CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Sierra Nevada Memorial Hospital **Provider** **vs.** **Blue Cross/Blue Shield Association** **United Government Services, LLC** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/00** **Review of:** **PRRB Dec. No. 2007-D40** **Dated: May 31, 2007**

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 section 1878(f) (1) of the Social Security Act (Act), as amended, 42 U.S.C. §1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. Comments were received from the Centers for Medicare Management (CMM) requesting that the Board's decision be reversed. Comments were received from the Provider requesting the Board's decision be affirmed. Accordingly, this case is now before the Administrator for final administrative decision.

ISSUE AND BOARD DECISION

The issue is whether the Provider's regular Medicare outpatient bad debts are not allowed until all collection efforts, including those of a collection agency, have ceased.

The Board reversed the Intermediary's adjustment, finding that the Provider properly claimed accounts as Medicare bad debts, even though they were still with an outside collection agency. The Intermediary disallowed a portion of the Medicare bad debts as the Provider failed to comply with the requirements of 42 CFR §413.80(e). The Intermediary's sole basis for the disallowance was the use of an outside collection

agency after the debt had been deemed worthless and written-off. The Intermediary concluded that the Provider was not entitled to claim reimbursement for any debts until such time that the collection agency ceased its collection activities and returned the accounts to the Provider. The Board found that the Provider's practice of writing off uncollected accounts after 120 days and then sending them to an outside collection agency is consistent with the regulations and program instructions. The Board was unable to reconcile the Intermediary's position with §310.2 of the Provider Reimbursement Manual, which allows a provider to seek reimbursement for accounts that remain uncollectible after it has engaged in reasonable and customary collection efforts for a period of at least 120 days. According to the Manual at §310.2A, a provider's use of a collection agency may be in addition to collection efforts undertaken by the provider. That same provision allows for a presumption of uncollectibility after a provider's reasonable and customary attempts to collect the bill has failed, and the debt remains unpaid for more than 120 days. The Board disagreed with the Intermediary's argument that the use of an outside collection agency negates the presumption of uncollectibility, even if the debt remains unpaid after 120 days.

The Board also found that §316 of the Manual provides that when a provider in a later reporting period recovers amounts previously claimed as bad debts, the provider's reimbursable costs in the period of recovery are reduced by the amounts so recovered. The Board found it is reasonable to infer that the Medicare program anticipates that providers can continue to pursue collection activities for debts that have been deemed uncollectible. The only publication that addresses the denial of a bad debt while an account is still at the collection agency after the 120 day mark is the Medicare Intermediary Manual (MIM). The Board found that the Administrator's interpretation requires undue efforts to collect bad debts and that such requirements do not foster program efficiency.

SUMMARY OF COMMENTS

CMM commented, requesting reversal of the Board's decision. CMM stated that Medicare policy does not allow a bad debt to be claimed, even after 120 days, while a provider is still engaged in collection efforts. Instead, active accounts at a collection agency cannot be stated as being worthless or having no likelihood of future recovery. Section §310.2 of the Provider Reimbursement Manual must be read in the context of the bad debt policy set forth in §§308 and 310. That is, until the provider's reasonable collection effort has been completed (both in-house and, if used, a collection agency) a bad debt cannot be properly claimed. If an account is in collection, it has not been determined to be uncollectible. A provider, therefore, cannot have established that it is worthless and there is no likelihood of recovery in

the future. CMM noted that the Intermediary Manual confirms the long-standing policy that bad debts cannot be properly claimed while an account is still in collection at a collection agency, as there is still likelihood of future recovery.

The Provider stated that the Board's decision was careful and well-reasoned and should be affirmed in all respects.

DISCUSSION AND EVALUATION

Section 1861(v)(1)(A) of the Act requires that providers of services to Medicare beneficiaries are to be reimbursed the reasonable costs of those services. Reasonable cost is defined as 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 ..." 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 statute is that Medicare shall not pay for costs incurred by non-Medicare patients and that non-Medicare patients shall not pay for costs incurred by Medicare beneficiaries, 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 costs must be based on costs related to the care of Medicare beneficiaries. Relevant to this case, the regulation at 42 CFR §413.80(a) (2000)[1] 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. Bad debts are defined at 42 CFR §413.80(b) (1) as: "Amounts considered being uncollectible from accounts and notes receivable that were created of acquired in providing services."

