PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D11

PROVIDER - Corporacion de Las Vegas, Inc. Manati, Puerto Rico	**DATE OF HEARING-** May 29, 1998
Provider No. 40-7014	Cost Reporting Period Ended - May 31, 1995
vs.	
INTERMEDIARY - Blue Cross and Blue Shield Association/ United Government Services	**CASE NO.** 97-0831

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ISSUE:

Was the Intermediary's audit adjustment to durable medical equipment ("DME") bad debts proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Corporacion de Las Vegas, Inc. ("Provider") is a proprietary home health agency ("HHA") located in Manati, Puerto Rico. The Provider had a DME program in effect during the year ended May 31, 1995 ("FY 95"). During FY 95 it incurred $7,352 in uncollected amounts or bad debt on these services for their Medicare beneficiaries. The Provider claimed these uncollected bad debts on Worksheet D-Part II of the Medicare cost report.

United Government Services ("Intermediary") disallowed these bad debts as the result of a clarification received from the Health Care Financing Administration ("HCFA") Bureau of Policy Development. HCFA has determined that bad debts are no longer applicable to DME since payments are made on a fee schedule basis rather than on a reasonable cost basis. This change in payment methodology was the result of Section 4062 of the Omnibus Reconciliation Act of 1987 ("OBRA 87").

The Provider appealed the Intermediary's adjustment to the Provider Reimbursement Review Board ("Board"). The Provider's filing has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841.[1] The Provider was represented by Thomas P. Ward, Esquire, of Lorenz and Associates. The Intermediary was represented by James Grimes, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustment disallows allowable DME bad debts. The adjustment is based on an Intermediary policy that states that payment for bad debts for DME furnished by home health agencies is not an allowable cost since DME is not reimbursed on the basis of reasonable costs. This policy affects home health agencies in Puerto Rico, which have historically been reimbursed for bad debts relating to the coinsurance portion of DME for patients covered under the Medicare program.

The Provider further contends that it sees no basis in the statute, regulations, or manual provisions for this policy. The principle set forth in 42 C.F.R. § 413.80 states that bad debts attributable to the deductible and co-insurance amounts are reimbursable under the program. "Bad debt" is restricted in subpart (d) of that section and states:

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[1] The Provider's issue in dispute is less than the regulatory limit of $10,000. However, the Provider's request for hearing was in excess of that amount. Other disputed issues were administratively resolved.

> (d) Requirements for Medicare - Under Medicare, costs of several services furnished by beneficiaries are not to be borne by individuals not covered by the Medicare programs, and conversely, costs of services provided for other than beneficiaries are not to be borne by the health insurance program. Uncollected revenue related to services rendered to beneficiaries of the program generally means the provider has not recovered the costs of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts which remain unpaid are added to the Medicare shared allowable costs. Bad debts arising from other sources are not allowable costs.

Id.

The regulation makes no distinction between Medicare Part A and Part B costs. The Program traditionally has referred to Medicare in its entirety; that is, both Part A and Part B. The regulation also states that the bad debt must be related to a "covered service." 42 C.F.R. § 413.80(e)(I). If the regulation is intended to distinguish between Part A and Part B, it would have been written with such a distinction.

The Provider notes that under 42 U.S.C. § 1395x(v)(1)(A), the statutory language bolsters the regulation that the bad debt regulation is based upon:

> [T]he necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs . . .

Id. (Emphasis added).

"This title" obviously means Title XVIII of the Social Security Act, which created both Parts A and B.

The Provider argues that the Provider Reimbursement Manual ("PRM") section on bad debts discusses Part B: "In the determination of unrecovered costs due to bad debts, the Medicare Program is considered as a whole without distinction between Part A and Part B of the Program" Provider Reimbursement Manual, HCFA 15-1 ("HCFA Pub. 15-1") § 304. Thus, the Intermediary's policy that bad debt reimbursement is available only under the reasonable cost system is erroneous. Further, the Provider notes that the Intermediary's memorandum cites two statutory provisions regarding Part B reimbursement where bad debts reimbursement is specifically prohibited: hospital-based nurse anesthetists § 1833(l)(5)(B) of the Social Security Act and nurse practitioners Section 1861(s)(2)(k)(iii) of the Social

Security Act. No similar prohibition exists in the DME law. If Congress had seen the need to explicitly forbid reimbursement of Medicare bad debts in certain instances, such as DME, specific legislation would have been enacted.

Finally, the Provider observes that Lorenz & Associates the Provider's consultant, wrote a letter with these arguments to HCFA on May 15, 1996.[2] On May 23, 1996, HCFA issued a cursory reply that did not explain its position.[3] Lorenz & Associates wrote HCFA again on June 13, 1996, asking specific questions about the policy and HCFA's May 23 letter.[4] On August 26, 1996, Lorenz and Associates wrote HCFA requesting a response to the June 13 letter.[5] Subsequently, the Provider's representative made repeated telephone calls to HCFA but has not received a response to its letter.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that OBRA '87[6] changed the method of reimbursement for durable medical equipment. Prior to the changes, the cost of providing durable medical equipment was reimbursed on a cost basis, with the actual costs of a provider reduced by the amount of co-pays and deductibles. In those cases where the co-pays and deductibles became bad debts, Medicare recognized the bad debts in order to avoid cost shifting of Medicare cost to other payers. However, with the enactment of OBRA '87, a provider can no longer be reimbursed for the cost of durable medical equipment. The exclusive payment mechanism under § 4062 of OBRA is the lesser of a fee schedule or actual charges. The Intermediary noted the Act specifically states that the statutory language states "[t]his subsection shall constitute the exclusive provision of this title for payment for covered items under this part." 42 U.S.C. §§ 1395m and § 1834(a)(1)(C) of the Social Security Act. The intent of Congress is clear that payment of 80% of the fee schedule is the only payment a provider can claim from the Medicare program.

