

**PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION**

ON-THE-RECORD
99-D71

PROVIDER -
Methodist Hospital Of McKenzie
McKenzie, Tennessee

DATE OF HEARING-
September 2, 1999

Provider No. 44-0182

Cost Reporting Period Ended -
December 31, 1992

vs.

INTERMEDIARY -
Riverbank Government Benefits
Administrator

CASE NO. 96-1086

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ISSUES:

- (1) Was the Intermediary's adjustment disallowing Medicare reimbursement for a portion of the Provider's bad debts proper?
- (2) Was the Intermediary's reclassification of home health agency costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Methodist Hospital of McKenzie ("Provider") is a 25-bed hospital located in McKenzie, Tennessee. The Hospital is one of several hospitals and other providers which are members of the Methodist Health System, headquartered in Memphis, Tennessee. On September 8, 1995, Riverbank Government Benefits Administrator ("Intermediary") issued a Notice of Program Reimbursement ("NPR") for the Provider's fiscal year ending December 31, 1992. In Audit Adjustment No. 30, the Intermediary disallowed payment for \$6,916 of the \$91,644 in Medicare bad debts claimed by the Provider. The Medicare reimbursement effect of this adjustment is approximately \$7,000.¹ In Audit Adjustment Nos. 3 and 9, the Intermediary reclassified costs for a home health billing clerk from the home health cost center to the Hospital A&G cost center. The Medicare reimbursement effect of these adjustments is approximately \$16,000.² On March 4, 1996, the Provider filed a timely appeal of these issues with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Provider is represented by Mary Susan Philp, Esq., of Powers, Pyles, Sutter & Verville, P.C. The Intermediary is represented by Bernard M. Talbert, Esq., of the Blue Cross and Blue Shield Association.

Issue No. 1-Bad Debts:Facts:

During the cost reporting period under appeal, the Provider segregated its Medicare bad debts into two groups. The group of bad debt amounts which were identified as Medicare/Medicaid crossover patients were not subjected to a review for reasonable collection efforts or uncollectibility because patients who qualify for Medicaid are considered to be medically indigent by the Medicare Program. Due to this fact, only the group of bad debts which are not categorized as Medicare/Medicaid crossovers were reviewed by the Intermediary to determine if the 120 day rule was met. These non-

¹ Provider Position Paper at 2. Intermediary Position Paper at 2 indicates that the reimbursement effect of this adjustment is \$9,334. See Intermediary Exhibit I-1. Pg. 5.

² Provider Position Paper at 2. Intermediary Position Paper at 2 indicates that the reimbursement effect of this adjustment is \$14,000.

crossover bad debts are referenced in the Intermediary workpapers as "Medicare Part A Bad Debts." See Intermediary Exhibit I-1, Provider Exhibit 3.

In making the determination that the bad debt amounts in question were not allowable, the Intermediary examined the entire population of "Medicare Part A Bad Debts." According to the Intermediary, the adjustment was not made on the basis of an error rate. A total of \$9,334 of Medicare Part A bad debts was excluded due to the Provider writing off these claims prior to the application of the 120 day rule.³

The Provider adopted a bad debt collection policy on November 5, 1987 which applied to all system hospitals.⁴ On October 19, 1992, the Provider revised this policy to explicitly state that there is no presumption that a bill is uncollectible before 120 days from the date that the Hospital mails its first bill. The policy states that "[f]or these debts, the Hospital must be prepared to demonstrate that the debt was 'actually uncollectible.'"⁵

The Provider's bad debt collection policy requires it to issue a bill shortly after discharge or death of the patient.⁶ The policy also requires additional collection efforts, including subsequent billings, letters, telephone calls and personal contacts. Id. The collection effort must be a genuine, rather than a token effort and may include using, or threatening to use, court action. Id. The policy also states that the Provider may use a collection agency. Id. In addition, the collection procedures are identical for Medicare and non-Medicare patients. Id.

PROVIDER'S CONTENTIONS:

The Provider's primary contention is that its bad debt collection efforts were reasonable and complied with Medicare requirements. The Provider points out that the Medicare regulations require that the following criteria be met before bad debts are 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 Intermediary Position Paper at 4. See also Intermediary Exhibit 1 for copy of audit workpaper and applicable portion of adjustment report.

⁴ See Provider Exhibit 1.

⁵ See pg. 3 of Provider Exhibit 2.

⁶ See Provider Exhibits 1 and 2.

(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.

42 C.F.R. § 413.80(e)

In addition, the Provider acknowledges that the program instructions state that a provider may deem a debt to be uncollectible if, after the provider makes reasonable and customary attempts to collect the debt, the debt remains unpaid more than 120 days after the first bill is mailed to the beneficiary. HCFA Pub. 15-1 § 310.2.

The Provider contends that the sole basis for the disallowance of a portion of its Medicare bad debts was the Intermediary's determination that the bad debts were not allowable because the Provider had written off the debt in less than 120 days. The Provider rejects this argument, contending that it is met all the requirements of 42 C.F.R. § 413.80(e). The Provider contends that its collection policies included sending at least four statements to the beneficiary, as well as making telephone calls and personal contacts. The Provider argues that it was only after all of these actions were taken that it made an internal entry on its books to write off the debt. Accordingly, the Provider believes that it has met the last three regulatory requirements under 42 C.F.R. § 413.80(e) to claim the bad debts. The debt collection efforts were reasonable, the debt was actually uncollectible, and sound business judgment established that there was no likelihood of recovery at any time in the future. Therefore, the Provider feels its bad debts are allowable.

