PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2000-D56

PROVIDER -
Methodist Hospital of Dyersburg
Dyersburg, TN

Provider No. 44-0072

vs.

INTERMEDIARY -
Blue Cross Blue Shield Association/ Blue Cross Blue Shield of Tennessee

DATE OF HEARING-
April 25, 2000

Cost Reporting Period Ended -
December 31, 1992

CASE NO. 96-1215

INDEX

ISSUES:

1. Was the Intermediary=s adjustment disallowing Medicare reimbursement for a portion of the bad debts proper?

2. Was the Intermediary=s reclassification for home health agency costs proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Methodist Hospital of Dyersburg ("Provider") is a 125 bed hospital located in Dyersburg, Tennessee. The Hospital, certified 7/1/66, contains a provider-based hospice (certified 12/1/92), and a provider-based home health agency (certified 3/2/84).[1] The Hospital is one of several hospitals and other providers which are members of the Methodist Health System headquartered in Memphis, Tennessee.

On October 9, 1995, Blue Cross/Blue Shield of Tennessee (a.k.a. Riverbend Government Benefits Administrator) ("Intermediary"), issued a Notice of Program Reimbursement ("NPR") for the Provider=s FYE December 31, 1992. Audit Adjustment # 51 disallowed payment for $89,707 of Medicare bad debts claimed by the Hospital.[2] Audit Adjustment #5 reclassified costs attributable to billing functions for a home health agency finance manager, data processor, and data entry clerk from the HHA A&G cost center to the Hospital A&G cost center.[3] The Medicare reimbursement effect for the Provider is approximately $90,000 on Issue 1, and $50,000 on Issue
2. On March 8, 1996, the Provider timely filed an appeal of the issues with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. ээ 405.1836-1841.
The Provider is represented by Mary Susan Philp of Powers, Pyles, Sutter & Verville, P.C. The Intermediary is represented by Bernard M. Talbert of Blue Cross Blue Shield Association.

ISSUE 1 - Bad Debts

PROVIDER=S CONTENTIONS:

The Provider contends that the sole basis for the disallowance of a portion of the Hospital=s Medicare bad debts results from the Intermediary=s legally incorrect application of the A120 day

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[1] Intermediary=s Position Paper, at 1.

[2] Provider=s Position Paper, Exhibit 4

[3] Provider=s Position Paper, Exhibit 22

rule."[4] Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") ə2310.2.
The Provider notes that Medicare regulations (42 C.F.R. ə 413.80(e)) require that four (4) criteria be met before bad debts can be claimed:

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.

42 C.F.R. ə413.80(e)

HCFA Pub. 15-1 ə2310.2 further states that a presumption of uncollectibility can be made after 120 days of reasonable collection efforts.

The Provider states that the Methodist Health System adopted a bad debt collection policy on November 5, 1987.[5] In 1992, the policy was modified to warn system members against a presumption of debt uncollectibility prior to 120 days from the date the Hospital mails its first bill.[6] The policy requires at least four (4) bill mailings, a 30 day "dun" letter,[7] and final placement of the debt with a collection agency.[8] The Provider maintains that the debts were related to covered Medicare services, that it made reasonable collection efforts which demonstrated that the claims were worthless, and that sound business judgment was employed to establish that there was no likelihood of recovery. Based on meeting the four prongs of 42 C.F.R. ə 413.80(e), the Provider maintains that it was not required to wait 120 days to establish a presumption of uncollectibility, having already demonstrated actual uncollectibility of the bad debts at issue in this case.

The Provider suggests that the root of the problem may be a misunderstanding on the part of the Intermediary relevant to the internal use of the term "write-off" by the Methodist Health System.

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[4] Provider=s Supplemental Position Paper, at 1.

