PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2008-D21

PROVIDER –
Vitality Rehab, Inc.
Long Beach, California

Provider No.: 05-6833

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF HEARING –
October 16, 2007

Cost Reporting Period Ended -
December 31, 1999

CASE NO.: 01-1910

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ISSUE:

Whether the Intermediary properly disallowed bad debts claimed for uncollectible deductibles and coinsurance amounts related to outpatient therapy services furnished to Medicare beneficiaries dually eligible for Medicare and Medicaid, and paid under the Part B fee schedule.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

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. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

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 portion 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.

Section 4541(a)(2) of the Balanced Budget Act of 1997, Public law 205-33, (BBA) requires payment under prospective payment system for outpatient rehabilitation services furnished on or after January 1, 1999. The issue in this appeal involves the proper treatment of bad debts arising from the uncollectible deductibles and coinsurance amounts for outpatient rehabilitation services provided to Medicare beneficiaries and billed under a fee-based reimbursement system.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Vitality Rehabilitation, Inc. (Provider) is a Medicare certified outpatient rehabilitation facility located in Long Beach, California. During the period ended December 31, 1999, the Provider rendered outpatient therapy services to patients who were dually eligible for Medicare and Medicaid and received payment for those services under the Medicare Part B fee schedule. On its cost report for the period, the Provider claimed bad debts for

uncollectible coinsurance and deductibles arising from the therapy services rendered to its dually eligible patients. Mutual of Omaha (Intermediary) disallowed the entire amount of Medicare Part B bad debts claimed on the cost report because the therapy services were paid based on a fee schedule. The Provider filed a timely appeal with the Provider Reimbursement Review Board (the Board) and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841.

PARTIES' CONTENTIONS:

The Provider argues that bad debts are reimbursable notwithstanding the fact that BBA changed the payment for these services from a cost-based to a fee-based reimbursement system. The Provider states that 42 C.F.R. §413.80(a)[1] requires the reimbursement of Medicare bad debts. Neither the BBA nor subsequent CMS implementing guidance altered this section, its definitions, or procedures. Therefore, it remains controlling on the issue of bad debts. The Provider contends that the amounts that it claimed for bad debts met all the requirements set forth in 42 C.F.R. §413.80 and are properly reimbursable under its provisions.

The Intermediary, referring to 42 C.F.R. §413.80, states that Medicare policy permits reimbursement for uncollectible coinsurance and deductibles for services that are paid on a cost reimbursement basis but that this policy does not apply to services for which Medicare payment is based on a fee schedule or reasonable charge methodology. Once the BBA changed payment for outpatient rehabilitation services to the physician fee schedule instead of cost beginning with cost reporting period on or after January 1, 1999, providers are no longer entitled to bad debt reimbursement for coinsurance and deductibles for these services.

The Intermediary asserts that this policy was stated in a CMS letter referring to outpatient therapy services at a skilled nursing facility. See, CMS Letter, Region VI, April 10, 2000, Intermediary's Final Position Paper at Exhibit I-3. The Intermediary also indicates that this policy was upheld by the Board in Corporacion de Las Vegas, Inc. v. Blue Cross Blue Shield Association/United Government Services, PRRB Hearing Dec. No. 99-D11, November 25, 1998, Medicare & Medicaid Guide (CCH) ¶80,141, aff'd, CMS Administrator, declined rev., January 15, 1999 (pertaining to the disallowance of durable medical equipment (DME) bad debts after DME reimbursement changed from reasonable cost to the lesser of a fee schedule or actual charges as a result of Section 4062 of the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203)). See, Exhibit I-4. And more recently, the CMS Administrator reversed the Board's decision, in Extendicare 99 Uncollected Co-In Dual Eligi Group v. Blue Cross Blue Shield Association/United Government Services, LLC-WI, PRRB Dec. No. 2006-D36, July 21, 2006, Medicare & Medicaid Guide (CCH) ¶81,542, rev'd, CMS Administrator, September 12, 2006, Medicare & Medicaid Guide (CCH) ¶81,604 (Extendicare) and Glenwood Park, Inc. v. Blue Cross Blue Shield Association/United Government Services, LLC-WI, PRRB Dec. No. 2006-D57, September 28, 2006, Medicare & Medicaid Guide (CCH) ¶81,614, rev'd, CMS Administrator, December 28, 2006, Medicare & Medicaid Guide (CCH) ¶81,626

[1] Redesignated 42 C.F.R. §413.89(a)(2004).

