CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Dameron Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/ United Government Services, LLC** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/99** **Review of: PRRB Dec. No. 2006-D16 Dated: February 17, 2006**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board decision number 2006-D16. 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) and the Intermediary both 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 administrative review.

ISSUE AND BOARD DECISION

The issue before the Administrator is whether the Intermediary's disallowance of the Provider's inpatient and outpatient Medicare bad debts was proper.

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 also noted that the mere "active" status of an account with an outside collection agency, while suggestive of collectibility of that account, is not in and of itself proof of value or collectibility. Therefore, an account that is actually worthless and uncollectible could languish as an "open" or "active" account in an outside collection agency indefinitely. Consequently, the Board reasoned that this is why neither the 120-day presumption of uncollectivibility in the PRM, nor the presumption of collectibility of collection agency accounts in the Intermediary Manual, can operate as conclusive presumption, and that the four criteria in 42 C.F.R. §413.80(e) must control.

The Board also held that the Intermediary's present rejection of the Provider's bad debt policy, after having repeatedly accepted it for prior years, was statutorily barred, pursuant to §6023 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239(Dec. 19, 1989). The Board found that beginning with the FYE 1999 audit, the Intermediary for the first time rejected bad debt submissions on accounts that remained "active" with an outside agency. The Intermediary, applying program rules in effect on August 1, 1987 with respect to collection agency referrals, accepted the Provider's bad debt collection policy before that date. Pursuant to section 6023 of OBRA, the Board held that the Intermediary cannot now apply the same rules to declare the policy unacceptable and require the Provider to change this bad debt collection policy. 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 §413.80 and the requirements in the PRM.

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.

CMM commented that pursuant to §6023 of the Omnibus Budget Reconciliation Act, when Intermediaries change and the first Intermediary, prior to August 1, 1987, allowed a hospital's bad debts for accounts sent to a collection agency, Medicare will permit that Intermediary to continue to allow the bad debts. However, CMM argued that, if the new Intermediary's position is to disallow the hospital's bad debts for accounts sent to a collection agency consistent with Medicare policy, Medicare expects it to disallow the bad debts after it becomes the hospital's Intermediary. Accordingly, UGS, the Provider's Intermediary since 1999, should disallow the Provider's bad debts for accounts sent to a collection agency until the collection agency has completed its collection effort and returned the uncollected accounts to the Provider.

The Intermediary, commented requesting reversal of the Board's decision. The Intermediary argued that under Medicare rules, including CMS instruction, the Provider's Medicare accounts at an outside collection agency could not be deemed worthless and uncollectible until the agency activity has stopped and the accounts returned to the Provider. Accordingly, if the accounts are not determined to be worthless and uncollectible, they cannot be considered as bad debts for cost reporting purposes. The Intermediary argued that the Board was in error, when it held that the Medicare regulations, program instructions and CMS memorandums did not establish any presumption that accounts assigned to an outside collection

agency should be considered to have value because collection efforts continue. Thus, the Intermediary contended that the Board's reasoning in this case violated the regulations and program instructions, and should be reversed.

The Provider, commented requesting affirmation of the Board's decision. 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. The fact that some accounts resided at an outside agency at the time of the FYE 1999 audit cannot overcome the overwhelming evidence that each of the accounts are now, and were "actually uncollectible when claimed as worthless," and without any "likelihood of recovery in the future."

Further, the Provider argued that, although they have a right to reimbursement without reliance on OBRA 1989, that law renders the Intermediary's reliance on Part IB 13-2 of the MIM and the presumption of collectibility inapplicable here. The Provider notes that prior to August 1987, the fiscal Intermediary accepted its practice of writing off bad debt, and submitting it for regular bad debt reimbursement at or about the time of assignment to an outside collection agency.

Finally, the Provider noted that the in-house collections department personalizes its collection efforts to respond to the facts and circumstances that are understandably unique in each collection account. These personalized efforts are the model of thoroughness and consistency in Medicare and non-Medicare accounts alike, because they focus on the factors that maximize collections in each account. 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 program, 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.[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 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 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

[1] See also, Section 304 of PRM.

