PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2015-D25

PROVIDER –
Faxton - St. Luke's Healthcare
Utica, NY

vs.

Provider No.: 33-0044

MEDICARE CONTRACTOR –
National Government Services, Inc.

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DATE OF HEARING -
December 11, 2013

Cost Reporting Periods Ended -
December 31, 2004 and
December 31, 2005

CASE NOs.: 08-0143 and 09-0403

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ISSUE STATEMENT:

Whether the Medicare Contractor's[1] adjustment to Faxton - St. Luke's Medicare bad debts was proper.[2]

DECISION

For the subset of bad debts at issue involving non-indigent patients for fiscal years ("FYs") 2004 and 2005, the Board finds that the Medicare Contractor properly disallowed them with the exception of the bad debt of $688 for Patient D for FY 2004 which both parties now agree was appropriate.[3] For the subset of bad debts at issue involving indigent patients for FYs 2004 and 2005, the Board finds that the Medicare Contractor improperly disallowed them. Accordingly, the Board reverses the disallowance of the Patient D non-indigent bad debt for the FY 2004 sample, reverses the disallowance of the indigent bad debts for the FY 2004 and 2005 samples, affirms the disallowance of the remainder of the non-indigent bad debts for the FY 2004 and 2005 samples, and directs the Medicare Contractor to recalculate the extrapolated allowable bad debt amount for FYs 2004 and 2005.

INTRODUCTION

Faxton - St. Luke's Healthcare ("Faxton - St. Luke's" or "Provider"), is a not-for-profit acute care hospital located in Utica, New York. Faxton - St. Luke's designated Medicare contractor is National Government Services, Inc. ("Medicare Contractor"). The Medicare Contractor denied reimbursement for bad debts for FYs 2004 and 2005 based upon an audit of a sample of bad debt claims from each fiscal year. Specifically, the Medicare Contractor denied bad debt reimbursement for debts owed by two categories of patients: (1) *non-indigent* patients because Faxton - St. Luke's failed to provide documentation regarding its collection efforts and those of its collection agency; and (2) *indigent* patients because Faxton - St. Luke's failed to follow its own collection policy to establish the patients' indigency.[4] Faxton - St. Luke's estimates the reimbursement impact of the Medicare Contractor's adjustments to exceed $195,000 in FY 2004 and $190,000 for FY 2005.[5]

Faxton - St. Luke's timely appealed the Medicare Contractor's determinations. At the hearing Faxton St. -Luke's was represented by its Director of Reimbursement, Richard W. Martin. The Medicare Contractor was represented by Brendan G. Stuhan, Esq. of the Blue Cross and Blue Shield Association.

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[1] The contractors charged by the Secretary with administering Medicare Part A are known as Fiscal Intermediaries ("FIs") or Medicare Administrative Contractors ("MACs"). FIs and MACs will be generally be referred to as Medicare Contractors.

[2] *See* Transcript ("Tr.") at 6.

[3] *See* Medicare Contractor's Post-Hearing Brief for FY 2004 at 12; Medicare Contractor's Final Position Paper for FY 2004, Exhibit I-20. Claim D represents the allowable $688 claim and the Medicare Contractor deleted this claim from the list of the FY 2004 claims at issue in this appeal because "it is "no longer under dispute." *See* Medicare Contractor's Post-Hearing Brief for FY 2004, Exhibit I-24.

[4] *See* Tr. at 25-28.

[5] *See* Provider's Revised Final Position Paper for FY 2004 at 3; Provider's Final Position Paper for FY 2005 at 3.

STATEMENT OF THE FACTS

For both FY 2004 and FY 2005, the Medicare Contractor conducted an audit of Faxton - St Luke's collection efforts by examining a sample of business office files for patients who were referred to a collection agency or whose debt was written off because the hospital had determined the patient to be indigent.[6] Based on the audit of these samples, the Medicare Contractor disallowed bad debt write-offs of 40 cases in FY 2004 and 21 cases in FY 2005. The Medicare Contractor made these adjustments because it found that Faxton - St. Luke's did not document reasonable collection efforts, including activities of a collection agency it used or that Faxton - St. Luke's failed to document indigency for some patients.[7] The specific reason the Medicare Contractor disallowed each bad debt is set forth on a summary chart for each year.[8]

Faxton - St Luke's produced evidence of its policy to collect unpaid deductibles and coinsurance from its Medicare patients. This policy included the following actions which are not described in great detail:

1. Faxton - St. Luke's sending 2 statements to the patient;

2. A referral to at least one collection agency, CCI, to write two letters for a period of 35 days;

3. A referral to MedRev (and maybe other collection agencies); and

4. A referral to a finance company, CSI, if the patient wanted to make arrangements to finance the debt.[9]

Testimony at the hearing also indicated that at some point, some of the consumer debt may have been sold to an Indiana corporation, Senex Services Corporation.[10] Faxton - St. Luke's also provided redacted files for five patients who had been determined indigent based on tax returns, Medicaid applications, and Social Security Benefit Statements.[11]

DISCUSSION, FINDINGS OF FACT, CONCLUSIONS OF LAW:

The regulations governing bad debt are located at 42 C.F.R. § 413.89 (2004).[12] To ensure that the cost of covered services furnished to Medicare beneficiaries are not borne by patients who are not eligible for Medicare, subsection (d) reimburses hospitals for unpaid Medicare

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[6] *See* Provider's Revised Final Position Paper for FY 2004, Exhibit P-4 (copy of the FY 2004 audit papers).
[7] Intermediary's Post-Hearing Brief for FY 2004 at 2.
[8] *See* Medicare Contractor's Post Hearing Brief for FY 2004, Exhibit I-24; Medicare Contractor's Post Hearing Brief for FY 2005, Exhibit I-18.
[9] *See* Provider's Additional Information Request For the Board, Exhibit 5 (copy of Faxton St. Luke's policy on self-pay balances after insurance revised as of June 10, 2003); Medicare Contractor's Final Position Paper for FY 2005, Exhibit I-16 at 7 (copy of Faxton – St. Luke's collection workflow revised as of May 10, 2007). *See also* Tr. at 39:13-25; 45-46; 61-62.
[10] *See* Tr. at 45-46. *See also* Provider's Additional Information Request For the Board, Exhibit 1.
[11] *See* Provider's Additional Information Request For the Board, Exhibit 7; Medicare Contractor Final Position Paper for FY 2005, Exhibit I-16 at 9 (identified at bottom of page as "Uncompensated Care Policy"),
[12] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

deductibles and coinsurance if criteria specified in subsection (e) are met. Subsection (e) requires the following:

(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.

The Provider Reimbursement Manual, Part 1, CMS Pub. No. 15-1 ("PRM 15-1"), § 310 allows a hospital, as part of its reasonable collection effort, to refer a patient to a collection agency "in addition to or in lieu of subsequent billings, follow up letters, telephone or personal contacts." Section 310 also requires that the provider's collection effort be documented in the patient's file by copies of bill(s), follow up letters, reports of telephone and personal contact.[13]

PRM 15-1 § 312(B) outlines the procedure for a determination of the patient's indigence including that the provider must "take into account a patient's total resources which include, but are not limited to, an analysis of assets,…liabilities and income and expenses." Subsection D of this section also requires that the "patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate this determination."

NON INDIGENT PATIENTS-COLLECTION EFFORTS

Faxton - St. Luke's contends that it should be paid for the bad debts related to its non-indigent patients because it followed its collection policies and referred all uncollected patient charges of like amount to a collection agency.[14] According to Faxton - St. Luke's, once it turns the debt over to a collection agency further documentation of collection agency actions is not required.[15] Faxton - St. Luke's also argues that § 805(b) of the Fair Debt Collection Act prohibits the collection agency from providing further information to Faxton - St. Luke's about what the collection agency does to collect the debts referred to it.[16]

Faxton - St. Luke's contends that it furnished to the Medicare Contractor the written collection policy purportedly in effect at the time Faxton - St. Luke's attempted to collect the debts at issue and that this policy was clear on how the debts were collected.[17] Faxton - St. Luke's argued that this collection policy required different collection efforts depending on whether the patient's account was less than $1,000, between $1,000 and $5,000, or over $6,000.

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[13] *See* Medicare Contractor's Final Position Paper for FY 2005, Exhibit I-4 (copy of PRM 15-1, Ch. 3 addressing bad debts).
[14] *See* Provider's Revised Final Position Paper for FY 2004 at 4.
[15] *See* Tr. at 65:19-66:2.
[16] *See* 15 U.S.C. § 1692c(b); Provider's Additional Information Request For the Board, Exhibit 3; Tr. 10:5-11:5.
[17] *See* Provider's Additional Information Request for the Board, Exhibit 5.

