PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2017-D25

PROVIDER– Florida Hospital	**DATE OF HEARING** – March 17, 2016
Provider No.: 10-0007	Cost Reporting Periods Ended - 12/31/2006, 12/31/2007 and 12/31/2008
vs.	
MEDICARE CONTRACTOR – First Coast Service Options, Inc.	**CASE NOs.:** 13-1196, 13-1198 and 13-0900

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ISSUE STATEMENT:

Whether the Medicare Administrative Contractor properly disallowed a portion of the Hospital's indigent bad debts claimed for the cost reporting periods for fiscal years ("FYs") ending December 31, 2006, December 31, 2007 and December 31, 2008, on the basis that the Hospital did not adequately document patient indigence even though the Hospital obtained a signed witness patient/financial statement in accordance with the [charity] policy and with the minimum documentation requirements specified under Florida law.[1]

DECISION:

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that the Medicare Contractor properly disallowed the bad debts for all but 2 of the sampled accounts. The Provider Reimbursement Review Board ("Board") remands the FY 2007 and FY 2008 cases to the Medicare Contractor to reverse the adjustments for Patient #6 for FY 2007 and Patient #15 for FY 2008, and to recalculate the extrapolated bad debt adjustments for these years accordingly.

INTRODUCTION:

Florida Hospital ("Florida" or "Hospital") is located in Maitland, Florida. The Medicare Contractor, First Coast Service Options, Inc., disallowed the indigent bad debts for patient accounts of $1,000 or less that were claimed on the Hospital's cost reports for the years at issue because the Hospital's documentation was insufficient to determine the patient's indigence.[2]

Florida timely appealed these determinations for FYs 2006, 2007 and 2008 to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1840. The Board held a live hearing on March 17, 2016. The Hospital was represented by Stephanie Webster, Esq., and John A. Siracusa, Esq., of Akin Gump Strauss Hauer & Feld LLP. The Medicare Contractor was represented by Scott Berends, Esq., and Edward Lau, Esq., of Federal Specialized Services.

STATEMENT OF FACTS:

Florida claimed Medicare bad debts on its Medicare cost reports for FYs 2006, 2007, and 2008. The Medicare Contractor disallowed bad debts for patient accounts of $1000 or less based on the Hospital's failure to adequately document the patients' indigence. The Hospital retained only a signed Patient Financial Statement for account balances at or below $1,000. The Medicare Contractor denied the bad debts associated with these accounts asserting that the Patient Financial Statement did not sufficiently support the Hospital's indigence determination and is inconsistent with the Hospital's own charity care policy.[3] The Hospital disagrees.

[1] Hearing Transcript ("Tr.") at 5-6.
[2] Stipulations at ¶¶ 17, 18, and 20.
[3] It should be noted that the Medicare Contractor signed a stipulations of fact where they agreed that the Hospital did follow its own policy. See Parties' Stipulations ¶15. However, during the live hearing the Medicare Contractor explained that "we have stipulated that the Hospital complied with its charity policy. The issue though … is about lack of documentation, not about whether or not they complied with their policy." Tr. at 49.

The Hospital states that its charity care policy required its patients to submit a minimum of one out of the eight possible documentation items, which was similar to the Florida Agency for Health Care Administration[4] ("AHCA") guideline for documentation.[5] If the debt was $1,000 or less, consistent with its Charity Care Policy, the Hospital's Finance Review Committee reviewed "all available information presented" regarding the patient, including, but not limited to, the financial information reported by the patient on the Patient Financial Statement and credit report information.[6] Based on this review, the Finance Review Committee made a determination regarding each patient's eligibility for charity care prior to write-off.[7]

Florida points out that the Medicare Contractor stipulated to the fact that Florida followed its Charity Care Policy.[8] Florida contends that its customary methods of determining patient indigence and supporting documentation fully satisfied all applicable Medicare bad debt rules.

The Medicare Contractor argues that Florida failed to maintain records relating to its determination of indigence that were necessary for the Contractor to properly audit its bad debts as claimed on the cost reports. While it acknowledges that the Hospital maintained the Patient Financial Statements for each indigent bad debt write-off, it did not maintain the credit report or other documentation for these patients so that the Medicare Contractor could not properly audit the Hospital's indigence determinations as required by federal regulations.[9]

The Medicare Contractor points out that 42 CFR § 413.24 requires a Hospital to submit adequate cost data capable of verification by an auditor. The Medicare Contractor states it is not questioning or circumventing the Hospital's indigence determinations. Rather the Medicare Contractor asserts the issue is in this appeal is the Hospital's failure to retain the documents that support the Hospital's indigent determinations. This documentation is required under the Hospital's own internal charity care policy and is necessary for the Medicare Contractor to perform a CMS compliant audit.[10]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The regulations governing bad debt are located at 42 C.F.R. § 413.89 (2004).[11] Subsection (a) states the general rule that bad debts are deductions from revenue and are not to be included in allowable costs. However, in order to ensure that costs attributable to covered services furnished

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[4] The AHCA was statutorily created by Chapter 20, Florida Statutes as the chief health policy and planning entity for the state. It is primarily responsible for the state's estimated Medicaid program, the licensure of the state's health care facilities and the sharing of health care data through the Florida Center for Health Information and Policy Analysis. See http://ahca.myflorida.com/Inside_AHCA/index.shtml.
[5] *See* Provider's Post-Hearing brief at 9.
[6] *Id.* at 10-12.
[7] *Id.* at 12.
[8] Parties Stipulations ¶15. Also see *Tr.* at 50-51 where the Medicare Contractor explained that "for purposes of the hearing we can assume that they did follow it, but they have failed to support that following to the auditors."
[9] Provider's Post Hearing Brief at 13-16; Stipulations at 17, 18, and 20; and Medicare Contractor's Post Hearing Brief at 4-5.
[10] Medicare Contractor's Post Hearing Brief at 6-7.
[11] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

to Medicare beneficiaries are not borne by individuals who are not covered by the Medicare program, subsection (d) specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs. Bad debts must meet the following criteria specified in subsection (e) to be considered allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
(2) The Hospital must be able to establish that reasonable collection efforts were made.
(3) The debt was actually uncollectible when claimed as worthless.
(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

CMS has provided extensive guidance on its bad debt policy in the Hospital Reimbursement, Manual, CMS Pub. No. 15-1 ("PRM 15-1"), §§ 308, 310, 312 and 322. PRM 15-1 § 308 requires that the Hospital make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM 15-1 § 310 requires that a provider undertake a "reasonable collection effort" unless it determines that a patient is indigent. PRM 15-1 § 312 allows a hospital to "deem" a Medicare beneficiary indigent if the individual has been determined eligible for Medicaid. However, if he/she cannot be deemed indigent, the Hospital should apply its customary methods for determining the indigence of Medicare patients using the following guidelines:

A. The patient's indigence must be determined by the Hospital, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

B. The Hospital 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 Hospital should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

C. The Hospital 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.[12]

[12](emphasis added).

In addition, federal regulations, 42 C.F.R. §413.20(d)(1) and 42 C.F.R.§413.24(c) require that auditable, verifiable documentation that assures proper payment by the program be made available for review.

42 C.F.R. §413.20(d)(1) requires that a hospital "furnish such information to the intermediary as may be necessary (i) to assure proper payment by the program . . . (ii) to receive program payments, and (iii) to satisfy program overpayment determinations."

42 C.F.R. §413.24 (c) requires that adequate cost information must obtained from the Hospital's records and that this data be capable of being audited as is consistent with good business concepts and effective and efficient management of any organization.

The Board reviewed the Hospital's charity guidelines and finds that this policy requires Hospital staff were to "[a]ssemble all available financial documents (Financial form, Proof of Income, Credit report, Property Check) and scan into PC prior to presenting account(s) to Financial Review Committee.[13] This policy also requires Florida's Finance Review Committee to determine charity care based on a review of one AHCA document plus a credit report.[14]

The Board's finds that there is evidence in the record to conclude that the Patient Financial Statement was consistently submitted to, and reviewed by, the Financial Review Committee to make indigent determinations. These documents were provided to the Medicare Contractor in its review of the Hospital's indigent determinations for the fiscal years in these cases. [15] However, the Board finds there is insufficient evidence to conclude that Florida consistently used credit reports in making these determinations as this information was not provided to the Medicare Contractor during its audit or included in the record on appeal for these cases. The Board notes that although Florida stated "credit reports were contemporaneously requested via batch processing using Equifax for the indigent patients whose accounts are at issue in this appeal"[16] the record only contains credit reports for patient #6 for FY 2007[17] and for Patient #15 for FY 2008.[18]

The Board finds that Medicare regulations at 42 C.F.R. §413.20(d)(1) and 42 C.F.R.§413.24(c) require that Hospitals supply adequate information, capable of being audited, in order to receive Medicare payment. As Florida did not supply the Medicare Contractor with all the credit reports the Hospital's charity guidelines required,[19] the Board concludes, with the exception of Patients # 6 for FY 2007 and Patient #15 for FY 2008, the Medicare Contractor's disallowance of bad debts due to lack of supporting documentation was proper.

Accordingly, the Board reverses the $271.47 bad debt disallowance pertaining to Patient #6 for 2007 and the $744.00 bad debt disallowance pertaining to Patient #15 for 2008, as sufficient

[13] Provider's Consolidated Position Paper; Exhibit P-1 at 4.
[14] Provider's Consolidated Position Paper; Exhibit P-1 at 2.
[15] Stipulations at 17, 18 and 20.
[16] Provider's Post Hearing Brief; Exhibit P-12.
[17] Provider's Post-hearing brief at 25 and Exhibits P-7 and P-13.
[18] Provider's Post-hearing brief at 26 and Exhibits P-9 and P-14.
[19] Provider's Post Hearing Brief; Exhibit P-1 at 2.

documentation was submitted for these patients.[20] The Board confirms the Medicare Contractor's bad debt disallowance for the remainder of the sampled accounts, as documentation required by Florida's own charity guidelines was not submitted. The Board remands the FY 2007 and FY 2008 cases to the Medicare Contractor to recalculate the extrapolated bad debt adjustments based on these findings.

DECISION:

After considering the Medicare law and regulations, the parties' contentions, and the evidence submitted, the Board finds that the Medicare Contractor properly disallowed the bad debts for all but 2 of the sampled accounts. The Board remands the FY 2007 and FY 2008 cases to the Medicare Contractor to reverse the bad debt adjustment for Patient #6 for FY 2007 and Patient #15 for FY 2008, and to recalculate the extrapolated bad debt adjustments for these years accordingly.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Charlotte F. Benson CPA
Jack Ahern, M.B.A.

FOR THE BOARD:

/s/
L. Sue Andersen, Esq
Chairman

DATE: September 7, 2017

[20] See Stipulations at 18 and 20 stating the Patient Financial Statements were submitted and Exhibits P-13 and P-14 for credit reports.