The Provider points out that the Intermediary offered the same reason for disallowing each of the bad debt claims -- i.e., the Provider wrote off the debt in less than 120 days.⁷ The Provider contends, however, that the Intermediary made errors in its analysis, as well as misinterpreted and misapplied Medicare requirements regarding the presumption of noncollectibility of bad debts. The Provider refers to several examples in its supplemental position paper where the Intermediary made errors in calculating the number of days between the "first bill date" and the date the account was "written-off."⁸ The Provider contends that when it tried to resolve the "errors", the Intermediary refused to recognize the bad debts associated with the purported errors contending that the "first bill date" should not be used for purposes of applying the 120-day rule because no demand for payment was made. The Provider contends that the Intermediary has cited absolutely no authority for this position. The Provider further contends that it cannot be disputed that in each case a statement was sent to the patient on the date in

⁷ The Intermediary's bad debt audit adjustments workpapers are included at Provider Exhibit 3.

⁸ See Provider Supplemental Position Paper at pgs. 1-3.

question, which is denoted on the statement as the "billing date."⁹ Thus, the Provider contends that the Intermediary has no basis for disallowing its bad debts as to these particular patients.

The Provider argues that HCFA Pub. 15-1 § 310.2 does not mandate the length of time in which a provider must engage in active collection efforts; it merely states that a claim is presumed uncollectible 120 days from the date the first bill is mailed.¹⁰ It is the Provider's position that the intent of § 310.2 is clearly signaled by its title "Presumption of Noncollectibility." (Emphasis added.) The Provider contends the intent is made absolutely clear by the provision's use of the words "may be deemed." (Emphasis added.) The Provider cites several court cases that have consistently construed the word "deemed" as establishing a "conclusive presumption." See, e.g., Ohio Power Co. v. FERC, 880 F.2d 1400, 1413 (D.C. Cir. 1989) (Mikva, J. concurring), H.P. Coffee Co. v. Reconstruction Finance Corp., 215 F.2d 818, 822 (Emer. Ct. App. 1954), Gulf Oil Corp. v. Heath, 255 Ark. 604, 501 S.W.2d 787, 789-790 (1973). Thus, by using the words "may be deemed," HCFA Pub. 15-1 § 310.2 establishes a conclusive presumption that a Medicare debt is uncollectible if it remains unpaid more than 120 days after issuance of the first bill. The Provider closes this portion of its argument by asserting that a Medicare provider that has made "reasonable and customary" collection efforts may properly rely on that conclusive presumption to claim reimbursement for a Medicare bad debt.¹¹

The Provider continues its argument by explaining that the problem may be a misunderstanding caused by the term "write-off." The term "write-off" suggests that a hospital expunges the account from its files or notifies the patient that the debt is forgiven. However, the Provider contends that it has never taken any such action with respect to its accounts either before or after the 120-day period. The only thing that the Provider did was, in some cases, discontinue its own active collection efforts before the passage of 120 days.¹² The Provider asserts that the write-off was strictly an internal act that was not communicated to either the patient or the Medicare program and constituted neither forgiveness of the debt nor a claim for Medicare reimbursement. Id. The Provider further asserts that it retained a record of the account and did not claim the account as a Medicare "bad debt" until long after expiration of the 120-day "deeming" period in § 310.2.

The Provider cites numerous Board and HCFA Administrator decisions in its position paper that support its contention that HCFA Pub. 15-1 § 310.2 provides a presumption of noncollectibility only and that a provider may write off bad debts in less than 120 days if it demonstrates that its collection

⁹ See Provider Exhibit 9.

¹⁰ Provider Position Paper at 6.

¹¹ Id. At 7.

¹² Provider Position Paper at 7.

efforts were reasonable.¹³ Lourdes Hospital v. AdminiStar of Kentucky, PRRB Dec. Nos. 95-D58, 95-D59, 95-D60, August 31, 1995, Medicare & Medicaid Guide (CCH) ¶43,585; HCFA Adm. October 25, 1995, Medicare & Medicaid Guide (CCH) ¶43,723 , King's Daughters' Hospital v. Blue Cross and Blue Shield of Kentucky, PRRB Dec. No. 91-D5, November 14, 1990, Medicare & Medicaid Guide (CCH) ¶38,950,, Scotland Memorial Hospital v. Blue Cross and Blue Shield Association of North Carolina, PRRB Dec. No. 84-D174, September 18, 1984 Medicare & Medicaid Guide (CCH) ¶34,225,, HCFA Adm. Dec., November 8, 1984, Medicare & Medicaid Guide (CCH) ¶34,410.

The Provider also explains that its cost report, in which it claims Medicare bad debts, is customarily filed 3 months after the fiscal year end. Therefore, any bad debts it claims have been outstanding at least 90 days of the 120 day “deeming period” in § 310.2.¹⁴ The Provider contends that the Intermediary improperly disallowed its bad debt claims. The Provider asserts that it made reasonable collection efforts which demonstrated that the claims were worthless, and sound business judgment established that there was no likelihood of recovery at any time in the near future. The Provider, therefore, contends that it was not required to wait 120 days before ceasing its internal collection efforts and its bad debt claims are proper.

The Provider also argues that a statutory moratorium on changes in bad debt collection policy precludes the Intermediary’s disallowance.¹⁵ The Provider points out that Congress has prohibited HCFA and its fiscal intermediaries from making changes in bad debt policies which were in effect on August 1, 1987. See Omnibus Budget Reconciliation Act of 1987 ("OBRA-87"), Pub. L. No. 100-203, 4008(c). The Provider contends that by making audit adjustments to its bad debt claims related to the 120-day rule, the Intermediary has violated the statutory moratorium on changes to bad debt policies. The Provider points out that prior to August 1, 1987, its bad debt claims had not been disallowed for reasons related to the 120-day presumption.¹⁶ Therefore, the Provider contends that the Intermediary's disallowance of its bad debt claims is a change in its audit practices and a violation of Congress' moratorium against these changes. See Harris County Hospital District v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 43,621 (5 th Cir. 1995).