[5] Provider=s Position Paper, Exhibit 1

[6] Provider=s Position Paper, Exhibit 2, page 3

[7] Provider=s Position Paper, page 4; Exhibit 3

[8] Provider=s Position Paper, page 4, Footnote 2

The term "write-off" suggests that a hospital expunges the account from its files or notifies the patient that the debt is forgiven. The Provider has never taken any such action with respect to its accounts, either before, or after, the 120 day period. The only thing the Provider did, in some cases, was to discontinue its own active collection efforts before the passage of 120 days, but only after exhaustion of it=s own internal bad debt collection policy. Further, the Provider retained a record of the account, and did not claim it as a Medicare "bad debt" until long after expiration of the 120 day "deeming" period of HCFA Pub. 15-1ə2310.2, and faithfully offset all "recoveries" against its Medicare "bad debt" claims.[9] In addition, the account was referred to Consolidated Recoveries at the time that the Provider made its internal entry. Although the Provider had ceased its internal collection efforts, Consolidated Recoveries continued to attempt to collect the debt.

Provider Exhibits 6 - 16 portray the computer-generated bad debt lists accepted by the collection agency, Consolidated Recoveries, Inc.[10] The Provider notes that each list is labeled as bad debt write-offs for a specific month, but the entries note the internal "write-off" date, which occurred one month prior to the shift of the debt from the Provider to the collection agency. In applying the "120 day rule", the Intermediary used the earlier "internal" write-off date, rather than the actual bad debt transfer date. The Provider contends, as noted supra, collection efforts by the Provider continued up to the later bad debt-transfer-to-collection agency date, and beyond, via the collection agency efforts.[11]

Finally, the Provider cites Lourdes Hospital v. AdminaStar of Kentucky , PRRB Dec. Nos.95-D58, 95-D59, 95-D60, Medicare and Medicaid Guide (CCH) &43,585 (1995); King=s Daughters= Hospital v. Blue Cross and Blue Shield of Kentucky, PRRB Dec. No. 91-D5, Medicare and
Medicaid Guide (CCH) &38,950 (1990); St. Francis Hospital and Medical Center v. Kansas Hospital Service Assn.., PRRB Dec. No. 86-D21, Medicare and Medicaid Guide (CCH) &35,302 (1985), and Scotland Memorial Hospital v. Blue Cross and Blue Shield Association of North Carolina, PRRB Dec. No. 84-D174, Medicare and Medicaid Guide (CCH) &34,225 (1984) in support of its contention that if all four (4) prongs of 42 C.F.R. ə413.80(e) are met, the 120 day rule of HCFA Pub. 15-1 ə2310.2 is moot. In Lourdes, the Board ruled, and the Administrator concurred, that ə2310.2 provides a presumption of uncollectibility only, and that the provider may write off bad debts in less than 120 days if its collection efforts are reasonable. The collection efforts in the instant case are strikingly similar to Lourdes, including removal of the debt (Awrite-off≅) from the hospital=s accounting records at the same time it turned over the debt to the collection agency. King=s Daughters=, St. Francis, and Scotland Memorial all speak to the Provider=s contention that, following reasonable collection efforts, as demonstrated by the

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[9] Provider=s Position Paper, at 8

[10] Provider=s Position Paper, Exhibits 6 - 16

[11] Provider=s Position Paper, at 10

Provider in the instant case, Medicare bad debts can be written off in less than 120 days, the presumption of HCFA Pub. 15-1 ə2310.2 notwithstanding.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its adjustments were proper. The Intermediary examined all Medicare Part A bad debts listed by the Provider. The adjustment was not based on a "sample" or "error rate" estimate.[12] The Intermediary cites 42 U.S.C.ə 1395x(v)(1)(A), prohibiting cross-subsidization, as the basis for its audit adjustment to the Provider=s Medicare bad debt claims. Because the Program acknowledges that the inability of providers to collect deductibles and coinsurance amounts from Medicare beneficiaries could result in cross-subsidization of Medicare
costs by non-Medicare patients, the Program will pay providers for allowable Medicare bad debts, providing the four (4) criteria of 42 C.F.R. ə413.80(e) are met. In the instant case it was the Provider=s inconsistent collection efforts, and lack of effort to document the 289 exceptions to the 120 day rule, that led to exclusion of $37,548 of claimed Medicare bad debts.[13] But see Provider=s Position Paper, at 2. The Intermediary conceded that: "[i]f the debt is documented by the provider to be actually uncollectible and reasonable collection efforts have been performed, the Intermediary would be able to allow the amounts claimed." Intermediary=s Position Paper, at 8. However, in the instant case, the Intermediary notes that: "[s]ince the Provider has made no effort to document the uncollectibility of the debts at issue in this case, the Intermediary must disallow the amounts claimed" (Id., at 10) because "[t]he burden of proof that the bad debts in question are allowable rests with the Provider". Id. Further, even conceding evidence that the bad debts were turned over to a collection agency, the Intermediary reiterates the contention that the Provider has produced no evidence substantiating its own "reasonable collection efforts", and without that evidence, and without documentation that the Provider met the underlying 120 day rule, the Intermediary can not further presume that a collection agency will continue "appropriate collection procedures" unless the Provider provides proof of such efforts. Absent that proof, the Intermediary must conclude that reasonable collection efforts were not pursued.

