PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2019-D4

PROVIDER –
Mackey Family Practice, P.A.

DATE OF HEARING – July 10, 2018

PROVIDER NO. – 42-8960

COST REPORTING PERIOD –
September 30, 2014

vs.

MEDICARE CONTRACTOR –
Palmetto GBA

CASE NOS. – 17-0685

Page No.

ISSUE

Whether the Medicare Administrative Contractor's ("Medicare Contractor") disallowance of the Medicare bad debts claimed by Mackey Family Practice was proper.[1]

DECISION

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that Mackey Family Practice, P.A., (hereinafter, "Provider") is not able to establish that reasonable collection efforts, as required under the applicable Medicare regulations, were made with respect to the Medicare bad debts that it claimed on its cost report for the fiscal year ending ("FYE") on September 30, 2014. Therefore, the Board affirms the Medicare Contractor's adjustment to the Provider's bad debt reimbursement.

INTRODUCTION

The Provider is a freestanding rural health clinic with facilities in both Lancaster and Indian Land, South Carolina.[2] The Provider filed its Medicare cost report for the FYE September 30, 2014, with a claim for Medicare bad debt reimbursement. Upon review, the Medicare Contractor disallowed the Medicare bad debts due to the Provider's failure to provide appropriate supporting documentation to demonstrate the Provider's collection efforts.[3]

The Provider filed a timely appeal and met the jurisdictional requirements of 42 C.F.R. §§ 405.1853-405.1840. The Board held a telephonic hearing on July 10, 2018. Michelle M. Knight, Insurance Manager, represented the Provider and Joseph J. Bauers, Esq. of Federal Specialized Services represented Palmetto GBA,[4] the Medicare Contractor.

STATEMENT OF THE FACTS AND RELEVANT LAW

The regulations governing Medicare bad debts are located at 42 C.F.R. § 413.89.[5] Under 42 C.F.R. § 413.89(a), bad debts attributable to Medicare deductibles and coinsurance amounts are reimbursable under the Medicare program, provided that certain criteria are met. The regulatory text at 42 C.F.R. § 413.89(d) explains that the failure of Medicare beneficiaries to pay the deductible and coinsurance amounts could result in the related costs of covered services being borne by individuals other than Medicare beneficiaries. To avoid such situations, the costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs, under the following criteria in 42 C.F.R. § 413.89(e):

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[1] Transcript of Proceedings ("Tr.") at 5-6 (July 10, 2018).
[2] Medicare Contractor's Final Position Paper at 2.
[3] Provider's Group Appeal Request, Tab 2, at 4 (Nov. 21, 2016 email from NGS to Provider); Medicare Contractor's Final Position Paper at 6.
[4] During the hearing, Mr. Robert Lee testified as a witness for the Medicare Contractor and stated that, while Cahaba Government Benefit Administrators was the original Medicare Contractor for the Provider, those duties have since been reassigned to Palmetto GBA. NGS performed audit duties as a subcontractor. Tr. at 138-39.
[5] Redesignated from 42 C.F.R. § 413.80. 69 Fed. Reg. 48915, 49254 (Aug. 11, 2004).

> (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 regulation does not, however, define what a provider must do to engage in "reasonable collection efforts" or to establish that it has made such "reasonable collection efforts."[6] The Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), contains interpretive guidelines regarding certain Medicare regulations.[7] Section 310 of the PRM 15-1 provides some guidance regarding the Secretary's interpretation of "reasonable collection efforts":

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It 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. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment.

Section 310.B explains that a provider's collection effort should be documented in the patient's file by copies of bills, follow-up letters, reports of telephone and/or personal contact, etc. Section 310.2 further states that if, after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the patient/beneficiary, the debt may be deemed uncollectible. As thoroughly explained in prior decisions on this issue of the reasonableness of bad debt collection efforts, the Board has interpreted this "reasonable *and customary*" language to require a provider both to have a written debt collection policy memorializing the process for its "collection effort," and to follow that written policy in its debt collection process.[8]

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[6] *District Hospital Partners v. Sebelius*, 932 F. Supp. 2d 194, 200 (D.D.C. 2013) (citing *GCI Health Care Ctrs., Inc. v. Thompson*, 209 F. Supp. 2d 63, 69 (D.D.C. 2002)).