INTERMEDIARY’S CONTENTIONS:

It is the Intermediary’s position that in order for bad debts to be reimbursable by the Medicare program, four major criteria must be met. Those criteria, as outlined in 42 C.F.R. §413.80(e), state:

¹³ Id. at pgs. 8-10.

¹⁴ See Fn. 2 at Provider Position at 8.

¹⁵ Provider Position Paper at 11.

¹⁶ Provider Position Paper at 13.

- (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.

42 C.F.R. §413.80(e).

The Intermediary notes that Medicare bad debts did not vary significantly over the prior year, therefore, testing was not performed to verify the deductible. As a result, the Intermediary does not consider the first criterion listed above to be an issue in this case. It is the Intermediary's position that the remaining three criteria set forth above are closely related to each other.

The Intermediary argues that determination that a debt is worthless includes a judgment regarding the likelihood of future recovery as well as the obvious prerequisite that reasonable collection efforts were made. In the current case, the Intermediary asserts that the Provider's collection efforts appear to be inconsistent among the population of Medicare bad debts. The Intermediary points out that 17 of the total of 32 bad debt items were not written off until after the 120 day period.¹⁷ However, the Intermediary contends that the Provider made no effort to document how the 15 exceptions (i.e. write-off in less than 120 days) to the 120 day rule would be allowable. The Intermediary notes that a patient who died without an estate would be an example of an exception to the 120 day rule and therefore qualify for an immediate write-off.

The Intermediary refers to the program instructions found in the Provider Reimbursement Manual, (HCFA Pub. 15-1) § 310.2 which states:

[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.

Id.

Based on the above program instruction, the Intermediary asserts it has the authority to presume that a debt is uncollectible after 120 days of reasonable collection efforts. If the debt is written off sooner, the Intermediary contends that it has the responsibility to examine the Provider's documentation to

¹⁷ See Intermediary Exhibit I-1.

determine if the account is actually worthless when written off. The Intermediary maintains that the presumption of "uncollectibility" is simply not available as an option to the Intermediary if the debt is written off in less than 120 days. If the debt is documented by the Provider to be actually uncollectible and reasonable collection efforts have been performed, the Intermediary maintains that it would be able to allow the amount claimed.

Due to the presumption of uncollectibility afforded it in HCFA Pub. 15-1 § 310.2, the Intermediary maintains that there is a clear distinction in how bad debts that have passed the 120 day test are to be treated as opposed to those which were written off in less than 120 days. The Intermediary argues that for bad debt claims for which there have been reasonable collection efforts attempted and which have been outstanding for more than 120 days, a presumption of uncollectibility may be applied. For those bad debt claims which have not been outstanding for more than 120 days, the Intermediary contends that not only is it mandatory for these debts to be pursued by reasonable collection efforts, but, furthermore, the Provider must prove to the Intermediary by adequate documentation that the debts are actually uncollectible. The Intermediary further contends that allowing bad debt claims without documentation that the debts are actually uncollectible would, in effect, grant them the same allowable status as those debts which are outstanding for more than 120 days.¹⁸ The Intermediary notes that a majority of the bad debts written off were written off in much less than 120 days.¹⁹

The Intermediary argues that the regulations at 42 C.F.R. § 413.20(d) require the Provider to maintain sufficient financial records and to furnish such information to the Intermediary as is necessary to assure proper payment. The Intermediary contends that the burden of proof that the bad debts in question are allowable rests with the Provider. The Intermediary further contends that since the Provider made no effort to document the uncollectibility of the debts at issue in this case, it must disallow the amounts claimed.

The Intermediary does not consider the Provider's contention that collection efforts continued after the date of write-off as a material fact in this case. While the Intermediary does not dispute the Provider's contention that the amounts were turned over to a collection agency, no documentation has been submitted demonstrating that the agency exercised reasonable collection efforts. When the Provider attempts to collect for 120 days, a presumption of uncollectibility is allowed at that time. If the presumption of uncollectibility is not available due to an early write-off, the Intermediary argues that it cannot assume that a collection agency continued appropriate collection procedures unless the Provider submits documentation demonstrating these procedures. The Intermediary maintains that the burden of proof rests with the Provider. Without documentation supporting a continuation of reasonable collection efforts after the write-off, the Intermediary must conclude that reasonable collection efforts were not made.

¹⁸ Intermediary Position Paper at 9.

¹⁹ See Intermediary Position Paper at 10 for examples. See also Intermediary Exhibit I-1.

Due to the reasons stated above, the Intermediary respectfully requests that the Board uphold its adjustment on Medicare Bad Debts.

Issue No. 2: Reclassification of home health agency costs:

Facts:

The Provider is a hospital-based home health agency which provides nursing, therapy and home health aide services to Medicare beneficiaries in their homes. In the Provider's "as-filed" FYE 12/31/92 Medicare Cost Report, the cost relating to a provider-based home health agency (HHA) clerical employee was directly assigned to the home health agency Administrative and General (A&G) cost center. The job description for this position,²⁰ titled "Billing Clerk" states that the employee was responsible for: 1) data entry/retrieval of financial information and reports required by agency/hospital policy and regulatory bodies; 2) data entry/retrieval of patient medical information and reports required by agency/hospital policy and regulatory bodies; 3) agency billing for patients with private insurance, Medicare, Medicaid and for co-insurance billing; 4) supporting and encouraging harmonious working relationships within the agency, hospital staff, patients/families and physicians and computer resources; and 5) adhering to and promoting agency/hospital policies.

The home health agency paid this individual a salary of approximately \$14,000 in fiscal year 1992. The salary and related costs for this individual were recorded in the home health agency A&G cost center. Each of the home health agency's cost centers below the home health agency A&G cost center on the cost report received an allocation of these costs using the step-down methodology.