ISSUE 2 - Home Health Agency Costs

PROVIDER=S CONTENTIONS:

The Provider contents that it properly reported the costs for the Home Health Agency finance manager,[14] data processor,[15] and data entry clerk,[16] in the home health A&G cost center. These

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[12] Intermediary=s Position Paper, at 4; Exhibit I-1

[13] Intermediary=s Position Paper, Exhibit I-1 at 3

[14] Provider=s Position Paper, Exhibit 17 - Finance Manager Job Description

individuals were employed by, and performed duties exclusively for, the hospital-based home health agency. The salary costs were costs of the home health agency, not the Hospital.[17]
The Provider states that the first requirement for direct costing in Medicare is that the direct assignment of costs must result in a more accurate allocation of the costs. 42 C.F.R. ∋413.24(d)(2)(ii); HCFA Pub. 15-1 ∋2310. In this case, the Provider=s methodology directly assigns the costs of the three personnel at question to the HHA, the foci of their duties. The Intermediary=s audit adjustment results in an allocation of these employees= costs to Hospital cost centers which receive no benefit from the employees services. For example, the costs are spread as far afield as the Hospital=s operating room, where the at-issue HHA employees had no involvement. The Provider contends that such an allocation violates HCFA Pub. 15-1 ∋ 2302.9, which states that general services costs are to be allocated on the basis of services rendered.[18]
The Provider further cites St. Elizabeth Hospital v. Blue Cross Assoc/Hospital Plan, Inc., PRRB Dec. No. 81-D69, Medicare and Medicaid Guide (CCH) & 31,475 (1981); St. Mary=s Hospital and Medical Center v. Blue Cross and Blue Shield Assn.., PRRB Dec. No. 90-D34, Medicare and Medicaid Guide (CCH) & 38,627 (1990); St. John=s Hospital & Health Center v. Blue Cross and Blue Shield Assn., PRRB Dec. No. 84-D131, Medicare and Medicaid Guide (CCH) & 34,163 (1984), and Chicago College of Osteopathic Medicine v. Heckler, Medicare and Medicaid Guide (CCH) &34,044 (N.D.Ill. 1984) as precedent for the premise that direct allocation of costs provides a more accurate methodology. See also: Upjohn Health Care Services, Inc. v. Blue Cross and Blue Shield United of Wisconsin, PRRB Dec. No. 96-D52, Medicare and Medicaid Guide (CCH) & 44,558 (1996); Upjohn Health Care Services, In. v. Blue Cross and Blue Shield United of Wisconsin, PRRB Dec. No. 96-D47, Medicare and Medicaid Guide (CCH) & 44,548 (1996); Medical Center of Garden Grove v. Blue Cross of California, PRRB Dec. No. 95-D1, Medicare and Medicaid Guide (CCH) & 42,913 (1994); Western Medical Center v. Blue Cross of California, PRRB Dec. No. 97-D2. Medicare and Medicaid Guide (CCH) & 44,744 (1996); Sierra Vista Regional Medical Center v. Blue Cross of California, PRRB Dec. No. 95-D11, Medicare and Medicaid Guide (CCH) & 42,969 (1994); Circle City Hospital v. Blue Cross of California, PRRB Dec. No. 95-D4, Medicare and Medicaid Guide (CCH) & 42,916 (1994); Arroyo Grande Community Hospital v. Blue Cross of California, PRRB Dec. No. 95-D3, Medicare and Medicaid Guide (CCH) & 42,915 (1994).