[7] *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401, 404 (6th Cir. 2007).

[8] *See, e.g., Marian Health Ctr. v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 85-D110 (Sept. 23, 1985), *declined review*, CMS Adm'r (Oct. 29, 1985); *Cooper Hosp. v. Blue Cross Blue Shield*, PRRB Dec. 2014-D11 (June 18, 2014), *declined review*, CMS Adm'r (Aug. 20, 2014). *See also Methodist Hosp. v. Wisconsin Physician Serv.*, PRRB Dec. 2014-D18 (Aug. 26, 2014), *declined review*, CMS Adm'r (Oct. 14, 2014); *St. John Health 2004-2005 Bad Debt Moratorium CIRP Grp. v. National Gov't Servs.*, PRRB Dec. 2014-D19 (Aug. 27, 2014), *rev'd on other grounds*, CMS Adm'r (Oct. 23, 2014); *HMA 2004-2006 Bad Debt Grp. Appeals v. Wisconsin Physician Serv.*,

In the instant case, Provider changed its *written* bad debt policy at the beginning of calendar year 2014. This change prompted the Medicare Contractor to review the Provider's bad debt collection efforts for the FYE September 30, 2014 cost reporting period.[9] In order to review Provider's collection efforts, the Medicare Contractor requested that the Provider produce its non-Medicare bad debt log for FYE September 30, 2014, so that the Medicare Contractor could compare it with the previously submitted Medicare bad debt log.[10] While the Provider was unable to produce a non-Medicare bad debt log in the format required by the Medicare Contractor,[11] the Medicare Contractor and Provider ultimately agreed that the Provider could submit "3 Medicare samples from the Medicare Bad Debt Log . . . and 3 non-Medicare samples with similar dates for comparison."[12] On July 14, 2016, the Provider faxed its bad debt "samples" and "supporting documentation for the samples" to the Medicare Contractor.[13] The samples and supporting documentation included a copy of the Provider's January 1, 2014 Bad Debt Policy, the bad debt log samples, claims summary screenshots, and billing screenshots that provided dates of patient billings.[14]

The Medicare Contractor issued the Provider's FYE September 30, 2014 Notice of Program Reimbursement ("NPR") on September 8, 2016.[15] On November 21, 2016, the Medicare Contractor notified the Provider that: "In reviewing that documentation, we were unable to identify any documentation of the issuance of a bill to the patient or subsequent collection attempts/efforts by your organization (as required by CMS)." As the documentation submitted did not support or demonstrate the collection efforts, the auditor disallowed all Medicare only bad debts, which was the same treatment as in the prior year for bad debts."[16] The Provider appealed its Medicare bad debt disallowance on December 29, 2016.

PRRB Dec. 2014-D30 (Sept. 25, 2014), *declined review*, CMS Adm'r (Oct. 28, 2014); *Momence Meadows Nursing & Rehab. Ctr., LLC v. National Gov't Servs.*, PRRB Dec. 2018-D23 (Feb. 12, 2018), *declined review*, CMS Adm'r (Apr. 6, 2018).