Since billing and other administrative costs of the Provider were also reported in the Hospital's A & G cost center, the Intermediary believed that directly assigning the same costs in the HHA created a duplication of these expenses through the cost allocation process to the HHA. The Intermediary made an adjustment during the cost report audit to reclassify the billing and other costs of this employee back to the Hospital's A & G cost center in order to eliminate what it perceived was a duplication of costs.²¹ It is the Provider's position, however, that all of this employee's functions related to, and benefitted the home health agency and that this individual did not perform any duties which directly or indirectly benefitted the hospital.²²

The effect of the Intermediary's adjustment was that the costs for the home health billing employee were allocated with the Hospital's A&G costs under the step-down method. Accordingly, the costs for the

²⁰ See Provider Exhibit 5,

²¹ See Intermediary Exhibit 6 for audit workpaper and applicable portion of adjustment report. The Provider notes that this adjustment was not made by the Intermediary during its audit of the 1991 cost report. See Provider's Exhibits 6 & 7.

²² Provider Position Paper at 15.

home health billing employee were allocated to all cost centers, including Hospital costs centers, below the Hospital's A&G cost center line on the cost report.

PROVIDER'S CONTENTIONS:

The Provider contends that it properly reported the costs for the home health agency billing employee in the home health agency A&G cost center. The billing clerk was employed by, and performed duties exclusively for, the hospital-based home health agency. The Provider argues that these costs were costs of the home health agency, not the Hospital. Accordingly, there is no reason for the costs to be reported in the Hospital A&G cost center or for other Hospital cost centers to receive a share of these costs. The Provider points out that the Intermediary has not disputed that the home health billing and clerical employee at issue here provided services only for the hospital-based home health agency and performed no services for the Hospital itself.²³ It is the Provider's position that reclassification of the home health billing clerk's costs to the Hospital administrative and general ("A&G") cost center means that these costs will be allocated to various Hospital cost centers which derived absolutely no benefit from the services of this individual. Id. Thus, the reclassification of the salary and related costs for this position to the Hospital A&G cost center violates a fundamental principle of Medicare cost allocation: general service costs must be allocated to other cost centers on the basis of services rendered. HCFA Pub. 15-1 § 2302.9 (Provider Exhibit 10).

The Provider contends that the Medicare provisions regarding direct allocations of general services costs support its methodology.²⁴ The Provider asserts that the first Medicare requirement for direct costing is that the direct assignment of costs must result in a more accurate allocation of costs. See 42 C.F.R. § 413.24(d)(2)(ii); HCFA Pub. 15-1 § 2310. In this case, the Provider contends that its methodology clearly results in more accurate cost finding, while the Intermediary's methodology results in an allocation of the home health billing employee's costs to Hospital cost centers which receive no benefit from the services of the billing employee.²⁵

The Provider maintains that the billing clerk performed duties exclusively for the hospital-based home health agency, and none of the Hospital cost centers benefitted from the services of the billing employee.

The Provider also offers an alternative argument that the provisions of the Medicare regulations and manuals regarding direct cost allocations are inapplicable to this case because the billing costs are the costs of the home health agency, not the Hospital. Because these are costs of the home health agency, the Provider asserts that they are properly reported with the home health agency's costs and there is no

²³ Provider Supplemental Position Paper at 3.

²⁴ Provider Position Paper at 18.

²⁵ Id.

need to "direct cost" these expenses.²⁶ Even with this argument aside, the Provider believes that the Medicare principles regarding direct costing support its cost reporting method.

As an example to support its argument, the Provider notes that one of the cost centers which received an allocation of the home health billing clerk's costs on the Hospital cost report is the Hospital's operating room cost center. The Provider asserts that the home health billing clerk had no involvement with any bills which were generated as a result of operating room services. Accordingly, the Provider maintains that an allocation of the costs for the home health billing clerk to this cost center violates HCFA Pub. 15-1 § 2302.9, which states that general service costs are to be allocated on the basis of services rendered. Additionally, the Provider notes that the Intermediary's allocation methodology results in the home health agency receiving only a small allocation of the total costs for the home health billing employee, despite the fact that the employee's time was devoted exclusively to home health billing matters. The Provider contends that this result is obviously improper because the billing employee worked exclusively for the home health agency.

The Provider contends that the Intermediary's argument, that assignment of these costs to the home health agency will result in a duplication of costs, is illogical and unpersuasive. The Provider points out that as part of the step-down cost allocation process, hospital-based home health agencies receive an allocation of costs from the hospital A&G cost center. This allocation is proper because the hospital-based home health agency benefits from the management and supervision furnished by the Hospital, as well as the indirect costs relating to that management and supervision. The Provider asserts that if the Intermediary's methodology were accepted, it would mean that there would be no hospital-based home health agency A&G costs since the same types of costs would also be found in the Hospital A&G cost center. The Provider further asserts that virtually every category of administrative function or cost which is included in the home health agency A&G cost center will have a counterpart in the hospital A&G cost center.

Under the Intermediary's rationale, all home health agency A&G costs would have to be reclassified to the hospital's A&G cost center in order to avoid duplication. The Provider contends that this approach is clearly inconsistent with established Medicare cost reporting requirements which require the establishment of a separate A&G cost center for the hospital-based home health agency.²⁷

The Provider points out that the Board has frequently held that certain costs should not be assigned to the A&G cost center, but rather, should be assigned to the specific cost center which benefited from

²⁶ Id.

²⁷ See Form HCFA-2552-92, Hospital and Hospital Health Care Complex Cost Report, Supplemental Worksheet H-4, Line I (Administrative and General-HHA Cost Center) (Provider Exhibit 15); HCFA Pub. 15-2, §§ 2845, 2845.1 (Allocation of HHA Administrative and General Costs) (Provider Exhibit 16).

those services. For example, the Board held in St. Elizabeth Hospital v. Blue Cross Assoc./Hospital Plan, Inc., PRRB Dec. No. 81-D69, Medicare & Medicaid Guide (CCH) ¶ 31,475 (Provider Exhibit I 1), that utilization review costs should not be assigned to a provider's A&G cost center because the costs related solely to inpatient services. Thus, allocation of the costs to outpatient cost centers as part of the provider's A&G costs was improper.