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

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:
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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.[4] (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 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,

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[3] See Id.

[4] See also Section 308 of the PRM.

> 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-collectible[5]. This instruction also explains the burden of the Provider to thoroughly document its claimed bad debts:

> Since bad debts are uncollectible 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:

> 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 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 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:

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> 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]

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.

Further, the statutory moratorium enacted by section 4008(c) of OBRA of 1987 prohibited the Secretary from making any changes in policies that were in effect on August 1, 1987 regarding reimbursement of bad debts, including the criteria of what constitutes a bad debt. Subsequently, this provision was amended by section 8402 of the Technical and Miscellaneous Revenue Act of 1988[7] and section 6023 of OBRA of 1989,[8] to provide that:

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a chance in the hospital's collection policy. (Emphasis added.)

The Conference Report to the Technical and Miscellaneous Revenue Act of 1988 states that in order for the moratorium to apply, the intermediary must affirmatively approve a provider's policy and that such acceptance cannot be inconsistent with the regulations and program instructions. The Report states:

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

[7] Pub. L. No. 100-647.

[8] Pub. L. No. 101-239.

> The conferees wish to clarify that the Congress intended the actions of fiscal intermediaries occurring prior to August 1, 1987 to approve explicitly hospital's bad debt collection practices, to the extent such action by the fiscal intermediary was consistent with the regulations, PRRB decisions, or program manuals and issuances, are to be considered an integral part of the policy in effect on that date, and thus not subject to change.
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> However, the conferees do not intend to preclude the Secretary from disallowing bad debt payments based on regulations, PRRB decision, manuals and issuance is [sic] in effect prior to August 1, 1987.[9]

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 wroteoff the debts for financial purposes.[10] 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 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

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[9] H.R. Rep. No. 1104, 100th Cong., 2d Sess 277 (1988), reprinted in 1988 U.S. Code & Cong. Ad. News at 5337. (Emphasis added.)

[10] See Transcript of Oral Hearing (Tr.) held April 14, 2005, pp. 14-24. 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.

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 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.

The Administrator also notes that section 316 of PRM 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. Thereby, if a provider deems a debt uncollectible after reasonable collection efforts, and, thus 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

Finally, the Administrator disagrees with the Board's conclusion that, pursuant to the language of section 6023 of the Omnibus Budget Reconciliation Act of 1989, the Intermediary's present rejection of the Provider's bad debt policy is statutorily barred. In this case, the record fails to show that the Intermediary "accepted" the Provider's policy (or procedures or practice) within the meaning of the moratorium. As the legislative history makes clear, an intermediary must explicitly approve a provider's policy in order for the moratorium to apply.[11] In this case, the record does not demonstrate an explicit approval by the Intermediary of the Provider's bad debt policy and practices.

[11] See H.R. Rep. No. 1104, 100th Cong., 2d Sess 277 (1988), reprinted in 1988 U.S. Code & Cong. Ad. News at 5337. See e.g., Hennepin County Medical Center v. Shalala, 81 F.3d 743 (8th Cir. 1996); University Health Services, Inc. v. Shalala, 120 F.3rd 1145 (1997).

The Administrator finds that the Provider submitted the Statements of the CFO and a print-out of the bad debt policy, dated after August 1, 1987. However, these documents do not demonstrate explicit approval by the Intermediary. The Administrator also notes the Provider's argument that it would have had to keep records an inordinate amount of time. However, regardless of recordkeeping requirements, under administrative law, the proponent of the rule has the burden of proof. 5 USC 556(d). In this instance, the Provider has the burden of proof to support its claim for bad debts by a preponderance of the evidence.

In addition, the Medicare statute provides that at Section 1815 of the Act that:

> [N]o such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid….

Consequently, the Administrator finds that it is the Provider's burden to demonstrate that the Intermediary explicitly approved its bad debt policy prior to August 1, 1987 for the moratorium to be applied. As the Provider has not demonstratated such explicit approval by the Intermediary of the Provider's bad debt policy prior to August 1, 1987, the Intermediary's disallowance in this case is not barred by the moratorium.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: 4/17/06

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