PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON THE RECORD
2005-D2

PROVIDER
Dialysis Clinic 94 Bad Debt
Expense Group

Provider Nos.: See Appendix

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Blue Cross and Blue Shield of Georgia

DATE OF HEARING
July 14, 2004

Cost Reporting Periods Ended
September 30, 1994 through
September 30, 1996

CASE NO. 96-2577G

INDEX

ISSUE:

Were the Intermediary's adjustments disallowing bad debts claimed by the Provider on uncollectable deductible and coinsurance amounts pertaining to items and services reimbursed outside of Medicare's composite rate for End Stage Renal Disease facilities proper?

STATEMENT OF THE CASE AND PROCEDURAL FRAMEWORK:

Dialysis Clinic, Inc. (Provider) owns and operates Medicare certified outpatient dialysis facilities located throughout the United States. This case arises from an adverse determination by the Intermediary, Blue Cross and Blue Shield of Georgia, over the amount of Medicare payment due for end-stage renal dialysis (ESRD) services furnished by the provider to Medicare beneficiaries.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. The Centers for Medicare & 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 the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

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

During Medicare cost reporting periods ended September 30, 1994 through September 30, 1996, many of the Provider's individual facilities claimed Medicare bad debt expenses pertaining to uncollectable deductible and coinsurance amounts related to items and services that are separately billed and paid in addition to the standard rate for ESRD service. The Intermediary disallowed these bad debt claims. The Provider appealed the Intermediary's adjustments to the Provider Reimbursement Review Board (Board) pursuant to 42 C.F.R. §§405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $1,033,628.[1]

[1] Provider Position Paper at 1.

The Provider was represented by James B. Riley, Jr., Esq., of McGuire Woods, Ross and Hardies, LLP. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, 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 that it furnishes to a Medicare beneficiary. 42 U.S.C. 1395rr(b)(7); 42 C.F.R. 413.170 *et.seq*.

The statute and regulations also provide for additional payments above the composite rate for certain items and services that are billed separately to Medicare. 42 U.S.C. 1395rr(b)(11); 42 C.F.R. §413.170(c)(6) & (7). A deductible and coinsurance applies to both the composite rate services and the additional payments for separately billed items. 42 C.F.R. §§413.170(c)(6)(iii)(E); 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[2]:

(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

[2] 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)*

> 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 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 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.

PARTIES' POSITIONS:

The Provider's ESRD facilities billed Medicare beneficiaries for deductibles and coinsurance. These billings generated bad debts relating to services covered under Medicare's composite rate as well as items and services billed separately.[3] The Intermediary disallowed the facilities' bad debt claims for the separately billed items.

In support of its disallowance, the Intermediary relies on Medicare's Provider Reimbursement Manual, Part I (HCFA – Pub. 15-1) § 2714.2. That section states "ensure that: Reimbursable bad debts claimed . . .relate to Composite Rate services and are not for separately billed items."

The Provider responds that, although the 1997 regulation[4] limits bad debt recoveries to composite rate services, the 1996 regulation is the one in effect for the cost report periods on appeal and it allowed all ESRD bad debts provided they were for covered services. The Provider also points out that regulations take precedence over manual instructions, citing the Board's prior decision in University Hospital v. Blue Cross Blue Shield Association, PRRB Dec. No. 95-D43, June 23, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,4872, rev'd., CMS Admin., August 21, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,692.

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[3] Intermediary's position paper at 2.
[4] See footnote 2 for the differences between the two regulations.

The Intermediary counters that the preamble to the 1997 regulation that explicitly limits bad debts to composite rate services explained that CMS was merely "clarifying" longstanding policy by amending the ESRD regulations to allow ESRD bad debts only for composite rate charges, 62 FR 43666 (August 15, 1997).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

The regulation in effect during the cost report periods appealed is controlling over contrary manual provisions that do not have the force of law. Christensen c. 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 the separately billed items in issue are covered under Medicare. Whether the covered services relate to Medicare's composite rate or to separately billed but nonetheless allowable services or items is irrelevant under the regulation. The Board concludes that the Provider's claimed bad debts are reimbursable.

The Provider's evidence that it met the regulatory requirements regarding collection efforts was uncontroverted by the Intermediary. The Board, therefore, further finds that the Provider satisfied the requirement to establish that the uncollected coinsurance and deductibles related to separately billed ESRD covered items and services were bad debts.

DECISION AND ORDER:

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

BOARD MEMBERS PARTICIPATING:

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DATE: November 18, 2004

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