The Provider points out that the courts have reached similar conclusions. For example, in Chicago College of Osteopathic Medicine v. Heckler, Medicare & Medicaid Guide (CCH) ¶ 34,044 (N.D. Ill. 1984) (Provider Exhibit 12), the federal district court held that the cost of a medical director's office should not have been classified as A&G because the medical director's activities related only to patient care services. The court concluded that the medical director expense could not be classified as A&G because A&G expenses are allocated to all components of the provider, including nonreimbursable cost centers which were not benefited by the medical director costs.

Similarly, the Board has ruled that the assignment of the costs of services furnished by outside contractors to individual departments which benefit from these services is more accurate than assigning such costs to a general service cost center. St. Mary's Hospital and Medical Center v. Blue Cross and Blue Shield Assn, PRRB Dec. No. 90-D34, Medicare & Medicaid Guide (CCH) ¶ 38,627 (1990) (Provider Exhibit 13); St. John's Hospital & Health Center v. Blue Cross and Blue Shield Ass'n, PRRB Dec. No. 84-D131, Medicare & Medicaid Guide (CCH) ¶ 34,163 (1984) (Provider Exhibit 14). The Provider argues that clearly here, in the current case, the assignment of the costs of the billing clerk to the home health agency results in a more accurate allocation of costs than does the Intermediary's methodology whereby these costs are allocated to various Hospital cost centers which derive absolutely no benefit from them.²⁸ Therefore, the Provider asserts that it meets the first requirement for the direct assignment of costs.

The Provider asserts that the second requirement for the direct assignment of costs is that the assignment must be made as part of the provider's "accounting system with costs recorded in the ongoing normal accounting process." HCFA Pub. 15-1 § 2307. As stated above, the home health billing employee was an employee of the home health agency. Therefore, the costs for the employee were recorded in the home health agency's financial records as part of its routine accounting process, and the Provider meets this second requirement.

The Provider acknowledges that the third requirement for the direct assignment of costs is that the intermediary must grant prior approval. HCFA Pub. 15-1 § 2307. The Provider contends however, that in recent cases, the Board has adopted a "no harm, no foul" approach to this requirement and allowed providers to use a more sophisticated cost allocation methodology without prior approval if the methodology resulted in a more accurate allocation of costs than the intermediary's methodology. See Pinnacle Care Drug Gross-Up Group Appeal, PRRB Dec. No. 97-D41, Medicare & Medicaid Guide

²⁸

(CCH) ¶ 45,167 (1997); Sunbelt Health Care Centers Group Appeal, PRRB Dec. No. 97-D13, Medicare & Medicaid Guide (CCH) ¶ 44,923 (1996). In the current case, the Provider contends that its method of cost reporting results in a more accurate allocation of costs than does the Intermediary's method, therefore, prior approval is not necessary.

The Provider also rejects the Intermediary's argument that HCFA Pub. 15-1 § 2307 requires that all costs in a general service cost center must be directly assigned if any costs are to be. (Emphasis added) The Provider asserts there is no such requirement in section 2307. The Provider contends that the applicable portion of this section only refers to the direct assignment of those costs "which can be directly allocated," and it does not state that all costs in the general service cost center must be directly assigned.

The Provider contends that this argument is also clearly contradicted by numerous Board rulings which have upheld the direct assignment of certain costs even though there is a general service cost center for that category of cost. See, e.g., Medical Center of Garden Grove v. Blue Cross of California, PRRB Dec. No. 95-D1, Medicare & Medicaid Guide (CCH) ¶ 42, 913 (1994) (upholding direct assignment of maintenance and repair costs to individual benefiting department rather than to maintenance and repair cost center) (Provider Exhibit 17); Western Medical Center v. Blue Cross of California, PRRB Dec. No. 97-D2, Medicare & Medicaid Guide (CCH) ¶ 44,744 (1996) (same) (Provider Exhibit 18).

Furthermore, the Provider explains that it must be kept in mind that the home health billing clerk's costs were recorded in the home health agency A&G cost center in the first place and were never recorded in the Hospital A&G cost center until the Intermediary reclassified them.

To summarize, the Provider contends that it properly recorded the costs for the home health agency billing employee in the home health agency A&G cost center. The Provider further contends that its methodology resulted in a more accurate allocation of costs than the Intermediary's methodology, the allocation was made as part of its routine record-keeping process, and has been approved by the Intermediary through its acceptance of this methodology for prior years. Accordingly, the Intermediary's reclassification was improper and should be reversed.

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that an integral part of the Medicare cost report in determining the proper Medicare reimbursement due to a Medicare provider is the allocation of overhead costs to the revenue-producing cost centers. This allocation process, called "cost finding", is addressed in 42 C.F.R. § 413.24 (See Intermediary Exhibit I-7). The Intermediary asserts that most providers, including the one in this case, use the cost finding method called the "step-down method" which is described as follows in section 413.24(d)(1):

"(I) Step-down method. This method recognizes that services rendered by certain nonrevenue producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue."

Id.

The Intermediary points out that in using the step-down method of cost finding, overhead costs in cost centers such as Administrative and General, Operation of Plant, and Housekeeping are allocated to the departments utilizing these services.