[9] Exhibit I-5 (June 20, 2016 email from NGS to Provider). During 2012 and 2013, the Provider had a "two part" Bad Debt Policy, with written collection procedures for patients with Medicare and separate written procedures for patients with no Medicare. Provider's Final Position Paper at 1-2. The Provider maintains that, while the Bad Debt Policy was comprised of two parts, the collection efforts for Medicare bad debt and non-Medicare bad debt were nonetheless "similar." *See* Tr. at 23-24. On May 20, 2014, the Provider's prior Medicare Contractor determined that the Provider's 2012/2013 Bad Debt Policy was not in compliance with Medicare regulation because it treated patients differently based on type of insurance. The Provider did not appeal the 2012/2013 bad debt policy decision, but instead revised the Bad Debt Policy to "state[] clearly that it is all inclusive, regardless of insurance type." Provider's Final Position Paper at 1-2. It was, apparently, this revision of the two part Bad Debt Policy to a single Bad Debt Policy that prompted the Medicare Contractor to review the Provider's 2014 bad debt collection policy and efforts for regulatory compliance. Medicare Contractor Final Position Paper at 5.

[10] *Id*. *See also* PRM 15-2, Ch. 11, § 1102.3(D) (as part of the cost reporting process, a provider claiming Medicare bad debt reimbursement must submit certain documentation to support the bad debts being claimed).

[11] Tr. at 12-13.

[12] Provider's Final Position Paper at 2.

[13] Exhibit I-10.

[14] Medicare Contractor's Final Position Paper at 8; Exhibit I-10.

[15] Provider's Group Appeal Request, Tab 2, at 5.

[16] *Id*. at 4 (Nov. 21, 2016 email from NGS to Provider).

DISCUSSION, FINDING OF FACT AND CONCLUSIONS OF LAW

In the instant case, during the course of its audit, the Medicare Contractor reviewed the Provider's January 1, 2014 Bad Debt Policy in order to confirm that the policy complied with Medicare regulations, and that collection efforts for Medicare and non-Medicare debts were similar and reasonable.[17] The Provider argues that its 2014 Bad Debt Policy[18] accurately describes its collections process and that this written policy shows that its "treatment of Medicare bad debts and regular bad debts [is] the same."[19] Moreover, the Provider claims that the documentation submitted to the Medicare Contractor for the 3 Medicare bad debt account samples and 3 non-Medicare bad debt account samples[20] demonstrated the Provider's compliance with its bad debt collection policy, and that the collection policy and efforts were reasonable because the account samples submitted "clearly show[ed] the date of first bill and date of write off."[21]

The Medicare Contractor argues that, although the Provider's written "bad debt policy is reflective of an all-inclusive policy," the documentation submitted by the Provider in support of its collection efforts "was not sufficient in demonstrating whether collection efforts were reasonable or similar[.]" Thus the Medicare Contractor disallowed the Medicare-only bad debts on the FYE September 30, 2014 cost report.[22] The Medicare Contractor states that Provider's documentation in support of its collection efforts included a copy of its Bad Debt Policy, the "sample listing, claims summary screenshots, and screenshots of a billing system that provided the date of first and monthly billing."[23] The Medicare Contractor concluded that the billing system screenshots did not provide the documentation required to demonstrate that Provider undertook a genuine collection effort rather than a token effort. The "[l]ack of appropriate support caused the Provider to fail the documentation requirement needed to substantiate that Medicare and non-Medicare bad debt collection efforts are treated similarly."[24]

During the hearing, the Provider's witness, the Insurance Manager, explained the Provider's written billing and collection policy.[25] Pursuant to Provider's Bad Debt Policy, after a patient's insurances have been billed and the insurances have "responded," the patient is then billed for its "responsibility portion."[26] The Insurance Manager testified that patient bills are mailed once a month for four months, and that, if after 120 days the patient has not responded, the Provider issues the first collection letter.[27] This collection letter offers payment plan options[28] or gives the option to pay the "delinquent balance" in full.[29] If the Provider does not receive a response to

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[17] Medicare Contractor's Final Position Paper at 5.
[18] Provider's Final Position Paper at 4.
[19] *Id.* at 2.
[20] Exhibit I-10.
[21] Provider's Final Position Paper at 2.
[22] Medicare Contractor's Final Position Paper at 6.
[23] Medicare Contractor's Final Position Paper at 8.
[24] *Id.* The Medicare Contractor cites the documentation examples listed in PRM 15-1 § 310 in support of its conclusion that Provider's submitted documentation did not substantiate its collection efforts.
[25] Tr. at 52.
[26] Provider's Final Position Paper at 4.
[27] Tr. at 39-40.
[28] Tr. at 84.
[29] Provider's Final Position Paper at 4.