PRM 15-1, § 310 allows the provider to make business decisions on how much and what types of "collection effort" it will expend to collect debts, including decisions about whether the provider will engage a "collection agency" to assist in that effort. Understandably, a "reasonable collection effort" will vary from provider to provider and should be described in its written debt collection policies, consistently executed and demonstrated to the Medicare auditor. The Board finds, in this case, that Faxton - St. Luke's demonstrated that it had a written collection policy but failed to show that it followed its own collection policy.[18] Documentary evidence in the record demonstrates this inconsistency.[19] Testing conducted by the Medicare Contractor revealed that Faxton - St. Luke's sent numerous debts directly to Med-Rev[20] without following Faxton - St. Luke's own collection policy which required first sending debts to CCI for collection efforts for 35 days where CCI was acting as an agent of the hospital for a set fee.[21] Testing also showed that Faxton - St. Luke's violated its own written policy when it failed to send debts that were greater than $1,000 to CSI for potential financing[22] and when Faxton - St. Luke's failed to send two statements to the guarantor on one debt.[23] Testing also showed another debt was only at CCI for a week rather than 35 days as stated in the collection policy.[24]

Faxton - St. Luke's written policy says "if no activity or payment on the account while at the collection agency within a 6-month period, close the bad debt out from the primary and refer to the secondary agency."[25] During the hearing Faxton - St. Luke's witness testified that it no longer used a secondary collection agency.[26] However, the Medicare Contractor's testing revealed that notes on many of the accounts reflect secondary collection agency involvement.[27] These discrepancies support the Medicare Contractor's position that Faxton - St. Luke's did not consistently follow its written collection policies.

Faxton - St. Luke's argues that any inconsistencies in its collection policies are the product of "professional judgment" exercised by its collectors or that the Medicare Contractor did not understand the collection notes contained in the patient files.[28] In addition, the Faxton - St. Luke's witness explained idiosyncrasies in its collection system that caused information to appear in collection notes for one of the patient's accounts when the action actually pertained to different patient's account.[29] In some cases, Faxton - St. Luke's simply disagrees with the

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[18] *See* Medicare Contractor's Post Hearing Brief for FY 2004, Exhibit I-24; Medicare Contractor's Post-Hearing Brief for FY 2005, Exhibit I-18.
[19] *See* Medicare Contractor's Final Position Paper Additional Exhibits for FY 2004, Exhibit I-21; Medicare Contractor's Final Position Paper Additional Exhibits for FY 2005, Exhibit I-15.
[20] *See* Medicare Contractor's Post Hearing Brief for FY 2004, Exhibit I-24; Medicare Contractor's Post-Hearing Brief for FY 2005, Exhibit I-18.
[21] *See* Providers Additional Information Request For the Board, Exhibit 5; Tr. at 46-47, 63, 117-118 (suggesting that CCI was not acting as a third party collection agency governed by the Fair Debt Collections Act but rather as an agent of Faxton – St. Luke's).
[22] *See* Medicare Contractor's Post Hearing Brief for FY 2005, Exhibit I-18,
[23] *See* Medicare Contractor's Post Hearing Brief for FY 2004, Exhibit I-24.
[24] *See id.*
[25] *See* Provider's Additional Information Request For the Board, Exhibit 5.
[26] *See* Tr. at 175:22-177:20.
[27] *See* Medicare Contractor's Post Hearing Brief for FY 2005, Exhibit I-18.
[28] *See* Tr.at 113:23-114:6; 118:13-19.
[29] *See* Tr. at 101:10-103:18.

Medicare Contractor regarding the information contained in the collection notes.[30] Faxton - St. Luke's further contends that it is unable to document the specific actions taken by its collection agency due to the Fair Debt Collection Practices Act's limitations on disclosure, but that documentation requirements are met by merely noting that debts have been referred to a collection agency.[31]

Although the Board understands a few errors found in a sample may be non – representative outliers, the number of discrepancies found by Medicare Contractor is significant enough to conclude that Faxton - St. Luke's was not consistent in following its own collection policies, including the referral of patients to its primary and secondary collection agency. In this case, the Faxton - St. Luke's witness concedes, there was no auditable documentation in the notes or elsewhere in the record demonstrating that its staff used professional judgment in handling any specific case in which Faxton - St. Luke's collection policy was not followed.[32]