(Glenwood Park), finding that the Intermediary properly denied the provider's claimed Medicare bad debts.

Finally, the Intermediary argues that its position is further supported by CMS Pub. 13-3, §3653, entitled Prospective Payment for Outpatient Rehabilitation Services and the Financial Limitation. See, Intermediary's Supplemental Position Paper, Exhibit I-4. In subsection V, concerning bad debts, it states:

> V. Bad Debts - - There is no payment for bad debts (unrecovered costs attributable to uncollectible deductible and coinsurance arising from covered services to beneficiaries considered in calculating payment to providers reimbursed on the basis of reasonable cost) with respect to services paid under the Medicare physician fee schedule. Under a fee schedule, payment is not based on incurred costs; rather payment is made based on a schedule for the specific service furnished. Whether a fee schedule has its basis in charges or is resource-based, the payment is not related to a specific provider's cost outlay for a service and does not embody the concept of unrecovered cost.
>
> Bad debts are allowable only to an entity to whom payment is made on the basis of reasonable cost.

The Intermediary asserts that outpatient therapy services are now paid under the fee schedule and, therefore, bad debts are no longer reimbursed.

The Provider responds that the services provided in this case were not rendered in a skilled nursing facility and therefore, the Intermediary's reliance on authorities in the BBA, regulations and manual concerning services in a SNF are not relevant to this case. Nevertheless, the Provider agrees with the Board's reasoning in Extendicare and Glenwood Park, even though both of these cases involved services in a SNF; therefore, the facts are distinguishable.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, finds and concludes that the Intermediary's adjustment to the Provider's uncollectible deductibles and coinsurance amounts arising from outpatient therapy services paid under the Part B fee schedule was improper.

Section 1861(v)(1)(A)(i) of the Social Security Act articulates the principle against cross-subsidization and states that the cost for individuals covered by the Medicare program must not be borne by individuals not covered by the program and the costs for individuals not covered by the program must not be borne by the program. In 1966, the Health Insurance Benefits Advisory Committee (HIBAC) initially recommended that Medicare cover the unpaid deductible and coinsurance amounts that arose in connection with the

provision of covered services to beneficiaries in an effort to avoid the cross-subsidization that might occur if hospitals or other entities tried to recoup Medicare bad debts from other payors. The Secretary adopted the bad debt policy and included it in the anti-cross-subsidization principle that is part of the definition of reasonable cost contained in section 1861(v) of the Act.

Prior to enactment of the BBA of 1997, payments for outpatient rehabilitation services were made using salary equivalent guidelines. The salary equivalency guidelines were a tool used to determine the reasonable cost of therapy services provided by practitioners other than physicians. The regulations at 42 C.F.R. §413.80 provided for reimbursement of bad debts and expressed as the rationale the statute's prohibition against cross-subsidization. It also established the standards under which bad debts would be reimbursed by the Medicare program. Fee-based schedules evolved parallel to the cost-based system as the reimbursement mechanism for physician services. CMS asserted that the physician fee schedule mechanism included all costs, including bad debt, and traditionally did not allow the recovery of bad debts for those services covered by these fee schedules.

Beginning with claims with dates of service on or after January 1, 1999, the BBA mandated that outpatient rehabilitation services be paid under a prospective payment system. CMS further provided that the Medicare Physician Fee Schedule would be used as the prospective payment system for these services.

While the BBA effectively shifted payment for outpatient rehabilitation services from reasonable cost to fee-based, it made no mention of the related bad debts, nor did CMS make any change to 42 C.F.R. §413.80. The Board majority considers these omissions significant. Congress addressed the issue of Medicare bad debt in the BBA for a variety of services. These provisions illustrate that Congress was fully aware of the distinctions between cost-based and fee-based reimbursement at the time that it made the shift. The Congress fully understood that the bad debt regulation was derived from the policy against cross-subsidization articulated in Section 1861(v), and that there were no concomitant regulatory provisions addressing bad debts for Part B services. The Board majority concludes that if Congress had intended to alter treatment of bad debts under established principles, it would have done so in the statutes, as it did for physician assistant[2] and CRNA[3] services. The Board majority considers Congress' silence on bad debts demonstrative of its intent that bad debt policy remain unchanged.

