PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2004-D43

PROVIDERS –
Ochsner Clinic-New Orleans Renal Dialysis Facility and Houma/Bayou Renal Dialysis Facility

Provider Nos.: 19-2531 and 19-2509

vs.

INTERMEDIARY –
BlueCross BlueShield Association/ Trispan Health Services

DATE OF HEARING –
December 2, 2003

Cost Reporting Period Ended - 12/31/1996

CASE NOs.: 00-3936 and 00-3937

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ISSUE:

Whether the Intermediary correctly disallowed Medicare Bad debts related to amounts not included in the End-Stage Renal Disease (ESRD) Composite rate.

STATEMENT OF THE CASE AND PROCEDURAL FRAME WORK:

Ochsner Clinic-New Orleans Renal Dialysis Facility and Houma/Bayou Renal Dialysis Facility (Providers) furnish end-stage renal dialysis (ESRD) services and are certified to furnish those services to Medicare beneficiaries as well as to other patients. This case arises from an adverse determination by Trispan Health Services, (Intermediary) over the amount of Medicare payment due for renal dialysis services furnished by these Providers to Medicare beneficiaries.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS—formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

During its cost reporting period ended on December 31, 1996, the Intermediary disallowed a portion of the Providers' claim for Medicare bad debts for uncollected coinsurance and deductibles for the drug Epoietin (EPO). The Providers timely filed this appeal and have met all the jurisdictional requirements.

The Providers were represented by Mark B. Davis of Deloitte & Touche LLP. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross Blue Shield Association.

THE MEDICARE PAYMENT FRAMEWORK:

ESRD facilities are reimbursed for Medicare outpatient dialysis services by payment of a "composite rate." Under this system, a provider of dialysis services receives a

prospectively determined payment for each dialysis treatment it furnishes to a Medicare beneficiary. 42 U.S.C. 1395rr(b); 42 C.F.R. 413.170 *et.seq*.

The regulations also provide for additional payments above the composite rate for certain items and services, including payment for administration of Epoetin (EPO), which is at issue in this case. 42 C.F.R. §413.170(c)(6). A deductible and coinsurance applies to both the composite rate services and the additional payments for EPO. 42 C.F.R. §§413.170(c)(7); 413.170(d).

When the facility is unable to collect the coinsurance and deductible, the regulations further provide that Medicare will reimburse facilities for their bad debts. For the 1996 cost report year in issue, the regulation governing treatment of ESRD bad debts provided as follows[1]:

(1) HCFA will reimburse each facility its allowable Medicare bad debts up to the facility's costs, as determined under Medicare principles, in a single lump-sum payment at the end of the facility's cost reporting period.

(2) A facility must attempt to collect deductible and coinsurance amounts owed by beneficiaries before requesting reimbursement from HCFA for uncollectible amounts. Section 413.80 specifies the efforts facilities must make.

(3) A facility must request reimbursement for uncollectible deductible and coinsurance amounts owed by beneficiaries by submitting an itemized list of all specific noncollections *related to covered services.* (emphasis added)

42 C.F.R. §413.170(e).

42 C.F.R. §413.80(d) explains the rationale for Medicare's reimbursing bad debts.

> Under Medicare, costs of covered services furnished to beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not

[1] The regulation was changed in 1997. Section 413.170(e) was recodified as section 413.178 and titled "Bad debts." Subsection 413.170(e)(3), recodified as 413.178(c), was changed to: A facility must request payment for uncollectible deductible and coinsurance amounts owed by beneficiaries by submitting an itemized list that specifically enumerates all uncollectable amounts *related to covered services under the composite rate. (emphasis added).* The Provider and the Intermediary erroneously referred to the 1997 regulation in their position papers.

> borne by others, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.

Under C.F.R. §413.80(e), a Medicare bad debt must meet the following criteria in order to be allowable:

(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 reasonanble 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.

PARTIES' CONTENTIONS

The Providers contend that they met the burden of proof regarding the allowability of Medicare bad debts as provided in the above regulation, and that their claimed bad debts meet the definition of bad debts as per 42 C.F.R. §413.80(b), which states: "Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services."

The Intermediary did not dispute the Providers' collection efforts, however, it disallowed the portion of Medicare bad debts which did not relate to the composite rate, primarily the separately billable drug Epoietin. The Intermediary claimed that EPO is paid as an add-on amount to the composite rate for each administration, and that bad debts are not to include amounts related to separately billed items. The Intermediary contends that the Provider Reimbursement Manual "clearly states that bad debts are not to include amounts related to separately billable items" and cites section 2714.2 of the manual in support of its position. This section states: "reimbursable bad debts claimed on Supplemental Worksheet I-3 and Schedule D relate to Composite Rate services and are not separately billed items."

As additional support for its position, the Intermediary also cites Provider Reimbursement Manual 15-2, §3655, which states: "the amounts on lines 3 and 4 (deductibles and coinsurance for Medicare Part B patients) must exclude coinsurance and deductible amounts for services other than dialysis treatments (e.g. epoietin)."

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and policies, evidence presented and the parties' arguments, the board finds and concludes as follows:

The regulation in effect during the cost report period in issue is controlling over contrary manual provisions that do not have the force of law. Christensen vs. Harris County, 529

U.S. 576,587 (2000). The regulation clearly provides reimbursement for bad debts relating to all covered ESRD items and services. It is undisputed that EPO is a covered item under Medicare. Whether the covered services related to Medicare's composite rate or to separately billed but nonetheless allowable services or items such as EPO is irrelevant. The Board concludes that bad debts related to EPO are reimbursable.

The Providers' evidence that they met the regulatory requirements regarding collection efforts was uncontroverted by the Intermediary. The Board, therefore, further finds that the Providers satisfied the requirements to establish that the uncollected coinsurance and deductibles related to EPO were bad debts.

DECISION AND ORDER

The Intermediary's adjustments disallowing bad debts claimed by the Providers on uncollectible deductible and coinsurance amounts pertaining to items and services reimbursed outside of Medicare's composite rate for ESRD services are improper and are reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Dr. Gary Blodgett
Martin W. Hoover, Jr. Esquire
Elaine Crews Powell, C.P.A.

DATE: September 20, 2004

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman