PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D45

PROVIDER -
Faxton-St. Luke's Healthcare

Provider No.: 33-0044

vs.

MEDICARE CONTRACTOR –
National Government Services, Inc.

HEARING DATE –
May 25, 2017

Cost Reporting Period Ended –
December 31, 2007

CASE NO.: 13-0489

INDEX

ISSUE STATEMENT:

The Provider contends that the disallowance of the bad debts claimed is not in accordance with the Medicare regulations and manual provisions as described in Centers for Medicare & Medicaid Services' ("CMS") Provider Reimbursement Manual ("PRM"), CMS Pub. 15-1 §§ 310 and 312. The Medicare Contractor has disallowed all bad debt claims for patients deemed indigent.[1]

DECISION:

After considering Medicare law and regulations, manual provisions, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that the Medicare Contractor erred in disallowing all indigent bad debts based on decisions in prior cost reporting years, rather than performing an audit of the current year. The Board remands this matter back to the Medicare Contractor to select a sample of the indigent bad debts at issue in this appeal and request the necessary documentation from the Provider. The Board directs the Provider to submit documentation for the sampled bad debts, and orders the Medicare Contractor to audit that documentation to determine the amount payable under Medicare regulations and policy.

INTRODUCTION:

Faxton-St. Luke's Healthcare ("Faxton-St. Luke's" or the "Provider"), is a not-for-profit acute care hospital located in Utica, NY. National Government Services (the "Medicare Contractor") disallowed all indigent bad debts on the Provider's fiscal year ending ("FYE") 2007 cost report.

The Provider timely filed its appeal from its Notice of Program Reimbursement and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-1840. Accordingly, the Board held a hearing on May 25, 2017. The Provider was represented by its Director of Reimbursement, Richard Martin. The Medicare Contractor was represented by John Hamada, Esq. and Edward Lau, Esq. of Federal Specialized Services.

STATEMENT OF FACTS:

Faxton-St. Luke's claimed Medicare bad debts for indigent patients on its 2007 cost report. The Medicare Contractor disallowed these bad debts because the Provider failed to provide documentation to support its determination that the patients were indigent.[2] Previously, the Medicare Contractor audited the Provider's 2004 and 2005 cost reports and disallowed the indigent bad debts on those cost reports because the Provider did not take into account all assets, liabilities, expenses, and income when determining a patient's indigence.[3] The Provider

[1] Transcript ("Tr.") at 5-6.
[2] Medicare Contractor's Post Hearing Brief at 1.
[3] *Id.* at 2. *See also* Provider's Final Position Paper, Exhibit P-5 at 1.

appealed these earlier determinations to the Board[4] and the Administrator upheld the Medicare Contractor's determinations.[5]

The regulations governing bad debt are located at 42 C.F.R. § 413.89 (2006).[6] 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 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 provider must be able to establish that reasonable collection efforts were made.
(3) The debt was actually uncollectible when claimed as worthless.
(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

CMS has provided extensive guidance on its bad debt policy in PRM 15-1 §§ 308, 310, 312, and 322. PRM 15-1 § 308 requires that a provider 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 provider to "deem" a Medicare beneficiary indigent if the individual has been determined eligible for Medicaid. However, if he/she cannot be deemed indigent, the provider 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 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 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;

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[4] *Faxton-St. Luke's Healthcare v. Nat'l Gov't Servs., Inc.*, PRRB Dec. No. 2015-D25 at 2 (Sept. 22, 2015), *available at* Medicare Contractor's Final Position Paper, Exhibit I-10.

[5] The Board found that the Provider's indigency determinations did not violate the requirements set forth in § 312 of the PRM and concluded that the Medicare Contractor's adjustment to remove the bad debts related to indigent patients should be reversed. The CMS Administrator reviewed and reversed the Board's decision regarding indigent bad debts, finding that the Provider did not meet the criteria set forth in the PRM for establishing indigency and did not meet its own requirements, therefore, the Medicare Contractor was correct to disallow those costs on the Provider's cost reports.

