CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Wilmington Treatment Center **Provider** **vs.** **Blue Cross/Blue Shield Association** **Cahaba Safeguard Administrators, LLC** **Intermediary**	**Provider Reimbursement for** **Cost Reporting Period Ending:** **09/30/99** **Review of:** **PRRB Decision 2006-D58** **Dated: August 24, 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 CMS' Centers for Medicare Management (CMM) and the Intermediary. Comments were also received from the Provider. Accordingly, this decision is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's disallowance of Medicare bad debts claimed by the provider was proper.

The Board, modifying the Intermediary's adjustment, held that the disallowance of bad debts related to indigent patients whose accounts were written-off without approval of the executive director was proper. In addition, the Board determined that the Intermediary's disallowance of bad debts claimed for accounts written-off in FYE 1998 and being claimed in the FYE 1999 cost report was proper. However,

the Board remanded the bad debts relating to non-indigent patients to the Intermediary for a determination of adequacy of the Provider's collection efforts. With respect to bad debts related to indigent patients, the Board found that the Provider did not follow its own bad debt write-off policy. The Board noted §312 of the Provider Reimbursement Manual (PRM) which explains that if a patient is indigent, a debt may be deemed uncollectible without applying collection procedures otherwise required. However, the Board found that the financial information submitted by the Provider did not have the proper signature approving the up-front administrative write-off due to patient indigence, which was contrary to the Provider's bad debt policy. The Board also concluded that certain bad debts that were written-off in a prior year but claimed on the present year cost report are not allowable.

However, with respect to bad debts related to non-indigent patients, the Board found that all nine of these bad debts listed in the Provider's Exhibit P-9 as (poor, fair, or good ability to pay) and those listed as "ATP unknown" must be reviewed by the Intermediary to determine whether the Provider's collection effort is adequate. Thus, the Board remanded to the Intermediary for a determination.

SUMMARY OF COMMENTS

CMM commented, requesting review of the Board's decision. CMM argued that although it agreed with the Board's decision with respect to indigent patient bad debts, it does not agree with the Board's remand to the Intermediary with respect to bad debts related to non-indigent patients.

CMM stated that intermediaries have a responsibility for a determination of the appropriateness of a provider's specific bad debt collection strategy. The Intermediary expects the provider to submit proper documentation to verify bad debt reimbursement. In this instance, the documentation furnished by the Provider was not timely and was not adequate. CMM noted that the Board did not adhere to the bad debt policy. Many of the accounts were written-off prior to 120 days of the first bill being mailed to the beneficiary, which is in violation of the Medicare policy. Contrary to the Board's decision, a debt cannot be properly deemed uncollectible prior to 120 days.

The Intermediary commented, requesting review of the Board's decision. The Intermediary referred to the arguments articulated in its post hearing brief and those stated by CMM.

The Provider commented in response to CMM. The Provider argued that CMM's objections to the PRRB remand are without merit. The Provider pointed out that the Intermediary did not make a separate determination as to the adequacy of the Provider's collection efforts for the non-indigent bad debts. Thus, the PRRB acted within its authority to remand the case for further factual development.

Further, the Provider contended that contrary to CMM's assertion, the plain language of the Provider Reimbursement Manual permits some debts to be considered uncollectible in less than 120 days. The Provider stated that the 120-day period referenced in §310.2 of the PRM creates a presumption that a debt can be claimed as a bed debt after the lapse of 120 days. However, the Provider argued that the PRM section did not establish an additional prerequisite for claiming a bad debt nor establish any minimum time period.

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.

With respect to the conditions for payment, Section 1815(a) of the Act states that Medicare payment will not be paid to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due to such provider for the particular cost period at issue. The Secretary has implemented this provision in the regulation at 42 C.F.R. §§413.20 and 413.24, which requires providers to maintain financial and statistical records sufficient for an accurate determination of program costs.

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.[1] 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

[1] See also, Section 304 of PRM.

> claims arising from the furnishing of services, and are collectible in money in the relatively near future.[2]

The regulation at 42 CFR §413.80(d) states that payment for deductibles and coinsurance amounts are the responsibility of the beneficiaries. However, 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.[3] 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:
>
> (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.[4] (Emphasis added).

Further, the Intermediary Manual explains that Medicare bad debts for deductibles 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 before they become worthless. This instruction also discusses that reliance on a collection agency may occur and the kind of documentation in which the providers are to 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 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 efforts.

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

[3] See Id.

[4] See also Section 308 of the PRM.

