PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2015-D14

PROVIDER –
Hampton Behavioral Health Center
Westhampton, New Jersey

Provider No.: 31-4021

vs.

INTERMEDIARY –
Novitas Solutions, Inc./
BlueCross BlueShield Association

DATE OF HEARING -
May 8, 2014

Cost Reporting Period Ended -
December 31**,** 2005

CASE NO.: 08-0362

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ISSUE:

Whether the Medicare Contractor improperly disallowed from the calculation of the Provider's bad debt expense, for the subject fiscal year, bad debts associated with patients whose accounts were not billed to Medicaid prior to the accounts being written off to bad debt.[1]

DECISION AND ORDER:

After consideration of Medicare law and guidelines, the parties' contentions, and the evidence of record, the Board finds that the Medicare Contractor properly excluded the unbilled dual-eligible bad debts at issue from the Provider's cost report for fiscal year ending December 31, 2005 ("FY 2005"), because the Provider failed to demonstrate that the debts were uncollectible at the time they were claimed as worthless. Accordingly, the Board affirms the Medicare Contractor's adjustments.

INTRODUCTION:

Hampton Behavioral Health Center ("Hampton" or "Provider") is a 100-bed psychiatric facility located in Westhampton, New Jersey. During FY 2005, Hampton claimed Medicare bad debts on its cost report for beneficiaries who were also potentially eligible for Medicaid benefits under the applicable state's Medicaid program (*i.e.*, dual eligible beneficiaries).

During the time period at issue, Hampton's designated Medicare Contractor, Riverbend Government Benefits Administrators ("Riverbend"), audited and adjusted Hampton's FY 2005 cost report. Novitas Solutions, Inc. ("Novitas") is Hampton's current designated Medicare Contractor. Collectively, Riverbend and Novitas will be referred to as the "Medicare Contractor."

The Medicare Contractor reviewed the Provider's claimed bad debts for FY 2005 and disallowed dual eligible bad debts based on the "must-bill" policy of the Centers for Medicare and Medicaid Services ("CMS"). This policy requires a provider to bill the state Medicaid program and receive a remittance advice before it can be reimbursed for Medicare bad debts when the patient is a dual eligible (*i.e.*, a Medicare beneficiary that is also eligible for Medicaid). Bad debts involving dual eligible are also referred to as "crossover bad debts."

Hampton does not contest the legality of CMS' "must bill" policy in this appeal.[2] Rather, Hampton contests this specific application of the "must bill" policy applicable to dual eligible patients because Hampton maintains that the two patient accounts at issue pertain to patients who were not eligible for Medicaid on the dates of service and therefore were not, at that point in time, dual eligible patients. The total amount in controversy in the appeal is approximately $21,630 (*i.e.*, approximately 70 percent of the $30,900 bad debt disallowed for the two patient accounts at issue).

[1] *See* Stipulations at ¶ 1 (Jan. 13, 2014).
[2] *See* Stipulations at ¶ 2.

The Provider was represented by Edward A. Moore from Universal Health Services of Delaware. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of the Blue Cross and Blue Shield Association.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board agrees with the parties that, in order to claim a bad debt on the cost report, the Medicare criteria for the allowance of bad debts set forth in 42 C.F.R. § 413.89(e) must be met and that the CMS "must bill" policy is applicable.[3] Pursuant to the criteria in § 413.89(e), a provider must demonstrate that a debt was uncollectible when claimed as worthless. Guidance on this criteria is located in the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 312(C) which specifies that: "The provider must determine that no source other than the patient would be *legally responsible* for the patient's medical bill; e.g., title XIX, local welfare agency and guardian." PRM 15-1 § 310 sets forth a "must bill" policy that requires billing to a party when that party is "legally responsible" for a deductible or coinsurance. Specifically, § 310 states: "It [i.e., the collection effort] must involve the issuance of a bill on or shortly after discharge or death of the beneficiary *to the party responsible* for the patient's personal financial obligations."[4] This "must bill" policy is applicable to crossover claims through PRM 15-1 §§ 310 and 312.[5]

On August 10, 2004, CMS issued to all Medicare Contractors a directive, Joint Signature Memorandum 370 ("JSM 370") entitled "Medicare 'Must Bill' Policy for Reimbursement of Dual-Eligible Beneficiaries."[6] JSM 370 explained that "[i]n order to fulfill the requirement that a provider make a 'reasonable' collection effort with respect to the deductibles and co-insurance amounts *owed by dual-eligible patients*, our bad debt policy requires the provider to bill the patient or entity legally responsible for the patient's bill before the provider can be reimbursed for uncollectible amounts."[7]

