CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Sutter Merced Medical Center **Provider** **vs.** **Blue Cross/Blue Shield Association** **United Government Services, LLC-CA** **Intermediary**	**Provider Reimbursement for** **Cost Reporting Period Ending:** **12/31/1999** **Review of:** **PRRB Decision 2006-D56** **Dated: September 27, 2006**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act). The parties were notified of the Administrator's intent to review the Board's decision. Comments were received from the Centers for Medicare Management (CMM) and the Intermediary. Accordingly, this decision is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary properly disallowed Medicare bad debts.

The Board, reversing the Intermediary's adjustment, held that the Provider properly claimed Medicare bad debts under the presumption of uncollectibility provisions of §310.2 of the Provider Reimbursement Manual (PRM), even though the accounts were still with the collection agency. The Board found that the Medicare regulations and program instructions do not support the Intermediary's decision to disallow a portion of the Provider's Medicare bad debts. The Board stated that the Intermediary's decision was solely based on 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. The Board noted that the Intermediary never

questioned that the bad debts were related to covered services; were furnished to Medicare beneficiaries; and, were attributable to deductibles and coinsurance amounts. The Board found the Intermediary's argument that the 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, without merit. In addition, the Board found that CMS' interpretation of the regulation required undue efforts by providers in attempting to collect their bad debts, and such requirements did not foster program efficiency.

Moreover, the Board noted §316 of the PRM which explains 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, the Board reasoned 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 noted that §310.2 of the PRM 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.

Finally, the Board found that the Intermediary's use of CMS' definition of "uncollectible" in the Administrator's reversal in Battle Creek Health System v. Blue Cross Blue Shield Association/United Government Services, LLC, PRRB Dec. No. 2004-D40, (CCH) Medicare & Medicaid Guide ¶81,193 (2004),[1] to be inappropriate. The Board found 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. Thus, the Board concluded that the Provider's practice of writing off uncollected Medicare accounts after 120 days and then sending them to a collection agency is a reasonable interpretation of the Medicare regulation.

SUMMARY OF COMMENTS

CMM requested reversal of the Board's decision, noting that for bad debts to be allowable by Medicare, they must meet the criteria set forth in 42 C.F.R. 413.89 and the relevant manual provisions in the PRM. Specifically, CMM pointed out that §310.2 of the PRM "Presumption of Noncollectibility" must be read within the context of the bad debt policy provided in §§308 and 310 of the PRM. That is, a

[1] But See Battlecreek Health Systems v. Thompson, 423 F. Supp. 2d 755 (March 30, 2006) affirming Secretary's position.

bad debt cannot be properly transferred to Medicare until all collection efforts have ceased, including both in-house efforts and usage of a collection agency. CMM argued that a debt cannot be deemed uncollectible just because it remains unpaid more than 120 days.

Further, CMM noted that the Board's decision indicated that the collection agency recovery report showed that the collection efforts continued on Medicare amounts after they had been written-off by the Provider. CMM asserted that the Board is incorrect in finding that Medicare policy permits a bad debt to be claimed, even after 120 days, while the Provider is still engaged in any collection effort. The longstanding policy, as reflected in the Intermediary Manual and the PRM, is clear that to be an allowable bad debt, the debt must be uncollectible when claimed as worthless and that sound business judgment established there was no likelihood of recovery at any time in the future. If an account is in collection, it has not yet been determined to be uncollectible, and a provider could not have established that there is no likelihood of recovery.

In addition, CMM argued that the Board is incorrect in stating that the Medicare Intermediary Manual is the only publication addressing the denial of bad debts while a Medicare account is at a collection agency. The Board has misinterpreted §413.80(e)(4). A provider is required to use sound business judgment as one of the criteria in claiming bad debts. Once the provider has pursued a reasonable collection effort for Medicare and non-Medicare patients after 120 days, the provider may choose to conclude collection efforts and deem it as uncollectible, and, thus, a bad debt. Or, if a provider believes that there is a likelihood of recovery, it may choose to continue the collection effort. However, if a provider does so, the debt is not yet worthless and policy does not permit claming this debt until all collection efforts has ceased. Finally, CMM noted, that contrary to the Board's finding, §316 of the PRM does not infer that Medicare anticipates that providers are to continue collection for accounts deemed uncollectible, then offset those collections received. Rather, §316 directs a provider to offset against claimed bed debts, debt repayments by patients that may occur after collection efforts have ceased.

The Intermediary requested reversal of the Board's decision. The Intermediary explained that the Provider wrote off its bad debts when the in-house collection effort was completed, but then sent the accounts to an outside collection agency. The Intermediary argued that under the Medicare rules and instructions, accounts at an outside collection agency cannot be considered to worthless or uncollectible because collection activity is ongoing. Further, if the accounts are not determined to be worthless and uncollectible then they cannot be considered as Medicare bad debts.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments are included in the record and have been considered.

Section 1861(v)(1)(A) of the Social Security Act requires that providers of services to Medicare beneficiaries are to be reimbursed the reasonable cost of those services. Reasonable cost is defined as the "the cost actually incurred, excluding therefrom part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included …" Id. This section does not specifically address the determination of reasonable cost, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable costs. One of the underlying principles set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs. These principles are reflected and further explained in the regulations. The regulations at 42 CFR §413.9(c) provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries.

