hosps. v. Novitas Solutions, Inc.*, CMS Adm'r Dec. (Nov. 28, 2016), *modifying*, PRRB Dec. No. 2016-D25 (Sept. 28, 2016). √

[40] *Cove Assocs. Joint Venture v. Sebelius*, 848 F. Supp. 2d 13, 28 (D.D.C. 2012).

[41] *Id.*

[42] *Select Specialty* Administrator's Decision at 18.

[43] Provider Exhibit P-7.

[44] 42 U.S.C. 1396a(n)(2), (3). Section 1905(p)(3) of Social Security Act imposes a liability for cost-sharing amounts for Qualified Medicare Beneficiaries(QMB) on the States, though Section 1902(n)(2) allows the States to limit that amount to the Medicaid rate and essentially pay nothing toward dual eligibles' cost-sharing if the Medicaid rate is lower than what Medicaid would pay for the service. La Cheim's established procedure removed QMB-eligible individuals from the listing to ensure that if Medi-Cal had an existing liability to pay deductibles and copayments for these individuals, the debt was not claimed as a bad debt for Medicare cost-reporting purposes. Provider's Final Position Paper at 2-4.

DECISION AND ORDER:

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board concludes that La Cheim has met the requirement in 42 C.F.R. § 413.89 for a reasonable collection effort related to its dual eligible non-QMB beneficiaries . Accordingly, the Board remands this matter back to the Medicare Contractor to pay La Cheim for its bad debts related to dual eligible non-QMB beneficiaries for FYs 2008, 2009 and 2010.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A.
Jack Ahern, MBA, CHFP

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: March 29, 2017

APPENDIX I

Model Form G: Schedule of Providers in Group

Group Name: La Cheim School, Inc.

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Representative: William J. Petzel

Date Prepared: July 25, 2010

Case No.: 10-101-8GC

Issue: Reimbursement for Improper Adjustment of Medicare "Bad Debt"

#	Provider Number	Provider Name / Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) Add/ Transfer
1	054654	La Cheim School Richmond, Contra Costa County, CA	6/08	Palmetto GBA	11-9-09	5-11-10	183	6	90,318		
1	054656	La Cheim Adult Behaviorial Health Services, Richmond, CC County, CA	6/08	Palmetto GBA	11-9-09	5-11-10	183	6	109,558		

Model Form G: Schedule of Providers in Group

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PROVIDER REIMBURSEMENT REVIEW BOARD

Group Name: LA CHEIM SCHOOL, INC. Page 1 of 1

Representative: William J. Petzel Date Prepared: July 1, 2011

Case No.: 10-1018G.C. Issue: Reimbursement for Improper Adjustment of Medicare "Bad Debt"

#	Provider Number	Provider Name / Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
	054654	La Cheim School 2853 Groom Dr. Richmond, CA 94806	6/09	Palmetto GBA	12-27-10	6-3-11	157	4	70,130	10-1018G.C.	
	054656	La Cheim Adult Behavioral Health Services 2853 Groom Dr. Richmond, CA 94806	6/09	Palmetto GBA	12-20-10	6-3-11	164	5	79,856	10-1018G.C.	

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PROVIDER REIMBURSEMENT REVIEW BOARD

Model Form G: Schedule of Providers in Group

Group Name: LA CHEIM SCHOOL, INC.

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Representative: William J. Petzel

Date Prepared: October 12, 2011

Case No.: 10-1018 G.C.

Issue: Reimbursement for Improper Adjustment of Medicare "Bad Debt"

Provider Number	Provider Name / Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
054654	La Cheim School 2853 Groom Drive Richmond, CA 94806	6/10	Palmetto GBA	8-10-11	10-31-11	82	6	65,518	10-1018	G.C.
054656	La Cheim Adult Behavioral Health Services 2853 Groom Drive Richmond, CA 94806	6/10	Palmetto GBA	8-10-11	10-31-11	82	6	98,204	10-1018	G.C.