Finally, contrary to Faxton – St. Luke's position, § 805(b) of the Fair Debt Collection Act does permit a collection agency to communicate with the creditor (*e.g.*, Faxton – St. Luke's) in connection with the collection of a debt without the consent of the consumer.[33] Further, when a provider retains a collection agency, the provider is making a business decision to use the collection agency to perform collection efforts in lieu of performing them in house. The Medicare rules and regulations governing bad debt collection efforts apply regardless of whether those collection efforts are performed by the provider directly or by a contractor or agent of the provider.[34]

The Board finds that Faxton - St. Luke's did not adequately document reasonable collection efforts for its non-indigent patients. Notwithstanding, the Board notes that the parties have agreed that the bad debt of $688 for Patient D for FY 2004 is appropriate and should be allowed.[35] Accordingly, the Board finds that the Medicare Contractor's adjustment to remove bad debts for the non-indigent patients was appropriate with the exception of Patient D for FY 2004.

INDIGENT PATIENT COLLECTION EFFORTS

Faxton - St. Luke's contends that it should be paid for the bad debts related to the indigent patients disallowed, in the samples for FYs 2004 and 2005 because each case file contains

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[30] *See* Tr. at 113:1-127:23.
[31] *See* Provider's Revised Final position Paper at 3-5.
[32] *See* Tr. at 140:18-141:3.
[33] Section 805(b) of the Fair Debt Collection Act states, in pertinent part, that "a debt collector may not communicate, in connection with the collection of any debt, with any person other than a consumer, his attorney, a consumer reporting agency if otherwise permitted by law, *the creditor*, the attorney of the creditor, or the attorney of the debt collector." (Emphasis added.)
[34] *See, e.g.*, PRM 15-1 § 310.1 (conditioning coverage of collection agency fees on the collection agency making "the reasonable collection effort described in §310").
[35] *See* Medicare Contractor's Post-Hearing Brief for FY 2004 at 12; Medicare Contractor's Final Position Paper for FY 2004, Exhibit I-20. Claim D represents the allowable $688 claim and the Medicare Contractor deleted this claim from the list of the FY 2004 claims at issue in this appeal because "it is "no longer under dispute." *See* Medicare Contractor's Post-Hearing Brief for FY 2004, Exhibit I-24.

sufficient documentation that the patient was indigent, including a review and approval of the indigent determination by the Hospital's credit manager.[36] The Medicare Contractor contends that Faxton - St. Luke's did not sufficiently document the patient's income, assets, and expenses as required by Faxton – St. Luke's own policy and the PRM.[37] The Medicare Contractor further contends that the Medicaid application is insufficient documentation, by itself, to establish that the patients were indigent.[38]

In this case, Faxton - St. Luke's indigency policy stated that the patient should apply for Medicaid, and should provide the following information:

- A copy of the latest year of tax filing.
- A listing of the patient's daily living expenses (i.e. food, clothing, shelter, prescriptions, auto, insurance policies for auto/home and utilities).
- A completed uncompensated care application, which is provided by the hospital.
- Proof of income information, we must consider bank accounts, pension checks and insurance policies. As the law states "only those assets convertible to cash and unnecessary for the patient's daily living".[39]

Faxton - St. Luke's determines if the patient is indigent by comparing the patient's net income (including assets that can be converted to cash) to twice the federal poverty guidelines. The determination is approved or denied by the credit manager with the patient being notified of the decision.[40]

The Medicare Contractor contends that Faxton – St. Luke's actions are contrary to the requirements of PRM 15-1 § 312.[41] The Medicare Contractor contends that Faxton - St. Luke's reliance on information contained in the patients' Medicaid applications[42] is inadequate because these patients were ineligible for Medicaid and the Medicaid program did not verify or examine additional income or assets.[43] The Medicare Contractor also states that Faxton - St. Luke's did not verify patient assets including items such as jewelry, collectables, and consumer electronics, in assessing indigency.[44] The Medicare Contractor believes the indigency assessments performed were inconsistent with Faxton - St. Luke's established indigency policy, which requires patients to provide supporting documentation.

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[36] *See* Provider's Revised Final Position Paper for FY 2004 and 2005 at 5.
[37] *See* Tr. at 27:19-31:18.
[38] *See* Tr. at 230:4-232:5.
[39] Medicare Contractor's Final Position Paper for FY 2005, Exhibit I-16 at 9.
[40] *See id. See also* Provider's Revised Final Position Paper for FY 2004, Exhibit P-6.
[41] *See* Medicare Contractor's Post Hearing Brief at 19-23.
[42] *See* Tr. at 84:7-23.
[43] *See* Tr. at 230:4-231:16.
[44] *See* Medicare Contractor's Post Hearing Brief for FY 2004 at 20.