The Intermediary argues that since the Provider is not being reimbursed on a cost basis, actual costs are not reduced by the amount of co-payments and deductibles. Therefore, it is not necessary to include bad debts related to durable medical equipment on the cost report. There can be no cost shifting from Medicare to non-Medicare patients since the only payment the Provider is entitled to is 80% of the lower of an actual charge or fee limit.

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[2] See Provider Exhibit 1.

[3] See Provider Exhibit 2.

[4] See Provider Exhibit 3.

[5] See Provider Exhibit 4.

[6] See Provider Exhibit 1-4.

The Intermediary notes that the situation is distinguishable from hospital outpatient Part B billing. Under § 344.2 of the HCFA Pub. 15-1, the amount reimbursable by the program for outpatient services is determined by applying 80% to the reasonable cost of covered services furnished to beneficiaries after application of the deductible provisions. The remaining 20% of the reasonable costs should be recovered from the beneficiary through the coinsurance amount. The PRM goes on to say that the Medicare Program reimburses a provider for the unrecovered costs resulting from the beneficiaries' allowable bad debts. This language supports the concept of recognizing bad debts in order to assure that the Provider is reimbursed actual costs. However, as a result of OBRA '87, durable medical equipment is not reimbursed on a cost basis. DME is not treated the same way as outpatient Part B services. DME is paid on a flat fee, not on a cost basis. The Provider's payment is not determined through cost finding, and there is no reduction of cost based on the amount of co-payments. The 80% of charges is the only payment the Provider can expect from the Program. The law is clear on the payment mechanism for DME.

The Intermediary is bound to follow policy as defined and clarified by HCFA. The policy set forth by HCFA was sent to providers in a Medicare Memo dated February 8, 1996. This clarification states:

> Medicare bad debt payment cannot be made for the following services because these items are no longer reimbursed on a reasonable cost basis --- DME and Oxygen furnished by home health agencies acting as suppliers on or after January 1, 1989.

Intermediary Exhibit I-1 (Emphasis added).

HCFA's policy was again reinforced in a response to a representative of the Provider questioning this policy. Ms. Stephanie Crowley, Director in the Office of Hospital Policy in the Bureau of Policy Development, stated in a letter dated May 23, 1996:

> Medicare payments to a provider of services for the deductible and coinsurance bad debts of Medicare beneficiaries applies ONLY to the reasonable cost payment provision in Section 1861(v)(1)(a) of the Social Security Act, as implemented in the regulation at 42 C.F.R. § 413.80. The bad debt policy does not apply to services for which Medicare payment is based on charges or a fee schedule.

Intermediary Exhibit I-2.

CITATIONS OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1833(l)(5)(B)	-	Uncollected Nurse Anesthetist Coinsurance
§ 1834(a)(1)(C)	-	Exclusive Payment Rule
§ 1861(s)(2)(K)(iii)	-	Nursing Practioner Services
§ 1861(v)(1)(A)	-	Reasonable Cost

2. Law - 42 U.S.C.:

§ 1395m	-	Payment for Durable Medical Equipment
§ 1395x(v)(1)(A)	-	Reasonable Cost

3. Law - Omnibus Reconciliation Act of 1987:

§ 4062	-	Payment for Durable Medical Equipment

4. Regulations - 42 C.F.R.:

§ 405.1835-.1841	-	Board Jurisdiction
§ 412.115(a)	-	Bad Debts
§ 413.80 et seq.	-	Bad Debts, Charity and Courtesy Allowances

5. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 304	-	Bad Debts Under Medicare
§ 344.2	-	Computation Under Part B

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after considering the facts, parties' contentions, evidence submitted and post hearing briefs, finds and concludes that the Intermediary properly disallowed the Provider's claimed Medicare bad debts relating to DME rentals and sales. As the Intermediary noted in its memo dated February 8, 1998,[7] DME services are no longer reimbursed on a reasonable cost basis as of January 1, 1989. § 4062 of OBRA '87 changed the basis of payments to a fee schedule not to exceed the actual charge to the patient. The regulation at 42 C.F.R. § 412.115(a) allows additional payment under Medicare's Prospective Payment System for bad debts in accordance with the requirements of 42 C.F.R. § 413.80. Subparagraph (d) of that section only allows reimbursement for the cost of Medicare debts for non-payment of Medicare deductible and coinsurance payments by Medicare beneficiaries. That section does not address bad debts arising from charges for DME made by providers to the Medicare program or its patients. As a result, the uncollected charges do not meet the definition of bad debts included in 42 C.F.R. § 413.80(d) and are not allowable.

The Board finds that the above treatment of the DME charge-based bad debts is similar to Medicare's treatment of physician bills. If a physician or its agent bills a Medicare patient directly for services rendered, any bad debt arising from uncollected deductible or coinsurance billed to the patients is not reimbursed by the Medicare program.

DECISION AND ORDER:

The Intermediary properly denied reimbursement of claimed Medicare bad debts relating to DME equipment. The Intermediary's adjustment is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr., Esquire
Charles R. Barker

Date of Decision: November 25, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman

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[7] See Intermediary Exhibit I-1.