The Provider rejects the Intermediary=s contention that assignment of the costs at issue to the home health agency will result in duplication of costs because the HHA also receives an

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[15] Provider=s Position Paper, Exhibit 18 - Data Processor Job Description

[16] Provider=s Position Paper, Exhibit 19 - Data Entry Clerk Job Description

[17] Provider=s Position Paper, at 18

[18] Provider=s Position Paper, at 19

allocation of A&G costs from the parent Hospital.[19] Using the Intermediary=s rationale, the Provider notes that all HHA A&G costs would have to be reclassified to the parent Hospital=s A&G cost center to avoid "duplication," an approach clearly inconsistent with Medicare cost reporting requirements which require the establishment of a separate A&G cost center for the home health agency.[20] See Form HCFA 2552-92, Hospital and Hospital Health Care Complex Cost Report, Supplemental Worksheet H-4, Line 1 (Administrative and General - HHA Cost Center);[21] Provider Reimbursement Manual, Part II (HCFA Pub. 15- 2) ээ 2845, 2845.1 (Allocation of HHA Administrative and General Costs).[22] Further, the Provider finds no support in HCFA Pub.15-1 э2307[23] for the Intermediary=s contention that all costs in a general service cost center must be directly assigned if any costs are to be.

The Provider asserts that the second requirement for the direct assignment of costs is that the assignment must be made as part of the provider=s ". . . accounting system with costs recorded in the ongoing normal accounting process."[24] HCFA Pub. 15-1 э 2307. All costs for the three HHA employees were routinely recorded in the HHA=s financial records; the Provider thus states it meets the requirement of э 2307.

HCFA Pub. 15-1 э 2307 details the third requirement for direct costing to be "prior approval" of the proposed provider methodology by the intermediary. The Provider takes note of the Board=s "no harm, no foul" approach to this requirement if the methodology employed results in a more accurate allocation of costs than does the intermediary=s methodology.[25] See: Pinnacle Care Drug Gross-Up Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-D41, Medicare and Medicaid Guide (CCH) & 45,169 (1997); Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-D13, Medicare and Medicaid Guide (CCH) & 44,923 (1996). The Provider asserts that the "no harm, no foul" logic applies to the instant case.

The Provider also notes that the Board has accepted, as tacit approval, audit approval by the Intermediary of a prior year=s cost report where the direct costing methodology was employed

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[19] Intermediary=s Position Paper, at 13, 17, 18; Provider=s Supp. Position Paper, at 6

[20] Provider=s Supp. Position Paper, at 6

[21] Provider=s Supp. Position Paper, Exhibit 31

[22] Provider=s Supp. Position Paper, Exhibit 32

[23] Provider=s Supp. Position Paper, at 7; See: Footnote 6 at 7

[24] Provider=s Position Paper, at 23

[25] Provider=s Position Paper, at 23

by the Provider, and no adjustment was made by the Intermediary.[26] See: Glenwood Regional Medical Center v. Blue Cross and Blue Shield Assn./Blue Cross and Blue Shield of Maryland, PRRB Dec. No. 96-D18, Medicare and Medicaid Guide (CCH) & 44,066 (1996). Worksheet A-6 from the Provider=s 1991 as-filed cost report demonstrates that the direct costing methodology was employed in the year prior to the 1992 adjustment;[27] Worksheet A-6 for the 1991 audited cost report shows no reclassification of HHA employee costs to the Hospital A&G cost center in the year prior to the 1992 adjustment[28]. Thus, Glenwood would suggest that the Intermediary gave tacit approval of the Provider=s direct costing methodology.

