PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D40

PROVIDER -
Athens-Limestone Hospital
Athens, Alabama

Provider No. 01-0079

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Alabama

DATE OF HEARING-
November 14, 2000

Cost Reporting Period Ended -
September 30, 1994

CASE NO. 97-0843

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ISSUE:

Was the Intermediary's disallowance of the Provider's Medicare Part B bad debts for deductibles and coinsurance proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Athens-Limestone Hospital ("Provider") is a non-profit general acute care hospital located in Athens, Alabama. In its Medicare cost report for the fiscal year ending September 30, 1994 the Provider claimed Part B bad debts for deductibles and coinsurance totaling $787,454.

The Intermediary treated the Provider's claimed costs for all closed cost reports as requests for reopening, and only allowed the bad debt expense for those periods within the three year reopening limitations.

Chapter 3, Section 300 of HCFA Pub. 15-1 was cited as the basis for the adjustment, which served to reduce Provider reimbursement by $241,362. Subsequent to its audit, the Intermediary proposes to modify its disallowance to recognize as reimbursable additional claimed bad debts of $ 63, 207.98, which are applicable to the fiscal year ending September 30, 1990.

On January 16, 1997, the Provider appealed the Intermediary's disallowance of bad debts to the Provider Reimbursement Review Board ("Board"), and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by Winston V. Legge, Jr. Esq. of Patton, Latham, Legge, & Cole. The Intermediary was represented by James R. Grimes, Esq., of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that 42 C.F.R. § 413.80(f) provides that the amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In the instant case, the Provider has deemed that its fiscal year September 30, 1994 is the appropriate year for the bad debt claims to be charged off as worthless. The Provider argues that the claimed bad debts do not represent a proposed reopening of the Medicare cost report years 1986 through 1990. It further argues that the fact that the claimed bad debts were created more than three years prior to September 30, 1994 is irrelevant.

The Provider sites 42 C.F.R. § 413.80(e) as the criteria for an allowable Medicare bad debt. That regulation states:

> "(e) Criteria for allowable bad debt. A bad debt must meet the following criteria to be allowable.

1. The debt must be related to covered services and derived from deductible coinsurance amounts.

2. The Provider must be able to establish that reasonable collection efforts were made.

3. The debt was actually uncollectible and claimed as worthless.

4. Sound business judgement established that there was no likelihood of recovery at any time in the future."

The Provider contends that the determination of when an account becomes a "bad debt" requires that the Provider exercise specific subjective standards, including a determination that the debt was actually uncollectible, and that there was no likelihood of recovery at any time in the future. Under its established procedures, the Provider did not deem any account as a bad debt until the account was placed with an outside financial institution, an attorney, or there was a filing for a judgement in a court proceeding. Thus, while following the regulations, the Provider contends that it had the discretion to determine the point in time when the accounts at issue would become bad debts for Medicare cost report submission purposes.

The Provider points out that testimony at the hearing revealed the following:

1. The three-year rule applied by the Intermediary was memorialized during May 1996, a year after the Provider submitted its 1994 cost report.

2. The Intermediary witness testified that the regulation applicable to bad debts, 42 C.F.R. § 413.80(f) uses the terminology deemed to mean that the bad debt determination is based on the facts of the case.

3. The Intermediary witness testified that the factual determination should be made by a provider according to the provider's written collection procedures, and that the reasonableness of the time of the bad debt charge off is based on a provider's written collection procedures.

4. The Provider had not previously claimed any of the bad debts at issue.

Finally, the Provider argues that the Intermediary position that all bad debts must be determined by a provider and submitted within three years, is simply an arbitrary timeline not founded in rule or regulation. Accordingly, the Provider asserts it is entitled to the entire amount of bad debts originally disallowed in the amount of $241,362.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the very meaning of bad debts indicates they are uncollectible amounts arising from the furnishing of services and are related to accounts

receivable which would otherwise be collectible in the relatively near future. This is supported by the regulation at 42 C.F.R. § 413.80 (b) (1) which defines bad debts as follows:

> (b) Definitions—(1) Bad debts. Bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

The Intermediary further contends that the accounting period for charging off accounts as bad debts is governed by the regulation at 42 C.F.R. § 413.80 (f) that states in part:

> (f) Charging of bad debts and bad debt recoveries. The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless . . .

The Intermediary contends that the Provider's assertion (that uncollected accounts for services furnished in 1983 through 1989 were determined to be worthless in the year 1994) is without merit. The Intermediary asserts that the Provider's bad debts for these periods should have been charged off during the same accounting period for these services or during the immediately succeeding accounting period. It is reasoned that the Provider's customary collection efforts would have been exhausted for Medicare Part B amounts within the relative near future, usually within no more than six months after patient services were rendered. This time frame also coincides with any payment determinations by the Medicaid fiscal agent under the "crossover" billing procedures.

An analysis of the Provider's collection policy indicates that outpatient accounts are to be written-off within a time frame commensurate with completion of the hospital billing cycle, which extends for about six months. Provider testimony at the hearing revealed that crossover bad debts would have been written off for accounting purposes when payment for the claim was received from Medicare and Medicaid. Additionally, the Provider witness testified that the write-off would occur within a short time after the services were rendered. The Intermediary argues that this testimony supports the Intermediary's position that a receivable is a claim that is collectible in the near future.

The Intermediary points out that the Provider has presented no evidence that the disputed accounts were the object of continuing reasonable collection efforts until 1994. The Intermediary believes that several years of inactivity in this case does not constitute a reasonable collection effort. Instead, it would constitute an unwarranted delay in its uncollectibility determinations extending indefinitely into the long term.

The Intermediary opines that the Provider's contention that reasonable collection efforts extended for several years serves only to frustrate the rules in 42 C.F.R. § 405.1885 governing administrative finality. Those rules protect both providers and the Medicare program from unwarranted entry into past payment determinations.

