

**PROVIDER REIMBURSEMENT REVIEW BOARD**  
**DECISION**  
ON THE RECORD  
2006-D56

**PROVIDER -**  
Sutter Merced Medical Center  
Merced, California

Provider No.: 05-0444

**vs.**

**INTERMEDIARY -**  
BlueCross BlueShield Association/  
\United Government Services, LLC-CA

**DATE OF HEARING -**  
June 1, 2006

Cost Reporting Period Ended -  
December 31, 1999

**CASE NO.:** 04-0660

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ISSUE:

Whether the Provider's regular Medicare outpatient bad debts are not allowable until all collection efforts including those of a collection agency have ceased.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

According to Medicare regulations at 42 C.F.R. §413.80, a provider is entitled to claim as a reimbursement cost, bad debts attributable to deductibles and coinsurance amounts that remain unpaid by the Medicare beneficiaries it services.

Sutter Merced Medical Center (Provider) is a 174-bed acute care hospital located in Merced, California. In its Medicare cost report for its year ended December 31, 1999, the Provider claimed Medicare outpatient bad debts in the amount of 3,194,<sup>1</sup> which was net of bad debt recoveries. When United Government Services, LLC (Intermediary) audited the cost report, it eliminated all of the claimed bad debts. The Intermediary's adjustment was based on a sampling of 10 accounts which represented 57% of the total bad debts claimed. Following receipt of the NPR, the Provider filed a timely appeal of the bad debt adjustment to the Board.<sup>2</sup>

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<sup>1</sup> See Provider's second supplemental position paper at page 3.

<sup>2</sup> Id. and Intermediary Exhibit 1 to its supplemental position paper.

The only dispute in this case is whether uncollected Medicare accounts can be claimed as bad debts while they are still in the hands of an outside collection agency. The Provider's collection policy included both in-house and outside collection efforts, and both Medicare and non-Medicare accounts that remained outstanding following its in-house collection efforts of at least 120 days were referred to an outside collection agency. At the time the outstanding Medicare accounts were transferred to the outside agency, the Provider wrote off the accounts and recorded them as bad debts. The collection agency recovery report shows that collection efforts continued on Medicare accounts after they had been written off by the Provider. At the time of the audit, the Providers' bad debt listing showed recoveries as following:

Medicare Bad Debts	\$7,061
Less Recoveries	<u>3,867</u>
Bad Debts Claimed And Disallowed	<u>\$3,194</u>

The Provider's appeal meets the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by John P. Wagner, Esquire, of Nossaman, Guthner, Knox & Elliott, LLP. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

#### FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the facts, parties' contentions and evidence submitted, finds and concludes that the Provider properly claimed uncollectible Medicare accounts as bad debts even though the accounts were still with its collection agency.

The Intermediary disallowed a portion of the Provider's claimed Medicare bad debts claiming that the Provider failed to comply with the requirements of 42 C.F.R. §413.80(e) which set forth the criteria that must be met for bad debts to be allowable costs. The Intermediary's sole basis for the disallowance was the Provider's use of an outside collection agency as part of its collection efforts after the bad debt had been deemed worthless and written off. It concluded that the Provider was not entitled to claim Medicare reimbursement for any bad debts until such time that the collection agency ceased its collection activities and returned the account to the Provider.

The Medicare program reimburses providers for bad debts resulting from deductible and co-insurance amounts which are uncollectible from Medicare beneficiaries. Pursuant to 42 C.F.R. §413.80(e), bad debts must meet the following criteria to be allowable:

- (1) The debt must be related to covered services and derived from deductible and co-insurance 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.

The Board notes that the Intermediary never questioned that the bad debts claimed by the Provider related to covered services provided to Medicare beneficiaries, nor that they were attributable to deductibles and co-insurance amounts.

The Board is unable to reconcile the Intermediary's position with CMS Pub. 15-1 §310.2, which allows a provider to seek Medicare bad debt reimbursement for accounts that remain uncollected after a provider has engaged in reasonable and customary collection efforts for a period of a least 120 days. The Intermediary claims that the Provider must wait to claim a debt as uncollectible until either the collection agency returns the account to the Provider, or the collection agency makes a determination that the account is worthless. According to the Provider Reimbursement Manual (PRM) §310.2, a provider's use of a collection agency may be in addition to or in lieu of collection efforts undertaken by the provider itself. That same section allows a presumption of uncollectibility after a provider's reasonable and customary attempts to collect the bill have failed and the debt remains unpaid for more than 120 days. Thus, the Board finds merit less the Intermediary's argument that the Provider's use of an outside collection agency deems the debt collectible and of some value until all such collection efforts have ceased, even if the debt remains unpaid after 120 days of reasonable collection effort. Moreover, the Provider argues and the Board concurs that PRM §316 indicates that when a provider, in a later reporting period, recovers amounts previously claimed as allowable bad debts, the provider's reimbursable costs in the period of recovery are reduced by the amounts recovered. Thus, based on this Medicare program instruction, the Board finds that it is reasonable to infer that the Medicare program anticipates that providers may continue to pursue collection activities with respect to debts that have been deemed uncollectible for Medicare reimbursement purposes.

The Board also concurs with the Provider's contention that the Medicare regulations and program instructions do not support the Intermediary's decision to disallow the Provider's Medicare bad debts. The only CMS publication that addresses the denial of a bad debt while a Medicare account is still at the collection agency after the 120-day collection activity period is the Medicare Intermediary Manual (MIM). The MIM addresses the audit procedures and steps which intermediaries must use in performing their audits. The Board finds that this instruction directed to intermediaries goes beyond the requirements of the regulations and program instructions applicable to providers.

The Board finds the Intermediary's use of CMS' definition of "uncollectible" in the CMS Administrator's reversal of the PRRB decision in Battle Creek Health System v. Blue Cross Blue Shield Association/United Government Services, LLC, PRRB Dec. 2004-D40, 9/16/04, Medicare & Medicaid Guide §81,193 (Battle Creek) to be inappropriate. In that reversal, the Administrator stated, "Until a provider's reasonable collection effort has been completed, including both in-house efforts and the use of a collection agency, a Medicare bad debt may not be reimbursed as uncollectible." The Board finds that "uncollectible," within the meaning of the regulation, means that no payments have been

received or are expected to be made on an account based on the provider's experience and sound business judgment.

The Board finds that the CMS Administrator's interpretation of the regulation requires undue efforts by providers in attempting to collect their bad debts, and such requirements do not foster program efficiency. Substituting CMS' requirements regarding bad debt collection policy for a provider's judgment based on its own operational experience and the nature of its bad debts subjects providers to counter-productive burdens that are not required by the regulation.

The Board finds that the Provider's practice of writing off uncollected Medicare accounts after 120 days as allowed by HCFA Pub. 15-1 §310.2 and then sending them to a collection agency is a reasonable interpretation of the Medicare regulation and program instructions. Furthermore, CMS is not disadvantaged by this procedure, because if the Provider does recover funds from previously written off bad debts, such recovery will reduce allowable bad debts in a later period. In summary, to follow CMS' prescribed methodology for collecting bad debts by using an audit manual generally unavailable to a provider is arbitrary and can be cost-inefficient.

DECISION AND ORDER:

The Provider properly claimed Medicare bad debts under the presumption of uncollectibility provisions of CMS Pub. 15-1 §310.2 even though the accounts were still with the collection agency. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire  
Gary B. Blodgett, D.D.S  
Elaine Crews Powell, C.P.A.  
Anjali Mulchandani-West  
Yvette C. Hayes

FOR THE BOARD:

DATE: September 27, 2006

Suzanne Cochran  
Chairperson