The regulation at 42 CFR §413.80(d) states that the payment for deductibles and coinsurance amounts are the responsibility of beneficiaries. However, recognizing the reasonable costs principle at section 1861(v)(1)(a) of the Act, which prohibits cross subsidization, the Medicare program states that the inability of providers to collect deductibles and coinsurance amounts from Medicare beneficiaries could result in a part of the costs of Medicare-covered services being borne by the individuals who are not beneficiaries. Therefore, to prevent such cross-subsidization,

[1] Redesignated as 42 CFR §413.89.

Medicare reimburses providers for allowable Medicare related bad debts. Consequently, Providers may receive reimbursement for Medicare bad debts, if they meet all of the criteria set forth in 42 CFR §413.80(e):

> 1. The bad 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.

Under the Secretary's interpretive authority, the Provider Reimbursement Manual has been issued, which clarifies the reimbursement regulations. Relevant to the issue in this case, §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 refers to a collection agency its uncollected non-Medicare 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.

In further explaining reasonable collection effort, §310.2 of the Manual 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 Manual 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 non-collectible.

Consistent with the law, 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 before they become worthless. 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.

Further, consistent with §1815 of the Act, the regulations at 42 C.F.R. §§413.20 and 413.24(a) requires that reimbursement claims must be supported by "adequate cost data" based on "financial and statistical records which must be capable of verification by qualified auditors."

In this case, the parties agreed that the Provider wrote-off Medicare bad debts at 120 days, while continuing collection efforts with several collection agencies. Applying the foregoing provisions of the Act, the regulations and instructions to the facts in this case, the Administrator finds that the intermediary properly determined that the Provider's Medicare bad debts were not allowable. In this instance, 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. The Administrator recognizes that §310.2 of the Manual permits debts 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. This does not therefore suggest that this presumption relieves the provider from meeting the general regulatory documentation requirements or the specific documentation requirements in §§310.B and 314. The presumption only applies where a provider has otherwise demonstrated, through appropriate verifiable contemporaneous documentation, that it engaged in reasonable collection efforts.

Further, as the CMS has explained, since Medicare bad debts have a direct dollar for dollar affect 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 that it is not worthless. The Administrator therefore finds it reasonable to expect a provider to demonstrate that it has completed its collection effort, including outside collection, before claiming debts as worthless. In this case, the Provider did not meet its burden of demonstrating it completed its collection efforts and that, consequently, did not demonstrate that the debt was actually uncollectible when claimed as worthless and that sound business judgment established that there was no likelihood of recovery at any time in the future.

The Administrator also notes that §316 of the Manual provides only an instruction, in the event that a Medicare bad debt is subsequently recovered, for reporting such revenue and its reimbursement effect. This constitutes 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. Therefore, if a provider deems a debt uncollectible after reasonable collection efforts and, thus, has determined that it is worthless, a provider would not be expected to pursue further collection activities. However, if a provider does continue to pursue collection activities, clearly it does not believe the debt to be worthless.[2]

[2] The record shows that the Intermediary reviewed the documentation provided by the Provider and, inter alia, also found that there were inconsistent collection efforts used for Medicare and non-Medicare bad debts. Intermediary's Final Position Paper; Exhibit I-1 (Audit Adjustment Report)("Auditor reviewed non-Medicare activity notes and found that inconsistent collection efforts exists among the Medicare and non-Medicare payors. It is noted that [the collection agencies] had more extended collection effort for self-pay patients than Medicare patients ...") The Provider submitted credit agency letters stating that the policy was to use the same collection efforts. Provider Exhibit P-11 The record was not further developed as to this basis for the denial before the Board.

DECISION

Consistent with the foregoing opinion, the Administrator reverses the Board's decision. The Intermediary properly adjusted the Provider's Medicare bad debts in this case.

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

Date: 7/27/07

/s/
Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services