the first collection letter after 10 days, a second collection letter is sent that offers the same repayment plans.[30] If the Provider does not hear from the patient within 20 days following the issuance of the second collection letter, the account is then flagged as "collect in full."[31] Then, following another 10 days, the account balance is written off as a bad debt. This process is memorialized in the Provider's Bad Debt Policy effective January 1, 2014.[32]

The Insurance Manager testified that, while the Provider's billing system noted the dates that the bills went out during the 120-day period, the system did not maintain copies of the patient bills or the collection letters that were sent to patients. The Insurance Manager further confirmed that the Provider did not save or print a copy of these documents for the patient files.[33] The Insurance Manager explained that the notations in the billing system were the dates that the patient bills were issued during the 120-day billing cycle before the collection letters were issued, and that the system did not retain any dates related to the issuance of collection letters.[34]

The Board finds that the documentation that the Provider submitted for the sampled accounts reflects the date that the Provider sent the first bill to the patient and the write-off date. The Provider presented no evidence of its collection efforts between those dates to confirm that it complied with its Bad Debt Policy effective January 1, 2014.[35] The billing screenshots that the Provider submitted showed various account dates and balance amounts, but, during the hearing, the Insurance Manager was not able to provide billing details to clarify the entries since subsequent patient visits were not segregated or differentiated from the first visits.[36] The Provider did not present copies of bills, follow-up letters or reports of telephone calls or personal contacts to document its collection efforts.[37] Although the Insurance Manager argues that the Medicare Contractor never requested such documentation during the audit,[38] she also admits that she could not have provided this information even if it had been specifically requested, because the billing system did not maintain copies of the bills or collection letters, nor did the Provider print out and retain the bills in the patients' files.[39] For these reasons, the Board finds the Provider did not provide adequate documentation to demonstrate that it followed its Bad Debt Policy effective January 1, 2014 and that reasonable collection efforts were made with respect to its Medicare patients' bad debts.

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[30] *Id. See also* Tr. at 97-98.
[31] Provider's Final Position Paper at 4. *See also* Tr. at 99.
[32] Provider's Final Position Paper at 4.
[33] Tr. at 23-24.
[34] Tr. at 66-67, 90.
[35] When reviewing Provider's Medicare bad debt samples, the first patient account on the log appears to fall outside of Provider's bad debt collection policy. The Board notes that based upon Provider's written bad debt policy and the Insurance Manager's testimony during the hearing, Provider's "collection efforts" from the date of the first patient bill until the date that the account balance is written off as bad debt should be a minimum of 150 days. For the first Medicare patient on the bad debt log, the time period between the first bill date (4/24/2014) and the write off date (9/4/2014) is 133 days. *See* Exhibit I-10 at 8.
[36] Medicare Contractor's Final Position Paper Ex. I-10 at 10; Tr. at 115-124.
[37] Tr. at 29-31
[38] Tr. at 69, 151-154.
[39] Tr. at 24, 51-56.

DECISION:

After considering Medicare law and regulations, arguments presented, and the evidence admitted, the Board finds that the Provider is not able to establish that reasonable collection efforts, as required under the applicable Medicare regulations, were made with respect to the Medicare bad debts that it claimed on its cost report for FYE September 30, 2014. Therefore, the Board affirms the Medicare Contractor's adjustment to the Provider's bad debt reimbursement.

BOARD MEMBERS:

Clayton J. Nix, Esq.
Charlotte F. Benson, C.P.A.
Gregory H. Ziegler, C.P.A, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

/s/
Clayton J. Nix, Esq.
CHAIR

DATE: November 27, 2018