The Intermediary also refers to HCFA Pub. 15-1 § 2307 which discusses an alternative to cost finding called direct assignment of costs, or direct costing. The Intermediary defines direct costing as the process of identifying overhead costs specifically applicable to the revenue-producing cost centers and directly classifying these costs in those revenue-producing cost centers rather than allocating the cost on a statistical basis.²⁹ The Intermediary contends that section 2307 clearly states the criteria which must be met in order for direct costing to be allowed, the primary requirement being that "all direct costs be identified and assigned to the revenue-producing cost centers." Id. Intermediary Exhibit I-8 ("emphasis in original") The Intermediary maintains that all costs should be identified so that a provider is not able to select only certain costs to be directly assigned, therefore resulting in an inappropriate duplication or loading of the costs in a particular cost center.

The Intermediary explains that the Provider has a provider-based home health agency to which it has directly assigned certain agency administrative and general costs, those being the billing and other administrative costs in question, on the Medicare cost report.³⁰ The Intermediary maintains that these costs have been included in the home health agency's A&G cost center while the same type costs for all other departments of the Provider have been included in the Hospital's A&G cost center. The Intermediary contends that the Hospital's A&G cost center is allocated to all departments including the home health agency cost centers on the basis of accumulated cost, and because of this reporting, the home health agency is receiving a duplicative share of billing and other administrative costs by receiving 100 percent of the agency's costs and an allocated portion of the hospital's costs. Id.

The Intermediary argues that the Provider did not meet the criteria established in HCFA Pub. 15-1 when it directly assigned the billing and other administrative costs to the home health agency cost center on the Medicare cost report. The Intermediary asserts that all billing and other administrative costs on

²⁹ Intermediary Position Paper at 15.

³⁰ Intermediary Position Paper at 16.

the cost report have not been identified, only the home health agency costs. The Intermediary contends that the Provider has included directly assigned billing and other administrative costs in the home health agency cost center and has also allocated hospital billing and other administrative costs to the home health agency through the cost allocation process, thereby violating section 2307 with the duplication of costs.

The Intermediary points out that the Medicare cost report reflects a cost center entitled "Home Health Agency Administrative and General." According to the Intermediary, this cost center is designed to contain costs which would apply to all the other agency departments and to capture these departmental costs and allocate them to the various disciplines of the agency. It is the Intermediary's position that the home health agency A&G cost center was not designed to contain directly assigned costs when costs of the same type are not directly assigned to any other cost center, thereby creating a duplication by both directly assigning and allocating the same type costs.³¹

It is the Intermediary's primary contention that the duplication of the billing and other administrative costs in the HHA cost center benefits the Provider by shifting more of the Provider's cost to the Medicare Program, thus increasing the Provider's reimbursement from the Program. The Intermediary points out that cost-shifting has been addressed previously in the 1987 decision by the U.S. District Court for the Eastern District of California in the case of Childrens Hospital of San Francisco, a California nonprofit corporation, et al. v. Bowen, U.S. District Court for the Eastern District of California, Civ. No. S-85-0092-MLS, Sept. 3, 1987, Medicare & Medicaid Guide (CCH) ¶36,679 ("Childrens")³² The Intermediary contends that in this case, the Medicare Program was found to be erroneously cost-shifting Provider malpractice costs.

The Intermediary contends that prior to 1979, malpractice insurance costs were treated the same as any other overhead administrative and general cost, i.e., allocated to the ancillary cost centers through the cost allocation process, and reimbursed to the Provider based on the facility's Medicare utilization rate. The Intermediary points out that the Secretary then promulgated the 1979 malpractice insurance rule which removed malpractice costs from the standard allocation process, which in many instances shifted cost away from the Medicare Program, resulting in less reimbursable costs to the provider community.

The Intermediary asserts that the Program's practice of shifting malpractice insurance costs was overturned repeatedly in the court system. In the Childrens decision, the court stated that it "agrees with the decisions of the many circuit courts that have considered the validity of the rule that was previously in force ... and finds that the 1979 malpractice insurance rule is invalid because it violates the statutory prohibition against cost-shifting." Id.

³¹ Intermediary Position Paper at 18.

³² Intermediary Exhibit I-9.

The Intermediary contends that the prohibition against cost-shifting found in U.S.C. §1395x(v)(1)(A) applies to the issue in the instant case regarding HHA billing and other administrative costs. As the court ruled against the Program's shifting of malpractice costs in Childrens, the Board should so rule against the Provider's shifting of HHA billing and other administrative costs in this case. Therefore, the Intermediary respectfully requests that the Board uphold its adjustment to reclassify HHA billing and other administrative costs to the hospital A&G cost center.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
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2. Regulations - 42 C.F.R.:

§§ 405-1835-.1841	-	Board Jurisdiction
§ 413.20(d)	-	Financial Data and Reports- Continuing Provider Recordkeeping Requirements
§ 413.24 <u>et seq</u>	-	Adequate Cost Data and Cost Finding
§ 413.80 <u>et seq</u>	-	Bad Debts, Charity, and Courtesy Allowances

3. Program Instructions-Provider Reimbursement Manual, Part 1(HCFA Pub. 15-1):

§ 310.2	-	Presumption of Non- Collectibility
§ 2302.9	-	General Service Cost Centers
§ 2307	-	Direct Assignment of General Service Costs
§ 2310	-	More Sophisticated Methods

4. Program Instructions-Provider Reimbursement Manual, Part II (HCFA Pub. 15-2):

§ 2845 - Allocation of HHA
Administrative and General
Costs

3. Cases:

Ohio Power Co. v. FERC, 880 F.2d 1400 (D.C. Cir. 1989) (Mikva, J. concurring).

H.P. Coffee Co. v. Reconstruction Finance Corp., 215 F.2d 818 (Emer. Ct. App. 1954).

Gulf Oil Corp. v. Heath, 255 Ark. 604, 501 S.W.2d 787 1973).