Relevant to this case, the regulation at 42 CFR §413.80(a) specifically provides that bad debts are reductions in revenues and are not included in allowable costs. However, the regulation at 42 CFR §413.80(a) further provides that bad debts attributable to the deductible and coinsurance amounts of Medicare beneficiaries are reimbursed under the Medicare program.[2] Bad debts are defined at 42 CFR §413.80(b)(1) as:

> [A]mounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.[3]

The regulation at 42 CFR §413.80(d) states that payment for deductibles and coinsurance amounts are the responsibility of the beneficiaries. However,

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[2] See also, Section 304 of PRM.

[3] See also, Section 302 of the PRM.

recognizing the reasonable costs principle at Section 1861(v)(1)(A) of the Act, which prohibits cross subsidization, the regulation states that the inability of providers to collect deductibles and coinsurance amounts from the Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not beneficiaries. Therefore, to prevent such cross-subsidization, Medicare reimburses providers for allowable bad debts.[4]

Consequently, Providers may receive reimbursement for Medicare bad debt, if they meet all of the criteria set forth in 42 CFR §413.80(e):

> A bad debt must meet the following criteria to be allowable:
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> (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.[5] (Emphasis added).

Under the Secretary's interpretive authority, the Provider Reimbursement Manual (PRM) has been issued, which clarifies the reimbursement regulations. Relevant to the issue in this case, Section 310 of the Manual states:

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients.

Section 310.A of the Manual further explains:

> A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider

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[4] See Id.

[5] See also Section 308 of the PRM.

> refers to a collection agency its uncollected non-Medicare patient charges, which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency.

Further, in elaboration on the concept of reasonable collection effort, section 310.2 of PRM, provides:

> If 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.

Section 314 of the PRM states that uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which such debts are determined to be worthless and noncollectible. This instruction also explains the burden of the Provider to thoroughly document its claimed bad debts.

Moreover, consistent with the Act, the Secretary has also issued guidelines for an intermediary to follow when auditing cost reports. The Intermediary Manual explains that Medicare bad debts for deductible and coinsurance are reimbursed as a pass-through cost. Since they have a direct dollar for dollar effect on reimbursement, there is an incentive to claim bad debts.

This instruction discusses reliance on a collection agency and the kind of documentation in which the Provider should engage to support a conclusion of a reasonable collection effort. Specifically, the instruction states that:

> If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort.[6]

In this case, the record reflects that the Provider generally had engaged collection efforts for both Medicare and non-Medicare accounts that remained outstanding for at least at least 120 days were referred to an outside collection agency. When the outstanding accounts were transferred to the outside agency, the Provider wrote off

[6] Intermediary Manual, Part IB, 13-2.

the accounts as bed debts. On audit, the Intermediary disallowed the bad debts because collection efforts continued after the debts had been deemed worthless.

Applying the foregoing provisions of Act, the regulations and instructions to the facts in this case, the Administrator finds that the Intermediary properly determined that Medicare could not reimburse the bad debts claimed by the Provider. The Intermediary reasonably concluded that if there were continuing collection efforts that the Provider had not deemed that debt worthless. The record supports a finding that as the Provider had continued collection effort, the Provider did not establish that the accounts were "actually uncollectible" when claimed as worthless or that "sound business judgment" established that there was no likelihood of recovery at any time in the future.[7]

With respect to the "presumption of uncollectibility", the Administrator recognizes that section 310.2 of the PRM permits a debt unpaid for more than 120 days from the date the first bill is mailed to the beneficiary to be deemed uncollectible. However, the Administrator notes that the language of that section implies discretionary rather than mandatory application of the presumption, i.e., the debt "may" rather than "shall" be deemed uncollectible. That manual section does not suggest that this "presumption" relieves the Provider from meeting the general regulatory documentation requirements or the specific documentation requirements in sections 310.B and 314 of the PRM. The presumption only applies where a provider has otherwise demonstrated through appropriate documentation that it engaged in reasonable collection efforts. This means that to claim a debt at 120 days, the Provider must determine that the debt was actually uncollectible when claimed as worthless and that sound business judgment established that there was no likelihood of recovery. Thus, a debt cannot be written off as uncollectible at 120 days, when a Provider continues collection efforts.

Further, the Administrator notes the Board's finding that application of the cited Intermediary Manual provision goes beyond the requirements of the regulation and program instructions and creates undue burdens and promotes program inefficiency. However, as the agency explained, since Medicare bad debts have a direct dollar for dollar effect on reimbursement, there is an incentive to claim bad debts before they become worthless. If a provider continues to attempt collection of a debt, either through in-house or a collection agency, it is reasonable to conclude that the provider still considers that debt to have value and not worthless. Thus, contrary to the Board's finding, the Administrator finds it reasonable to expect a

[7] In this instance, the Administrator notes that, based on the collection agency recovery report, the Provider, in fact, recovered a significant amount of accounts previously written off.

provider to demonstrate that it has completed its collection effort, including outside collection, before claiming debts as worthless.

Finally, the Administrator disagrees with the Board's conclusion that, pursuant to the language of section 316 of the PRM, the Medicare program expects that providers will continue to pursue collection activities with respect to debts that have been deemed uncollectible. The Administrator notes that this PRM section provides only an instruction, in the event that a Medicare bad debt is subsequently recovered, for reporting such revenue and its reimbursement effect. This is a provision to prevent double dipping by the Provider at the expense of the Program. The Administrator finds that the language of the manual section in no way infers that the Medicare program expects, or even anticipates, providers to continue to pursue collection activities after claiming Medicare bad debts on their cost reports.

DECISION

The decision of the Board is reversed, consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 11/22/06 /s/

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