Furthermore, the Board majority finds that the existence of a proposed rule,[4] which proposed to eliminate bad debts arising from any service provided under a fee schedule, offers substantive evidence that CMS was aware that existing regulations allowed bad debts for some fee-based services. If CMS had believed that the bad debt policy articulated in 42 C.F.R. §413.80 applied only to cost reimbursed services, such a change

[2] Social Security Act (P.L. 74-271), Section 1842 (b).
[3] Social Security Act, Section 1833 (1)(5)(C).
[4] Federal Register dated February 10, 2003 (Vol. 68, No. 27).

would not have been necessary. CMS' failure to finalize its proposed rule suggests that it considered but rejected the policy change.[5]

The bad debt policy was established by operation of regulation. Absent a change in that regulation, via either a legislative change or through the rule-making process, the Board cannot modify or eliminate its mandate, and the majority must conclude that 42 C.F.R. §413.80 remains the controlling authority for the payment of bad debts. The Board majority therefore concludes that the Intermediary's adjustment eliminating the application of 42 C.F.R. §413.80 and disallowing the Provider's bad debts arising from therapy services paid under the Part B fee schedule improper.

DECISION AND ORDER:

The Intermediary's adjustment to the Provider's Medicare bad debts for uncollectible deductibles and coinsurance amounts arising from outpatient therapy services paid under the Part B fee schedule was improper. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A. (Dissenting)
Anjali Mulchandani-West, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A. (Dissenting)

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: March 17, 2008

[5] The Board notes that CMS ultimately modified the regulation at 42 C.F.R. §413.89(i)(2007).

Dissenting Opinion of Michael D. Richards and Elaine Crews Powell

The majority found that the Provider is entitled to claim reimbursement for bad debts related to deductible and coinsurance amounts for Part B therapy service paid under a fee schedule. We respectfully dissent.

In reviewing this case we asked two different questions. First, does a Law, Regulation, or CMS ruling bind the Board?[6] Second, is the CMS interpretation of the law reasonable?

There are two distinct areas of law applicable to this case. First there is the law related directly to the payment for Medicare bad debts. The relevant statute is found at §1861(v)(1)(A) of the Social Security Act (SSA). In this section entitled, "Reasonable Cost," it states in relevant part:

> The 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….

Even though this statute does not directly speak to Medicare bad debt reimbursement, the language has been incorporated into the bad debt regulation at 42 C.F.R. §413.80(d) as follows:

> *Requirements for Medicare.* Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for by others than beneficiaries are not to be borne by the Medicare program.

The second area of law is found at SSA §1834(k). This section sets up the required method for payments for the outpatient therapy services in this case, and states in relevant part:

> (k) PAYMENT FOR OUTPATIENT THERAPY SERVICES AND COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—
> (1) IN GENERAL.—With respect to services described in section 1833(a)(8) or 1833(a)(9) for which payment is determined under this subsection, the payment basis shall be—
> (A) for services furnished during 1998, the amount determined under paragraph (2); or
> (B) for services furnished during a subsequent year, 80 percent of the lesser of—
> (i) the actual charge for the service, or

[6] See, 42 C.F.R. §405.1867.

(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

(2) PAYMENT IN 1998 BASED UPON ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of –

(A) the charges imposed for the services, or

(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services, less 20 percent of the amount of the charges imposed for such services.

(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this subsection the term "applicable fee schedule amount" means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1848[7] for such services furnished during the year or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.

(4) ADUSTED REASONABLE COSTS.—In paragraph (2), the term "adjusted reasonable costs" means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to services described in section 1833(a)(8)(B) (related to services provided by hospitals).

(Footnote 8 added)

The Provider asserts that "[t]here is no legislative, regulatory, or court precedent that contradicts or obviates the express language of 42 C.F.R. §413.89(a),[8] insofar as the propriety of the reimbursement of bad debts arising from services by a Part B Outpatient Therapy Provider in a beneficiary's home or in it's office is concerned." The Provider then requests that the Board majority's logic expressed in decisions in similar cases be used in this case, that is: since the regulatory basis for Medicare bad debts has not changed and Congress was silent as to changes in bad debt reimbursement for outpatient therapy services, Medicare bad debts should continue to be paid, absent a change in the regulation.

The Intermediary's position is that the cost reimbursement rules regarding Medicare bad debts do not apply to payments made on a fee schedule basis. The Intermediary points out that Medicare does not reimburse bad debts to physicians, anesthetists and DME suppliers that are reimbursed subject to fee schedules. However, they characterize Congress' silence related to bad debts as indicating that bad debts should not be paid when payment is based on the physician fee schedule.