Lourdes Hospital v. AdminiStar of Kentucky, PRRB Dec. Nos. 95-D58, 95-D59, 95-D60, August 31, 1995, Medicare & Medicaid Guide (CCH) ¶43,585; HCFA Adm. Dec., October 25, 1995, Medicare & Medicaid Guide (CCH) ¶43,723.

King's Daughters' Hospital v. Blue Cross and Blue Shield of Kentucky, PRRB Dec. No. 91-D5, November 14, 1990, Medicare & Medicaid Guide (CCH) ¶38,950.

Scotland Memorial Hospital v. Blue Cross and Blue Shield Association of North Carolina, PRRB Dec. No. 84-D174, September 18, 1984, Medicare & Medicaid Guide (CCH) ¶34,225, HCFA Adm. Dec., November 18, 1984, Medicare & Medicaid Guide (CCH) ¶34,410.

Harris County Hospital District v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 43,621 (5th Cir. 1995).

Childrens Hospital of San Francisco, a California nonprofit corporation, et al. v. Bowen, U.S. District Court for the Eastern District of California, Civ. No. S-85-0092-MLS, Sept. 3, 1987, Medicare & Medicaid Guide (CCH) ¶36,679.

Chicago College of Osteopathic Medicine v. Heckler, Medicare & Medicaid Guide (CCH) ¶ 34,044 (N.D. Ill. 1984).

St. Mary's Hospital and Medical Center v. Blue Cross and Blue Shield Assn, PRRB Dec. No. 90-D34, Medicare & Medicaid Guide (CCH) ¶ 38,627 (1990).

St. John's Hospital & Health Center v. Blue Cross and Blue Shield Ass'n, PRRB Dec. No. 84-D131, Medicare & Medicaid Guide (CCH) ¶ 34,163 (1984).

Pinnacle Care Drug Gross-Up Group Appeal, PRRB Dec. No. 97-D41, Medicare & Medicaid Guide (CCH) ¶ 45,167 (1997).

Sunbelt Health Care Centers Group Appeal, PRRB Dec. No. 97-D13, Medicare & Medicaid Guide (CCH) ¶ 44,923 (1996).

Medical Center of Garden Grove v. Blue Cross of California, PRRB Dec. No. 95-D1, Medicare & Medicaid Guide (CCH) ¶ 42, 913 (1994).

Western Medical Center v. Blue Cross of California, PRRB Dec. No. 97-D2, Medicare & Medicaid Guide (CCH) ¶ 44,744 (1996).

St. Elizabeth Hospital v. Blue Cross Assoc./Hospital Plan, Inc., PRRB Dec. No. 81-D69, Medicare & Medicaid Guide (CCH) ¶ 31,475.

4. Other:

Omnibus Budget Reconciliation Act of 1987 ("OBRA-87"), Pub. L. No. 100-203, 4008(c).

Form HCFA-2552-92, Hospital and Hospital Health Care Complex Cost Report, Supplemental Worksheet H-4, Line I (Administrative and General-HHA Cost Center)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

Issue 1- Bad Debts:

The Intermediary's adjustment was related to bad debts claimed by the Provider that were not outstanding for at least 120 days. The basis of the Intermediary's adjustment was that a presumption of uncollectibility is not available if a debt is written off in less than 120 days. The Intermediary also acknowledged that if the debt (those written off in less than 120 days) is documented by the Provider to be actually uncollectible and reasonable collection efforts have been performed, it would be able to allow the amount claimed.³³

The Provider asserts that the sole basis for the disallowance of a portion of its Medicare bad debts was the Intermediary's determination that the bad debts were not allowable because it had written off the debt in less than 120 days. The Provider rejects this argument, contending that it has met all the requirements of 42 C.F.R. § 413.80(e).

The Board notes that the regulations at 42 C.F.R. §413.80(e) provides four (4) criteria that a provider must meet with respect to a receivable from a beneficiary in order to claim that receivable as a bad debt. In general, a provider must establish that a debt relates to covered services and is derived from deductible and co-insurance amounts, that reasonable collection efforts were made, that the debt was actually uncollectible when claimed, and that sound business judgement indicates that there is no likelihood of future recovery.

The Board finds that there were two (2) Provider Medicare bad debt policies in effect during the cost reporting year at issue in this case.³⁴ The Board further notes that the bad debt policy in Provider Exhibit 1, dated November 5, 1987 was revised by the bad debt policy in Provider Exhibit 2, dated October 19, 1992. The Board finds that a significant difference in the two policies was that the 1992 policy specifically required documentation associated with writing off accounts in less that 120 days. More specifically, the 1992 policy states that, “.with respect to debts that are claimed in 120 days or less from the first bill. For these debts, the Hospital must demonstrate that the debt was “actually uncollectible”.³⁵ (Emphasis added.)

The Board notes that at the time the cost report was filed, the revised (1992) bad debt policy was in effect. Accordingly, the Board concludes that there was no documentation in evidence to support that the Provider was adhering to its revised bad debt policy as noted above. More specifically, there was no evidence in the record to demonstrate why 11 of 32 accounts were actually uncollectible and written off in less that 120 days, as compared to the 21 accounts that were written off in over 120 days.³⁶

The Board notes the sub-issue in this area relating to four (4) accounts in which the Provider asserts were clearly in error on the Intermediary's workpaper. The Board agrees with the Provider that the evidence supports its contention that these four (4) accounts were actually written off in over 120 days.

³⁴ See Provider Exhibits 1 & 2.

³⁵ Provider Exhibit 2, pg. 3 of 8, sec. C.

³⁶ The Intermediary's work paper, at Intermediary Exhibit 3, indicates that the Provider wrote off 15 of the 32 accounts in less that 120 days. The Intermediary's adjustment was based on its belief that these 15 accounts were written off in less than 120 days. The Provider has submitted documentation in its Supplemental Position Paper at Exhibit 9 in support of its contention that the Intermediary's analysis was in error for four (4) of the 15 accounts. Therefore, the Provider contends that the corrected workpaper should reflect that only 11 of the 32 accounts were written off in less than 120 days.