Finally, the Provider rejects, as irrelevant, the Intermediary=s reliance upon Children=s Hospital of San Francisco, a California nonprofit corporation, et al v. Bowen, (Civ. No. S-85-0092 MLS, E.D. Calif. (1985)), which involved Medicare=s malpractice rule.[29] That case involved apportionment, a methodology for determining Medicare=s share of a particular cost. The instant case involves allocation, a methodology for assigning costs to different cost centers. The Provider maintains that the findings in Children=s Hospital are not apropos to the instant case.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that its adjustment to the Provider=s cost report is proper in that it reclassified the administrative and clerical costs of the employees in question back to the Hospital=s A&G cost center in order to eliminate duplication of costs.[30] The Intermediary asserts that a vital element of cost finding, or determining Medicare=s share of the provider=s total cost, is that overhead expenses be consistently charged to the overhead cost centers and then allocated to the revenue producing departments, using a statistical basis. 42 C.F.R. ə 413.24(d)(1) describes the "step-down" method of cost finding, the method used by the Provider, as follows:[31]

> (1) Step-down method. This method recognizes that services rendered by certain nonrevenue producing departments or centers are utilized by certain other nonrevenue producing centers as well as by the revenue producing centers. All costs of nonrevenue

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[26] Provider=s Position Paper, at 24

[27] Provider=s Position Paper, Exhibit 20

[28] Provider=s Position Paper, Exhibit 21

[29] Provider Supp. Position Paper, at 8

[30] Intermediary=s Position Paper, at 13; Exhibit I-6

[31] Intermediary=s Position Paper, at 14, 15

> producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue.

42 C.F.R. ∋413.24(d)(1)

With respect to the instant case, the step-down methodology allocates the hospital=s A&G cost center to all departments, including the HHA=s cost centers, on the basis of accumulated cost. Therefore, the Provider=s direct assignment of certain HHA A&G costs would improperly result in the HHA receiving a share of billing and other administrative costs incurred by the hospital as well as 100 percent of its own, directly assigned, A&G costs.

The Intermediary notes that the Provider does not meet the criteria for direct assignment of costs (HCFA Pub. 15-1 ∋ 2307) because it has not identified all costs for direct assignment, but rather has used "step down" for parent Hospital A&G costs to the HHA, while using "direct costing" of the HHA A&G costs to the HHA A&G cost center.[32] Because of this combination, the home health agency is receiving a duplicative share of administrative and clerical costs by receiving 100% of the HHA=s costs and also an allocated portion of the parent Hospital=s costs.[33] Such a duplicative allocation results in a shift of greater A&G costs to the Medicare program. This is in direct violation of Medicare=s "cost shifting" or "cross-subsidization" prohibitions of 42 U.S.C. ∋1395x(v)(1)(A).[34] The Intermediary cites as precedence prohibiting cost shifting Children=s Hospital, cited supra, noting an analogy to the instant case.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

∋ 1395x(v)(1)(A)	-	Reasonable Cost

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

∋∋ 405.1835-.1841	-	Board Jurisdiction
∋ 413.24(d)(1)	-	Cost Finding Methods: Step-down Method
∋ 413.24(d)(2)(ii)	-	Cost Finding Methods: More Sophisticated Methods

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[32] Intermediary=s Position Paper, at 16

[33] Intermediary=s Position Paper, at 17

[34] Intermediary=s Position Paper, at 21; Exhibit I-3

э 413.80(e) - Criteria for Allowable Bad Debt

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

э 2302.9 - General Service Cost Centers

э 2307 - Direct Assignment of General Service Costs

э 2310et seq. - More Sophisticated Methods

4. Program Instructions-Provider Reimbursement Manual, Part II (HCFA Pub. 15-2):

э 2845 - Allocation of HHA Administrative and General Costs

э 2845.1 - Administrative and General - HHA Cost Center

5. Case Law:

Arroyo Grande Community Hospital v. Blue Cross of California, PRRB Dec. No. 95-D3, Medicare and Medicaid Guide (CCH) & 42,915 (1994).

Chicago College of Osteopathic Medicine v. Heckler, Medicare and Medicaid Guide (CCH) &34,044 (N.D.Ill. 1984).

Children=s Hospital of San Francisco, a California nonprofit corporation, et al v.Bowen, (Civ. No. S-85-0092 MLS, E.D.Calif. (1985)).