Consistent with the general documentation regulations at 42 C.F.R. §§413.20 and 413.24, the §310 of the PRM defines a "reasonable collection effort" and specifically requires that, "the provider's collection effort should be documented in the patient's file by copies of the bills, follow-up letters, reports of telephonic and personal contact, etc." The Administrator recognizes that §310.2 of the PRM permits a debt unpaid for more than 120 days from the date the bill is first mailed to the beneficiary to be "deemed" uncollectible. However, the Administrator notes that the language of that provision implies discretionary rather than mandatory application of the presumption, that is, the debt "may" rather than "shall" be deemed uncollectible. That provision of the PRM does not suggest that this presumption releases the provider from meeting the general regulatory documentation requirements or the specific documentation requirements set forth in the PRM at §310B and 314. The presumption only applies where the provider has otherwise demonstrated through appropriate documentation that it had engaged in reasonable collection efforts. Therefore, the Administrator finds that the Intermediary applied the correct standard in this case in requiring reasonable collection efforts for at least 120 days.

Further, the §312 of the PRM explains that individuals who are Medicaid eligible as either categorically or medically needy may be automatically deemed indigent. However, the PRM provision at §312(c) requires that, "The provider must determine that no source other than the patient would be legally responsible for the patient's medical bills." Section 312 also states that," Once indigence is determined, and the provider concludes that there has been no improvement in the beneficiary's financial condition, debt may be deemed uncollectible without applying the §310 procedure."

Finally, the PRM at §316 provides an instruction regarding the event that a bad debt is recovered subsequently, the reporting of such revenue and its reimbursement effect. This provision is intended to prevent "double dipping" by the provider at the expense of the Medicare program.

In this case, the Administrator finds that the Board's decision is correct and supported by the record with respect to the bad debts related to indigent patients and with respect to bad debts written off in a prior year. However, the Administrator disagrees with the Board's decision with respect to bad debts related to non-indigent patients. The Administrator finds that the Provider failed to establish that it engaged in a reasonable collection effort, 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."

The Administrator finds that the Intermediary properly denied costs for bad debts of non-indigent patients for lack of adequate, verifiable documentation. The Board erroneously remanded this case for further review of the Provider's collection efforts for bad debts of non-indigent patients. The record reflects that the Provider had ample opportunity to submit adequate, verifiable documentation, but failed to do so.

Consistent with section 1816 of the Act, the Secretary has delegated the responsibility of the determination of the amount of any payments due to providers to intermediaries. As reflected in this statutory language and consistent with the regulations, a provider must submit the documentation necessary to satisfy the Intermediary as to the amount due for services rendered. Therefore, to allow the Board to remand this case when the Provider has failed to meet its regulatory burden to document claimed costs would permit an unacceptable "second bite at the apple" for the Provider.

Finally, the Administrator notes that, contrary to the Board's finding, the Intermediary's sampling methodology was appropriate and sufficient. Section 4499 of the Medicare Intermediary Manual, Part 4, Audit Procedures, Exhibit 15 describes the specific audit procedures for claimed bad debts and indicates that Intermediaries are to utilize sampling. Case law provides no mention of a floor for conducting sampling, which auditors must exceed to ensure due process to providers.[5] Nor is there any evidence in this case to suggest that chosing the sampling from Part B bills skewed the error rate. Consequently, the Administrator finds that the failure was not the Intermediary's sampling methodology, but rather the Provider failure to submit the adequate documentation to its Intermediary to support its claimed bad debts.

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[5] Michigan Department of Education v. U.S. Department of Education, 875 F.2d 196 (6th Cir. 1989) ("There is no case law that states how large a percentage of an entire universe must be sampled."Id. At 1206.); Ratanansen v. State of California, 11 F.3d 1467, 1472 (9th Cir. 1993) ("Indeed, the sample of 3.4 percent in the instant case exceeds that of the sample in Michigan where a random, stratified sample of .4 percent was used as a starting point for determining improper procedures."); Webb v. Shalala, 49 F.Supp. 2d 1114 (W.D. AK 1999) ("We do not believe there is a statistically floor."). Moreover, consistent with the general documentation rules of Section 1814 of the Act and the regulation at 42 C.F.R. §§413.9, 413.20 and 413.24, courts have concluded that it is not unreasonable to place the burden on the challenging party to present evidence to rebut a statistical sample.

DECISION

Accordingly, the decision of the Board with respect to the Provider's bad debt claims is modified, consistent with the foregoing opinion.

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

Date: 11/22/06

/s/
Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services