While it is clear from the statute and regulation that Medicare bad debts are paid when a provider is cost reimbursed, it is also true that physicians paid on a fee schedule have not been reimbursed for Medicare bad debts. The statute clearly shows the change of payment methodologies for outpatient therapy services from adjusted reasonable costs to

[7] Section 1848 of the Social Security Act is entitled "PAYMENT FOR PHYSICIANS' SERVICES."
[8] The regulation at 42 C.F.R. §413.80 was redesignated to §413.89 in 2003.

the lessor of charges or fee schedule amounts. However, there is nothing in the statute or the regulations that states that Medicare bad debts should be paid when a provider is reimbursed under a fee schedule. Therefore, we must try to determine what CMS' policy for Medicare bad debts was and whether it was consistent with the statute and regulation.

CMS' written policy regarding bad debts can be found in three different documents. First, in Exhibit I-3 to the Intermediary's original paper there is a letter dated April 10, 2000 from HCFA, Region VI that states:

> Both the statute (§1861(v)(1)(A)) and the regulation (42 C.F.R. §413.80) assume a cost based reimbursement system for the payment of bad debts. Allowing reimbursement for bad debts is a feature of the reasonable cost payment principles and, with little exception is not applicable to any other payment system. Medicare bad debts are recognizable for prospectively based payment systems only when those systems are based on cost data. Therefore, SNF outpatient therapy services reimbursed on a fee schedule, deductibles and coinsurance are not allowable Medicare bad debts.

Published three years later is CMS Pub. 13-3 §3653. The relevant section states:

> V. Bad Debts—There is no payment for bad debts (unrecovered costs attributable to uncollectible deductible and coinsurance arising from covered services to beneficiaries considered in calculating payment to providers reimbursed on the basis of reasonable cost) with respect to services paid under the Medicare physician fee schedule. Under a fee schedule, payment in not based on incurred costs; rather payment is made based on a schedule for the specific service furnished. Whether a fee schedule has its basis in charges or is resource-based, the payment is not related to a specific provider's cost outlay for a service and does not embody the concept of unrecovered cost.
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> Bad debts are allowable only to an entity to whom payment is made on the basis of reasonable cost.[9]

Finally, on February 10, 2003 CMS published a proposed change to the bad debt regulation that precluded reimbursement for the bad debts at issue in this case. The Final Rule adopting the proposal was published on December 1, 2007. The pertinent language added to 42 C.F.R. §413.89[10] was:

> (i) Exception bad debts arising from covered services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

[9] January 24, 2003, Intermediary Manual, Transmittal No. 1872; Intermediary Supplemental Position Paper, Exhibit I-4 page 17.

[10] Id.

CMS regarded the addition to the regulatory language as being consistent with longstanding policy and not a change in policy.

Nothing in evidence indicates that the Intermediary's adjustment was inconsistent with CMS' longstanding bad debt policy. The Provider offered Exhibit P-4 as evidence that Medicare's policy was to reimburse bad debts after the change to fee schedule reimbursement. However, the Medicare auditor did not allow these bad debts when the FYE 1999 cost report was audited.[11] We find that Provider Exhibit P-3 does not relate to the issue in this case nor does it support the Provider's assertion that Medicare had a policy of reimbursing bad debts related to coinsurance and deductibles when payment is based on a fee schedule.

The circumstances in this case differ from when a provider can prove through evidence that CMS has changed its policy. When a policy change occurs, the change is not effective until proper notice is given to providers. We find that there is no evidence that CMS changed it bad debt policy; therefore, the tardiness of the manual and regulation changes is of no consequence.

We find that the Board majority's conclusion that because the bad debt regulation at 42 C.F.R. §413.80 did not change, bad debts are still reimbursed, misses the pertinent point – the regulation they rely on is not applicable to bad debts when a provider is not paid based on reasonable costs. We find nothing in the record to show that this has not always been CMS' policy.

We find that the Intermediary's disallowance of Medicare bad debts related to fee schedule payments is consistent with CMS' policy and that CMS' is policy is not inconsistent with statute or regulation; therefore, the adjustment should be affirmed.

Michael D. Richards, C.P.A. Elaine Crews Powell, C.P.A.

[11] See, Exhibit P-2 and Provider's Final Position Paper, page 2.