Circle City Hospital v. Blue Cross of California, PRRB Dec. No. 95-D4, Medicare and Medicaid Guide (CCH) & 42,916 (1994).

Glenwood Regional Medical Center v. Blue Cross and Blue Shield Assn./Blue Cross and Blue Shield of Maryland, PRRB Dec. No. 96-D18, Medicare and Medicaid Guide (CCH) & 44,066 (1996).

King=s Daughters= Hospital v. Blue Cross and Blue Shield of Kentucky, PRRB Dec. No. 91-D5, Medicare and Medicaid Guide (CCH) & 38,950 (1990).

Lourdes Hospital v. AdminaStar of Kentucky, PRRB Dec. Nos. 95-D58, 95-D59, 95-D60, Medicare and Medicaid Guide (CCH) & 43,585 (1995).

Medical Center of Garden Grove v. Blue Cross of California, PRRB Dec. No. 95-D1, Medicare and Medicaid Guide (CCH) & 42,913 (1994).

Pinnacle Care Drug Gross-up Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-D41, Medicare and Medicaid Guide (CCH) & 45,169 (1997).

Scotland Memorial Hospital v. Blue Cross and Blue Shield Association of North Carolina, PRRB Dec. No. 84-D174, Medicare and Medicaid Guide (CCH) & 34,225 (1984).

Sierra Vista Regional Medical Center v. Blue Cross of California, PRRB Dec. No. 95-D11, Medicare and Medicaid Guide (CCH) & 42,969 (1994).

St. Elizabeth Hospital v. Blue Cross Assoc/Hospital Plan, Inc., PRRB Dec. No. 81-D69, Medicare and Medicaid Guide (CCH) & 31,475 (1981).

St. Francis Hospital and Medical Center v. Kansas Hospital Service Assn., PRRB Dec. No. 86-D21, Medicare and Medicaid Guide (CCH) & 35,302 (1985).

St. John=s Hospital & Health Center v. Blue Cross and Blue Shield Assn., PRRB Dec. No. 84-D131, Medicare and Medicaid Guide (CCH) & 34,163 (1984).

St. Mary=s Hospital and Medical Center v. Blue Cross and Blue Shield Assn., PRRB Dec. No. 90-D34, Medicare and Medicaid Guide (CCH) & 38,627 (1990).

Sunbelt Health Care Centers Group Appeal v. Aetna Life Insurance Company, PRRB Dec. No. 97-D13, Medicare and Medicaid Guide (CCH) & 44,923 (1996).

Upjohn Health Care Services, Inc. v. Blue Cross and Blue Shield United of Wisconsin, PRRB Dec. No. 96-D47, Medicare and Medicaid Guide (CCH) & 44,548 (1996).

Upjohn Health Care Services, Inc. v. Blue Cross and Blue Shield United of Wisconsin, PRRB Dec. No. 96-D52, Medicare and Medicaid Guide (CCH) & 44,558 (1996).

Western Medical Center v. Blue Cross of California, PRRB Dec. No. 97-D2, Medicare and Medicaid Guide (CCH) & 44,744 (1996).

6. Other:

HCFA Form 2552-92, Hospital and Hospital Health Care Complex Cost Report, Supplemental Worksheet H-4, Line 1 (Administrative and General - H. A. Cost Center).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, and evidence presented, finds and concludes as follows:

ISSUE 1- Bad Debts

The Board finds that the Intermediary issued a Notice of Program Reimbursement (NPR) for Provider=s FYE December 31, 1992 on October 9, 1995. The Board finds that a portion of the Intermediary=s cost report adjustment (Audit Adjustment #51) was based on the Intermediary=s analysis of the 120 day rule (HCFA Pub. 15-1 ∋2310.2), in the amount of $37,548.[35] The Board finds no documentation to support the Intermediary=s contention based on an analysis of bad debt accounts. The Intermediary did test a small sample of bad debts,[36] but made no adjustments to bad debts based on the testing. The Board finds that the Provider had, and continues to maintain, an established bad debt collection policy and procedure, in place,[37] which was modified in 1992 to specifically speak to the 120 day rule.[38] Additionally, the Board notes that the Provider has an extensive computer-based bad debts collection system that automatically generates bills for delinquent accounts.[39] The Board also notes evidence presented by the Provider that indicates that bad debt recovery efforts continued beyond the 120 day time line, as documented by the recoveries made by Consolidated Recoveries.[40]