The Board finds that Faxton – St. Luke's indigency policy complies with PRM 15-1 § 312 because, under this policy, Faxton – St. Luke's is making the determination on idigency and, in making this determination, Faxton – St. Luke's takes into account a patient's total resources which would include, but are not limited to, an analysis of assets, liabilities, and income and expenses. The Board further finds that Faxton - St. Luke's exercised due and sufficient diligence in determining indigency by consistently obtaining and reviewing substantive and pertinent documents including Social Security benefit information, the State Medicaid medical assistance determinations, and a questionnaire of expenses.[45] The record demonstrates that Faxton - St. Luke's did establish and substantiate patient income, expenses and assets, as required by its collection policy, even though it did not obtain tax returns and bank statements from all of the patients. The Board notes that the Medicare Contractor incorrectly describes some of the indigency documentation as "Medicaid applications." This indigency documentation is the State Medicaid determination on medical assistance and includes findings on the income. The Board finds that Faxton - St. Luke's relied heavily on State Medicaid's findings on income that is contained in State Medicaid determination to establish the patients' lack of resources, supplemented this information with its patient questionnaire, and documented these efforts.[46] The Board finds that this as an acceptable methodology to review indigency because the State Medicaid application process and determination for medical assistance considers and makes findings on income and other resources such as bank accounts, pensions, insurance policies, *etc*.[47] Accordingly, the Board finds that Faxton – St. Luke's could rely on these State Medicaid findings and, consistent with its indigency policy, Faxton – St. Luke's did "consider" the patient's income and other resources such bank accounts, pensions, and insurance

The Board concludes Faxton - St. Luke's indigency determinations did <u>not</u> violate the requirements set forth in PRM § 312, and therefore the Board finds that the Medicare Contractor's adjustment to remove bad debts related to indigent patients should be reversed.

<u>DECISION AND ORDER</u>:

For the subset of bad debts at issue involving non-indigent patients for fiscal years ("FYs") 2004 and 2005, the Board finds that the Medicare Contractor properly disallowed them with the exception of the bad debt of $688 for Patient D for FY 2004 which both parties now agree was appropriate.[48] For the subset of bad debts at issue involving indigent patients for FYs 2004 and

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[45] *See* Tr. at 93:9-19, 86: 8 – 87: 8. The Board notes that, for one of the indigent patients (Patient AV for FY 2004), a listing of the prescription drugs the patient was taking was allegedly not located by the Medicaere Contractor in the audited documentation. However, Faxton – St. Luke's provided testimony confirming that the listing did exist in the audited documentation on the back side of th sheet where the patient listed their monthly expenses and furnished the Board with a copy of this listing. The Board is satisfied that this documentation existed and was available at the time of audit. *See* Tr. at 16-17, 180-181; Provider's Additional Information Request for the Board, Exhibit 7 at 1and at Tabs entitled "Case 4," "Drug List"

[46] *See* Tr. at 84:7-23, 93:9-19.

[47] *See, e.g.*, Provider's Revised Final Position Paper for FY 2004, Exhibit P-6 at 12-16 (State Medicaid medical assistance determination showing findings on income, bank accounts, and insurance).

[48] *See* Medicare Contractor's Post-Hearing Brief for FY 2004 at 12; Medicare Contractor's Final Position Paper for FY 2004, Exhibit I-20. Claim D represents the allowable $688 claim and the Medicare Contractor deleted this claim from the list of the FY 2004 claims at issue in this appeal because "it is "no longer under dispute." *See* Medicare Contractor's Post-Hearing Brief for FY 2004, Exhibit I-24.

2005, the Board finds that the Medicare Contractor improperly disallowed them. Accordingly, the Board reverses the disallowance of the Patient D non-indigent bad debt for the FY 2004 sample, reverses the disallowance of the indigent bad debts for the FY 2004 and 2005 samples, affirms the disallowance of the remainder of the non-indigent bad debts for the FY 2004 and 2005 samples, and directs the Medicare Contractor to recalculate the extrapolated allowable bad debt amount for FYs 2004 and 2005.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 22, 2015