The Intermediary contends that the bad debts at issue in this hearing could have, but were not claimed in the cost reports for the years 1986 through 1989. However, the Provider chose to include these bad debts in the 1994 Medicare cost report which was received by the Intermediary on March 14, 1995. Upon review of the1994 cost report the Intermediary contends that it properly attributed the bad debts to the cost years in which the service giving rise to the claim was rendered. It then treated the amounts claimed in the 1994 cost report as a request for reopening of the prior cost reports. It reopened and allowed the claims in all cases where the request was within three years of the issuance of the final Notice of Program Reimbursement. As a result, the Intermediary contends that the bad debts claimed for receivables that could have been written off as worthless in fiscal years ending September 30, 1986 –1989 were beyond the three year reopening limitation and could not be recognized. The amounts originally disallowed are as follows:

Period	Amount
Through September 30, 1986	$33,614.02
Through September 30, 1987	$27,591.60
Through September 30, 1988	$54,702.95
Through September 30, 1989	$62,245.10
Through September 30, 1990	$63,207.98
	$241,361.65

Upon further review, the Intermediary agreed that it should have recognized the bad debt expense for the fiscal year ending September 30, 1990, in that the NPR date for that year was less than three years old on March 14, 1995 (receipt date of the fiscal year 1994 Medicare cost report).

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Regulations – 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1885	-	Reopening a Determination Or Decision
§ 413.80 (b) (1)	-	Definitions- Bad Debts
§ 413.80 (e)	-	Criteria For Allowable Bad Debt

§ 413.80 (f)	-	Charging of Bad Debts and Bad Debt Recoveries

2. Program Instructions –Provider Reimbursement Manual, Part I (HCFA Pub.15-1):

§ 300	-	Principle
§ 2931.2	-	Reopening Final Determination

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented, testimony at the hearing, and post hearing briefs, finds and concludes as follows:

Upon review of the complete record presented by both parties, the Board finds that the main issue to be decided is an interpretation of when bad debts are deemed to be worthless. This is a question of fact that has to be determined based on the particular circumstances surrounding each case. The Board finds that testimony at the hearing revealed that the Provider's patients were determined to be indigent. As such, no attempts were made to collect deductibles and co-payments from those patients. In the instant case, a review of the Provider's collection and billing policy indicated that the Provider wrote off all crossover bad debts, for accounting purposes, as soon as the Medicaid determination and payment was made. These amounts were then placed into a contractual allowance account for inclusion in the Medicare cost report and were no longer carried as accounts receivable. However, the Board finds that due to an oversight the Provider did not claim the bad debts in question (dating from 1985 to 1994) on the Medicare cost report until the September 30, 1994 Medicare cost report was filed.

The Board notes that the Provider's position paper contained the following summary of bad debts for which it is seeking reimbursement.

Medicaid Remit Date	Amount
July/1985 - September/1986	$33,614.02
Oct./1986 - September/1987	$27,591.60
Oct./1987 - September/1988	$54,702.95
Oct./1988 - September/1989	$62,245.10
Oct./1989 - September/1990	$63,207.98(Subsequently Allowed by Intermediary)

The Board finds that the Provider is basing its case for reimbursement primarily on the regulation at 42 C.F.R. § 413.80(f) which states in part that:

> amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless".

However, using that regulation in isolation ignores the basic definition of a bad debt found in 42 C.F.R. § 413.80(b)(1) which states in part:

> Accounts receivable and notes receivable are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

This is supplemented by the regulation at 42 C.F.R. 413.80(e) which states in part:

> Sound business judgement established that there was no likelihood of recovery at any time in the future.

Applying these regulations as a whole, the Board finds that the Provider did not use sound business judgement in deferring its claim for reimbursement until fiscal year 1994. The Board concludes that the facts and testimony revealed that the accounts in question should have been deemed worthless and written off as a Medicare bad debt when the Medicaid program remittance advice was tendered to the Provider. The Provider did not demonstrate that any type of follow up or collection activity took place between the time it received the Medicaid remittance advice and the year it finally sought reimbursement. Accordingly, the Board finds that the Provider can not use the bad debt regulations to cure its admitted administrative omission. As such, the Board finds that the bad debts for the years 1986 through 1989 are not allowable for the reason stated above.

The Board also finds that while concurring with the Intermediary's disallowance, it is not in agreement with the basis used to support the adjustment. Nothing in the bad debt regulations indicate that bad debts must be claimed within a specific time period. Accordingly, the Board finds that the Intermediary's proposal to disallow all bad debts not claimed within a three year window is without merit. Secondly, the Intermediary's treatment (denial) of the cross-over bad debts claim does not constitute a denial of a reopening under 42 C.F.R. 405.1885 or HCFA Pub. 15-1 § 2931.2. The regulation and manual both require that the Intermediary give the Provider a written notice of a decision to reopen. In the instant case, the Provider claimed the costs for all the years in dispute on the 1994 Medicare cost report. The Intermediary's adjustment was made to the FYE 1994 cost report as opposed to reopening the years in dispute.

DECISION AND ORDER:

The Intermediary's adjustment to Medicare bad debts is affirmed. However, the basis for the adjustment is modified as discussed above. The Board also notes that the Intermediary allowed claimed bad debts for those years (that were subject to reopening- 1990 through

1994) although these years were not a part of this appeal. The bad debts for those periods were allowed in the 1994 fiscal year. Evidence in the record clearly supports the unpaid deductible and coinsurance amounts. The Board supports the Intermediary's allowance of these amounts to the extent they are in concert with the existing bad debt regulations.

Board Members Participating

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: August 08, 2001

FOR THE BOARD

Irvin W. Kues
Chairman