The Board concludes that the Provider followed it=s bad debt collection policy and procedure, and that the policy was adequate. The Board finds that the bad debts were "uncollectable" when turned over to the collection agency, thus meeting both the four (4) criteria of 42 C.F.R. ∋413.80(e), and the 120 day rule of HCFA Pub. 15-1 ∋2310.2. The Board finds that the Intermediary did not submit evidence sufficient to rebut the Provider=s documentation of an acceptable bad debt collection policy and procedure.

ISSUE 2 Home Health Agency Costs

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[35] Intermediary=s Position Paper, Exhibit I-1 at 3

[36] Intermediary=s Position Paper, at 6

[37] Provider=s Position Paper, Exhibit 1

[38] Provider=s Position Paper, Exhibit 2

[39] Provider=s Position Paper, at 4 (Footnote 1); at 11

[40] Provider=s Position Paper, Exhibits 6 - 16, ARecoveries≅ Column

The Board finds that the HHA, although hospital-based, is a Medicare Provider in it=s own right.[41] The Board also finds that the three (3) employees at issue were all 100% HHA employees.[42] These circumstances affirm the propriety of the Provider=s position that direct costing of the three (3) employees to the HHA reflects a more accurate, sound and proper accounting policy.

The Board finds that assigning the employee=s costs to the HHA cost center results in a more accurate method of cost finding than charging these expenses to the Provider=s parent A&G cost center. If the costs were allocated through the parent Provider=s A&G cost center, many hospital departments that received absolutely no benefit from the subject employees= efforts would receive a part of their costs. Also, since the allocation of the parent Provider=s A&G cost center is based on accumulated cost, and since the hospital=s costs are far greater than those of the HHA, the HHA would receive only a small portion of its own employee expenses.

The Board rejects the Intermediary=s argument that charging the subject employees= costs to the HHA cost center results in an improper allocation of the Provider=s or parent hospital=s overhead. The Board=s analysis of this argument is based on materiality. Assigning the subject employees= costs to the HHA cost center does not result in some additional parent hospital overhead being allocated to the HHA because, as previously mentioned, the allocation is based upon accumulated cost. Because the parent hospital=s costs are understood to be so much greater than those of the HHA, the actual effect of the employees= costs on the allocation is considered insignificant. While the Provider=s practice of recording the subject employees= costs directly in the HHA may not be the perfect cost finding methodology, it does result in a far more accurate methodology than that which results from the Intermediary=s reclassification. The Board strongly agrees with the Provider in that accuracy is the primary objective of the Medicare cost finding process. 42 C.F.R. ə 413.24(d)(2)(ii). The Board also notes that the Provider=s methodology is consistent with Medicare cost reporting requirements[43]. Further, the Board finds no support in HCFA Pub. 15-1 ə2307 for the Intermediary=s contention[44] that all costs in a general service cost center must be directly assigned if any costs are to be. Clearly, the Intermediary has not demonstrated the Provider=s failure to directly assign like costs, or the extent to which the Provider may have directly assigned any other costs.

DECISION AND ORDER:

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[41] Intermediary=s Position Paper, at 1

[42] Provider=s Position Paper, Exhibits 17 - 18 - 19

[43] Provider=s Supp. Position Paper, at 6; Exhibit 32

[44] Intermediary=s Position Paper, at 17; Exhibit I-8

Issue 1 - Bad Debts

The Intermediary=s reclassification disallowing $37,548 in bad debts claimed by the Provider was
improper. The Intermediary=s adjustment is reversed.

Issue 2 - Home Health Agency Costs

The Intermediary=s reclassification of certain salary and related costs from the HHA cost center to the parent hospital=s A&G cost center is improper. The Intermediary=s adjustment is reversed.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker
Stanley J. Sokolove

Date of Decision: May 30, 2000

FOR THE BOARD:

Irvin W. Kues
Chairman