CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Battle Creek Health System and Mercy General Health Partners **Provider** **vs.** **Blue Cross Blue Shield Association/ United Government Services, LLC** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 06/30/99** **Review of:** **PRRB Dec. No. 2004-D40** **Dated: September 16, 2004**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision[1] 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 USC 1395oo(f)). Comments were received from CMS, Center for Medicare Management (CMM) requesting reversal of the Board's decision. The parties were then notified of the Administrator's intention to review the Board's decision. The Provider also submitted comments, requesting that the Administrator affirm the Board's decision. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

[1] The Administrator notes that the Board's decision emcompasses two cases: Battle Creek Health System, PRRB Case No. 02-0431 and Mercy Health Partners, PRRB Case No. 02-0364. The only issue in the Mercy General case concerns Medicare bad debts. The parties have agreed to incorporate the Battle Creek Health System record pertaining to the Medicare bad debts issue on the record of Mercy General Health Partners. Thus, the Administrator's decision regarding the Medicare bad debts issue in the Battle Creek Health System case will, likewise, apply to the Mercy General Health Partners case.

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ISSUE AND BOARD DECISION

The issue before the Administrator is whether the Intermediary properly concluded that the Provider failed to make reasonable collection efforts and document such efforts with respect to certain claimed bad debts.[2]

The Board held that the Intermediary's adjustment disallowing Medicare bad debts due to inadequate collection efforts was improper. The Board found that the Intermediary disallowed the Provider's bad debts because the Provider failed to comply with the requirements of the regulation at 42 CFR §413.80 that sets forth certain criteria providers must meet for reimbursement. The Board stated that the Intermediary's sole basis for the disallowance was the Provider's use of an outside collection agency as part of its collection efforts. The Board noted the Intermediary's argument that the Provider was not entitled to claim Medicare reimbursement for any bad debt until such time that the collection agency ceased its collection activities and returned the account to the Provider. However, the Board found that the Intermediary's argument is contrary to Section 310.2 of the Provider Reimbursement Manual (PRM) which permits a provider to claim Medicare bad debts for accounts that remain uncollected after a provider has engaged in reasonable and customary collection efforts for a period of at least 120 days.

The Board noted that pursuant to Section 310.2 of the PRM, a provider's use of a collection agency may be "in addition to or in lieu of" collection efforts undertaken by the Provider itself. Thus, the Board found that the Intermediary's argument that the Provider's use of an external collection agency obligated the Provider to engage in its collection efforts for a period greater than the 120 day criterion is not supported by the applicable Medicare regulations or manual instructions.

The Board, referencing Section 316 of the PRM, noted that the manual indicates that when a provider, in a later period, recovers amounts previously included in allowable bad debts, the provider's reimbursable costs in the period of recovery are reduced by the amounts so recovered. Thus, the Board concluded that it is reasonable to infer that the Medicare program expects that providers will continue to pursue collection activities with respect to debts that have been deemed

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[2] The Board's decision involved two issues. With respect to Issue No. 1, concerning whether the Intermediary's adjustment to the Provider's TEFRA rate was proper, the Board affirmed the Intermediary's adjustment. The Administrator hereby summarily affirms the Board's decision as to Issue No. 1.

uncollectible. Thus, under the law, regulations and program instruction, the Board found that Provider is entitled to Medicare reimbursement for the bad debts at issue in this case.

SUMMARY OF COMMENTS

CMM commented, requesting reversal of the Board's decision. CMM argued that in order for bad debts to be reimbursable cost under Medicare, they must meet the criteria set forth in 42 CFR §413.89 and the requirements in PRM, Part I, Ch. 3.

CMM noted that Section 310.2 of the PRM provides specific guidelines regarding the noncollectibility of bad debts. Specifically, section 310.2 of the PRM 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." CMM argued that Medicare's intent has always been that section 310.2 of the PRM be read within the context of the bad debt policy as set forth at sections 308 and 310 of the PRM. That is, 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. CMM noted, that based on the relevant facts, the Provider's claimed bad debts were still active accounts held by the collection agency, were not yet deemed worthless or uncollectible, and not eligible to be claimed as reimbursable bad debts. Thus, CMM concluded that the Provider did not meet the reasonable collection effort requirements in the regulations or manual instruction.

The Provider, commented requesting affirmation of the Board's decision. The Provider claimed that the Board's decision was consistent with Medicare law and policy and the Board's decision benefits the Medicare program because it provides incentives for providers to continue to pursue collection activities, even after they deem these debts uncollectible. The Provider asserted that there is no dispute that the Provider met the first two criteria of the Medicare regulation at 42 CFR §413.80(e) and that it engaged in a reasonable collection effort.