Consistent with JSM 370, the Medicare Contractor issued a newsletter to providers (including Hampton) in November 2004 informing providers of CMS' must bill policy and stating that, "for cost reporting periods covering January 1, 2004 and forward, Riverbend will require the providers to have a processed State Medicaid Remittance Advice before we will allow the

[3] The Board notes that the moratorium which prohibits the Secretary from making changes to the bad-debt policy in effect as of August 1, 1987 (the "Bad Debt Moratorium") is not applicable to the Provider because the Bad Debt Moratorium only applies to hospitals and the Provider is a CMHC. *See* OBRA 1987, Pub. L. No. 100-203, § 4008(c), 101 Stat. 1330, 1355 (1987), *as amended by* Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8402,102 Stat. 3342, 3798 (1988), *as amended by* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6023, 103 Stat. 2106, 2167 (1989) (reprinted in 42 U.S.C. § 1395f note).

[4] (Emphasis added).

[5] PRM 15-1 § 322 addresses "Medicare Bad Debts Under State Welfare Programs." The section requires that deductible and coinsurance amounts not covered by state title XIX plans may be claimed as Medicare bad debts if they meet the requirements of PRM 15-1 § 312 or, if applicable, § 310. Section 310 is applicable because, as explained in § 312, "[t]he provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., *title XIX, local welfare agency* and guardian." (Emphasis added.)

[6] Joint Signature Memorandum from CMS to all Fiscal Intermediaries dated August 10, 2004.

[7] (Emphasis added.)

Medicare Crossover Bad Debt."[8] In March 2005, the Medicare Contractor issued a similar newsletter to providers with the same information on CMS' must bill policy.[9]

The Provider maintains that the two accounts at issue were included on the dual eligible bad debt log for FY 2005 in error because, even though both patients had New Jersey Medicaid numbers, neither patient was Medicaid eligible *at the time of their hospitalization*. The Provider further explains that "these two accounts were worked just like any other non-crossover account as far as collection is concerned and not written off until after 120 days."[10] As explained below, the Board finds that the evidence in the record does not support the Provider's arguments and that the Medicare Contractor properly disallowed the dual eligible bad debts.

First, while the Provider attempted to obtain confirmation from the New Jersey Medicaid program that neither of the two patients at issue were Medicaid eligible during their hospital stays, the Provider failed to obtain actual confirmation that neither patient was eligible during any portion of their hospital stay.[11] As an individual's Medicaid eligibility can be transient, it is unclear whether these two patients were, or were not, Medicaid eligible during their respective hospital stays. The Provider made no effort to bill Medicaid or to verify eligibility in a timely manner nor did the Provider take any other appropriate action to eliminate the confusion regarding the two bad debt accounts at issue.

Even assuming *arguendo* that neither of the two patients at issue were Medicaid eligible, the Board could not find any evidence in the record showing that the Provider actually made any collection effort on the two bad debts under appeal (or even implemented the Provider's own collection policy for non-crossover bad debts). Rather, the Provider's representative simply made an unsupported assertion in its final position paper that "these two accounts were worked just like any other non-crossover account as far as collection is concerned and not written off until after 120 days."[12]

DECISION AND ORDER:

After consideration of Medicare law and guidelines, the parties' contentions, and the evidence of record, the Board finds that the Medicare Contractor properly excluded from the Provider's cost report for FY 2005 the unbilled dual-eligible bad debts at issue, because the Provider failed to demonstrate that the debts were uncollectible when claimed as worthless. Accordingly, the Board affirms the Medicare Contractor's adjustments.

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[8] Provider Exhibit P-5 at 11.
[9] Provider Exhibit P-5 at 3.
[10] Provider's Final Position Paper at Tab 2 at 3.
[11] *See* Stipulations at ¶¶ 13-14. For the first patient, the Provider only established that the patient was not eligible during the first week of a 19 plus week hospital stay. For the second patient, the Provider only established that the patient was not Medicaid eligible for a one week period that occurred more than four months *after* the patient had been discharged from the hospital. *See id.*
[12] Provider's Final Position Paper at 3.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

/s/
Michael W. Harty,
Chairman

DATE: August 12, 2015