The Board also addresses the Provider's argument that a statutory moratorium on changes in bad debt collection policy precludes the Intermediary's disallowance. The Board concludes that since the Provider did not follow its own bad debt collection policies, the issue is moot.

Issue 2-Reclassification of home health agency costs:

The Provider is a 25-bed hospital that operated a HHA during the subject cost reporting period. The HHA, during this period, employed one full-time individual as a billing clerk. The Provider charged the salary and related costs of this individual to the HHA cost center within the hospital cost report. The Intermediary, however, reclassified these costs to the Provider's A&G cost center to be allocated to all revenue producing cost centers.

The Intermediary argues that the reclassification is necessary according to Medicare's "direct assignment" rules. In particular, the Intermediary asserts that the reclassification avoids an inappropriate allocation of overhead to the HHA, i.e., 100 percent of the subject clerk's costs plus a portion of the Provider's costs for the same types of services that would be allocated to the HHA through the cost report process.

The Provider asserts that Medicare's rules regarding direct assignment do not apply to the instant case because the individual in question was an employee of the HHA and not the Provider, and because this individual performed services exclusively for the HHA. Notwithstanding, the Provider also maintains that charging this individual's costs to the HHA cost center results in a more accurate method of cost finding than allocating the costs through the Provider's A&G cost center, which is the primary objective of Medicare's cost finding process.

The Board finds that the HHA, although hospital-based is, itself, a Medicare provider. It was certified by the Medicare program separately from the Provider's certification, and operates under its own Medicare provider number. These circumstances, coupled with the fact that the subject individual was employed by the HHA and worked solely for the HHA, affirms the propriety of the Provider's position. The Board finds that the Provider's practice of recording the costs of this particular employee in the HHA cost center reflects a sound and proper accounting policy.

The Board notes that the applicable Medicare cost reporting forms support the Provider's accounting of the clerk's costs. Specifically, the "H" series of the Form HCFA 2552, Medicare Cost Reporting Forms for Hospitals and Hospital Health Care Complexes, provides a mechanism for a hospital-based HHA to record and allocate its own A&G costs. While the instructions for these forms do not address the exact circumstances at issue, the Board finds no basis in the instructions to distinguish the administrative and general nature of the subject clerk's costs from any other A&G costs that may be charged to the HHA cost center.

The Board also notes that there are no disputes in this case regarding the Provider's assertion that the subject clerk was employed by the HHA and not by the Provider, or the contention that the clerk

worked only for the HHA. Evidence of the individual's responsibilities and commitment to HHA matters is provided at Provider Exhibit P-5.

The Board also finds that assigning the clerk's costs to the HHA cost center results in a more accurate method of cost finding than charging these expenses to the Provider's A&G cost center. As noted, the subject individual worked solely for the benefit of the HHA. Yet, if the costs were allocated through the Provider's A&G cost center, many hospital departments that received absolutely no benefit from the clerk's efforts would receive a part of the costs. Also, since the allocation of the Provider's A&G cost center is based upon accumulated cost, and since the hospital's costs are far greater than those of the HHA, the HHA would receive only a small portion of its own employee expenses.

In this same context, the Board rejects the Intermediary's argument that charging the clerk's costs to the HHA cost center results in an improper allocation of the Provider's or hospital's overhead. The Board's analysis of this argument is based upon materiality. That is, recording the clerk's costs in the HHA cost center does result in some additional hospital overhead being allocated to the HHA because, as previously mentioned, the allocation is based upon accumulated cost. However, because the hospital's costs are understood to be so much greater than those of the HHA, the actual affect of the clerk's costs on the allocation is considered insignificant. In all, the Provider's practice of recording the clerk's costs in the HHA cost center may not be a perfect cost finding methodology. However, it results in far more accurate methodology than that which results from the Intermediary's reclassification. Significantly, the Board agrees with the Provider, in that, "accuracy" is the primary objective of the Medicare cost finding process. 42 C.F.R. 413.24(d)(2)(ii).

The Board also rejects the Intermediary's argument that the HHA A&G cost center, within the Medicare hospital cost report, is not designed to contain costs such as those of the subject clerk. As discussed immediately above, the Board finds that the instructions for the pertinent cost reporting forms do not provide sufficient detail to distinguish the administrative and general nature of the clerk's costs from any other A&G costs that would be charged to the HHA cost center. The Board believes the Intermediary's position regarding this matter is speculative.

Finally, the Board rejects the Intermediary's reliance upon HCFA Pub. 15-1 § 2307. Essentially, the Intermediary argues that in order for a provider to directly assign any given costs, it must identify and directly assign all like costs to avoid a duplicate allocation of overhead. On this basis, the Intermediary maintains that its adjustment is proper because the Provider identified and directly assigned the costs associated with the subject clerk but failed to identify and directly assign all other like costs. The Board, however, finds no evidence in the record to substantiate this claim. Clearly, the Intermediary has not demonstrated that the Provider's failure to directly assign like costs, or the extent to which the Provider may have directly assigned any other costs, resulted in a duplication of costs allocated to the HHA.

DECISION AND ORDER:

Issue 1- Bad Debts

The Intermediary properly disallowed a portion of the Medicare bad debts claimed by the Provider. The Intermediary's adjustment is modified. The Board orders the Intermediary to modify its adjustment to allow the bad debts for the four (4) accounts which were in error on the Intermediary's workpaper.

Issue 2-Reclassification of Home Health Agency Costs:

The Intermediary's reclassification of certain salary and related costs from the HHA cost center to the hospital's A&G cost center is improper. The Intermediary's adjustment is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: September 30, 1999

FORTHE BOARD:

Irvin W. Kues
Chairman