Further, the Provider argued that, pursuant to a presumption set forth in section 310.2 of the PRM, it should receive reimbursement. The Provider claimed that it engaged in reasonable collection efforts for 120 days before claiming the amounts as bad debts. The Provider pointed out that the Intermediary Manual provision relied on by the Intermediary conflicts with the PRM presumption that the Medicare program expects providers to continue to pursue collection efforts, even after they deem bad debts uncollectible. In addition, application of the Intermediary Manual provision would adversely affect providers who diligently

engage in reasonable collection efforts. Thus, the Provider concluded that, pursuant to the plain language of the regulations and Provider Reimbursement Manual, it is entitled to Medicare reimbursement for its claimed bad debts.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments timely received have been included in the record and 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. However, if a provider's costs include amounts not reimbursable under the provider, those costs will not be reimbursable.

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.[3] 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.

[3] See also, Section 304 of PRM.

> "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.[4]

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 program 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.[5]

Consequently, Providers may receive reimbursement for Medicare bad debt, if they meet all of the criteria set forth in 42 CFR §413.89(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.[6] (Emphasis added).

Under the Secretary's interpretive authority, the Provider Reimbursement Manual (PRM) has been issued, which clarifies the reimbursement regulations. 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.

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

[5] See Id.

[6] See also, Section 308 of the PRM.

Section 310.A of the Manual further states:

> 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 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 non-collectable[7]. This instruction also embodies a burden of the Provider to thoroughly document its claimed bad debts:

> Since bad debts are uncollectable accounts…the Provider should have the usual accounts receivable records-ledger cards and source documents to support its claim…for each account included. Examples of the information that may be retained include…date of bills…date of write off.

Moreover, to ensure that Providers receive reimbursement for services they actually furnish, the Secretary has implemented a number of Medicare documentation regulations at 42 CFR §§413.9, 413.20 and 413.24. Consistent with the documentation regulations and relevant to Medicare bad debts, section 310.B of PRM provides:

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[7]

> Documentation Required. -- The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

Consistent with the Act, the Secretary has also issued guidelines for an intermediary to follow when auditing cost reports. The Intermediary Manual at Exhibit 11 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.

This instruction also discusses both that reliance on a collection agency may occur 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[8].

Finally, the Administrator notes that the agency issued policy memorandum, dated June 11, 1990 and April 1, 1992, which discussed the intent of the regulation, the Manual and the effects of the moratorium on the allowance of bad debts. Although the moratorium is not at issue in this case, the policy memorandum is equally instructive. Specifically, the June 11,1990, memorandum states that:

> [U]ntil 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. This is in accord with the fourth criterion in section 308 which provides that an uncollected Medicare account cannot be considered an allowable Medicare bad debt unless sound business judgment established that this is no likelihood of recovery at any time in the future. We have always believed that, clearly, there is a likelihood of recovery for an account sent to a collection agency and that claiming a Medicare bad debt at the point of sending the account to the agency would be contrary to the bad debt policy in sections 308 and 310….

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[8] Intermediary Manual, Part IB, 13-2 Exhibit 11.

As cited above, a provider is entitled to bad debts arising from Medicare coinsurance and deductibles. In order to be reimbursed for such bad debts, a provider must meet certain criteria. In demonstrating that the criteria have been met, among other things, a provider must show that debts are actually uncollectible when claimed as worthless and sound business judgment established no likelihood of recovery in the future.

In this case, the record reflects that the Provider generally had engaged in in-house collection efforts for a certain period of time and then turned accounts over to a collection agency. The Provider then wrote-off the debts for financial purposes.[9] On audit, the Intermediary disallowed the claimed bad debts and determined that the Provider failed to demonstrate that the debts in question were uncollectible when claimed as worthless and that there was no likelihood of recovery in the future.

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. 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 notes that the Provider's testimony suggested that the collection agency furnished a report telling the Provider which of its accounts were uncollectible and worthless, and which ones the collection agency still pursued. However, the Provider admitted that it did not request such reports and indicated that it had not attempted to compare what it had written off as bad debt and what the collection agency was actually still collecting on.[10] In addition, the record contains no evidence reflecting the point in time when the debts were actually uncollectible. There is no documentation of when, or if, the collection agency returned the debts to the provider, or otherwise informed the provider that collection efforts were terminated. Rather, the Provider relied on "a presumption of uncollectibility."

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[9] See Transcript of Oral Hearing (Tr.) held September 9, 2003, pp. 77-81. However, the record and testimony is unclear as to exact time period the Provider engaged in in-house collection efforts and when accounts were forwarded to the collection agency.

[10] Tr. at 106-107.

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. Thus, the presumption only applies where a provider has otherwise demonstrated through appropriate documentation that it engaged in reasonable collection efforts.

Further, the Administrator notes the Provider's argument that application of the cited Intermediary Manual provision creates a disincentive to providers and would adversely affect providers who diligently engage in reasonable collection. 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 Provider's argument, the Administrator finds it reasonable to expect a 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 on Issue No. 1 is summarily affirmed. The decision of the Board on Issue No. 2 is reversed in accordance with the foregoing opinion.

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

Date: 11/12/04 /s/

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Centers For Medicare & Medicaid Services