[6] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

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.*[7]

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. At the time of the hearing for FYE 2007, the Provider had not submitted, and the Medicare Contractor had not audited, the Provider's documentation for the 2007 indigent bad debts at issue in this case.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW:

The Medicare Contractor states that it told the Provider to resubmit its 2007 bad debts in accordance with the June 24, 2008 management letter which informed the Provider it must take into account the beneficiary's assets when determining indigence.[8] This is evidenced by a September 24, 2008 email to the Provider that contained an official request that the Provider review its 2007 cost report filing and "either resubmit or justify the rational for not re-submitting" its bad debts by November 26, 2008.[9] Additionally, on February 18, 2009 the Medicare Contractor sent the Provider a letter stating that the Medicare Contractor was performing a desk review for the 2007 cost reporting period and that additional documentation was to be submitted by March 12, 2009.[10] Finally, the Medicare Contractor points out it sent a letter to the Provider dated April 27, 2009, which included a copy of the preliminary adjustment report for 2007, and instructed the Provider to submit documentation for any issues it had with the preliminary adjustments.[11]

The Provider's witness testified that based on communications with the Medicare Contractor, he believed all of the Provider's 2007 bad debts for indigent patients would be disallowed because the Provider had not changed its charity care policy since the final determinations for the 2004 and 2005 cost reports.[12] The witness testified the Medicare Contractor selected a sample of the 2007 claimed bad debts for non-indigent patients and requested documentation in order to audit those claims but purposely did not include any bad debt claims for indigent patients in that sample. The Provider asserts that the Medicare Contractor simply denied all the 2007 bad debts for indigent patients based on the 2005 findings, without performing an audit to determine if the Provider's 2007 documentation was sufficient.[13]

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[7] PRM 15-1 § 312 (emphasis added).
[8] Medicare Contractor's Final Position Paper, Exhibit I-2 at 4.
[9] *Id.* at 1.
[10] *Id.* at 7-8.
[11] Medicare Contractor's Final Position Paper, Exhibit I-3; *see also* Provider's Final Position Paper, Exhibit P-5.
[12] Tr. at 27.
[13] *Id.* at 21.

Faxton-St. Luke's disagrees that all of its 2007 bad debts for indigent patients should be denied because the Provider was aware of the earlier issue with its indigent bad debts and changed its training to obtain everything in its policy. The witness believes if the Medicare Contactor "had audited the 2007 indigent claims, they would find that we have adequate documentation."[14]

The Board's review of the record indicates that the Medicare Contractor's denial of the indigent bad debts was due to lack of documentation.[15] However, the Medicare Contractor never selected a sample, requested documentation, or performed an audit prior to proposing an adjustment to disallow the indigent bad debts under appeal. Rather, it appears that the Medicare Contractor proposed an adjustment disallowing all the indigent bad debts based on prior year audit findings[16] and then expected the Provider, if it disagreed with the proposed adjustment, to submit documentation for all the accounts disallowed in the proposed adjustment.[17]

The Board points out the Medicare Financial Management Manual, CMS Pub. 100-06, Chapter 8 - Contractor Procedures for Provider Audits § 20.3 states:

> If you do not have all the information necessary to make an adjustment but it appears that an adjustment is required, request the information from the provider before making the adjustment. For example, do not prepare an adjustment if the provider claimed bad debts for Medicare deductible and coinsurance sooner than 120 days from the date of the first bill without first obtaining information necessary to establish that the patient is not indigent.
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> Be considerate of the amount of information you request.

In this case, the Board finds the Medicare Contractor did not follow the Medicare Financial Management Manual, Chapter 8 § 20.3. Instead, the Medicare Contractor proposed an adjustment without audit and expected the Provider to respond by submitting documentation for all of the 535 indigent bad debt accounts that were denied. The Provider estimates documentation for all 535 denied accounts would be more than 8,000 sheets of paper.[18] The Board finds that based on Chapter 8 § 20.3, the Medicare Contractor should have requested documentation for a sample of the indigent bad debts and audited that sample.

The Board notes that 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 and PRM 15-1 § 312 (D) states "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." Therefore, the Board finds the Provider must

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[14] *Id.* at 22 and 50.
[15] *Id.* at 35-36, 160-61.
[16] *Id.* at 183.
[17] *Id.* at 173-74.
[18] Provider's Post Hearing Brief at unnumbered page 2.

submit documentation, if requested, in order for the Medicare Contractor to perform the necessary audit work to determine the amount payable under Medicare regulations and policy.[19]

DECISION:

After considering Medicare law and regulations, manual provisions, arguments presented, and the evidence admitted, the Board finds that the Medicare Contractor erred in disallowing all indigent bad debts based on decisions in prior cost reporting years, rather than performing an audit of the current year. The Board remands this matter back to the Medicare Contractor to select a sample of the indigent bad debts at issue in this appeal and request the necessary documentation from the Provider. The Board directs the Provider to submit documentation for the sampled bad debts, and orders the Medicare Contractor to audit that documentation to determine the amount payable under Medicare regulations and policy.

BOARD MEMBERS:

Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD:

/s/
Charlotte F. Benson, CPA
Board Member

DATE: July 31, 2018

[19] 42 C.F.R. § 413.89 and PRM 15-1 § 312.