PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D66

PROVIDER –
Westminster at Lake Ridge
Lake Ridge, Virginia

Provider No. 49-5280

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
United Government Services, LLC--WI

DATE OF HEARING -
October 4, 2002

Cost Reporting Period Ended
December 31, 1997

CASE NO. 99-4073

INDEX

ISSUE:

Was the intermediary's adjustment disallowing Medicare Part A and Part B bad debt proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Westminster at Lake Ridge (Provider) is a Medicare certified skilled nursing facility located in Lake Ridge, Virginia. On its fiscal year ended (FYE) 12/31/97 cost report, the Provider claimed reimbursement for Medicare co-insurance that it deemed to be non-collectable. Trigon Blue Cross and Blue Shield, subsequently replaced by United Government Services (Intermediary), denied the claim for bad debts in its entirety. The Provider filed a timely appeal with the Provider Reimbursement Review Board (Board) and has met the jurisdictional requirements of the regulations at 42 C.F.R. §§ 405.1835-405.1841. The Medicare reimbursement at issue is approximately $114,729.[1]

The Provider indicated that in the period prior to the submission of the FYE 1997 cost report, it began a rigorous review of outstanding accounts receivable, including any amounts that were related to the payment of Medicare coinsurance for Part A and Part B claims.[2] During the review, the Provider conducted an additional final collection effort.[3] Commencing in November of 1997, the Provider sent out letters to the resident or responsible parties requesting payment for services rendered.[4] The "collection letters" for each bad debt account were as follows: the first one dated November 20, 1997, the second one dated January 22, 1998 (with header marked "Second Request"), and a third one dated March 10, 1998 (with header marked "Third Request").[5] The Provider determined the outstanding bad debts to be $121,807 for Part A and $29,377 for Part B and claimed them on its FYE 1997 cost report.

The Intermediary reviewed the Provider's cost report and initially denied the Provider's bad debt claim because the Provider had failed to file a bad debt list in support of its claim.[6] The Provider sent a letter to the Intermediary requesting additional time to submit the bad debt listing.[7] The record indicates that the Provider submitted the listing to the Intermediary on January 8, 1999.[8] On April 21, 1999, the Intermediary indicated it had concerns with the age of the bad debt claims.[9] The inpatient bad debts by year were as follows:

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[1] This amount represents the amount initially claimed of $151,184 minus $36, 455 which represents the amount subsequently recovered by the Provider since the filing of the cost report. See Providers Post Hearing Brief at 13.
[2] See Provider's Post Hearing Brief , Summary of Facts, No. 1 at p. 2.
[3] Id.
[4] Id.
[5] See Intermediary Position Paper at 4 and examples of these letters at Intermediary Exhibit I-14 at 3-6.
[6] See Intermediary Position Paper at 3 and Intermediary Exhibit I-1.
[7] Intermediary Exhibit I-2.
[8] Intermediary Exhibit I-3.
[9] Intermediary Exhibit I-4.

1993 7
1994 22
1995 15
1996 24
1997 0

There were also 32 claims with no service dates.[10] The Provider indicated that additional collection activity included monthly statements and remittance notices with copayment amounts due.[11] By letter dated June 17, 1999, the Intermediary agreed to review additional documentation.[12] The Provider submitted an example of support data it had in its files.[13] The Intermediary reviewed this information and determined that it was inadequate because it did not identify the deductible and coinsurance amounts due and there was no demand for payment.[14] On July 27, 1999, the Intermediary issued an NPR with a total disallowance of the claimed bad debts.[15] The Intermediary agreed to again review Provider's documentation so it could make an allowance for bad debts.[16] The actual onsite audit was carried out on August 26 and 27, 2002. On the first day of the audit, the Provider gave the auditor a list that totaled $52,621 in bad debt recoveries.[17] The Intermediary's determination after the audit was the same; the bad debts were not allowed due to inadequate collection efforts. The specific findings are reflected in a letter to the Provider dated September 13, 2002.[18] The Intermediary provided audit summaries of all accounts audited on August 26 and 27, 2002.[19]

The Provider's formal written collection procedures are in the record.[20]

The Provider was represented by Blake Gillman, President, Med 2 Resources. The Intermediary was represented by Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that its collection efforts met the requirements of the regulation and manual provisions and that it presented adequate documentation to this effect.

The Provider asserts that it understood that only two items were missing at the time of the tentative settlement – the bad debt listing and the recoveries. The Provider indicates that

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[10] See Intermediary Position Paper at 3
[11] Intermediary Exhibit I-5.
[12] Intermediary Exhibit I-6.
[13] Intermediary Exhibit I-7.
[14] Intermediary Exhibit I-8.
[15] Intermediary Exhibit I-9.
[16] Intermediary Exhibit I-11.
[17] See, Intermediary position paper at 5 and listing of bad debt recoveries at Intermediary Exhibit I-13.
[18] Intermediary Exhibit I-14.
[19] See Intermediary Exhibit I-19-35.
[20] Intermediary Exhibit I-16.

it subsequently provided the bad debt listing and that, at that time, there were no recoveries to report.

The Provider notes that the Intermediary was concerned with the age of the bad debts but that CMS Pub. 15-1 § 314 states that "[u]ncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the bad debts are determined to be worthless." The Provider contends that if the uncollectible amounts were not deemed worthless until 1997, it was proper to include them on the FYE 1997 cost report as was done.

The Provider contends that the subsequent audit of its bad debt records was done hastily and was incomplete. It claims that it did not copy and include the resident histories that were made available at the time of the audit but that these histories clearly indicate that billing activity occurred from the date of the start of care.

The Provider contends that it has demonstrated "reasonable effort to collect" as required by CMS Pub. 15-1 § 310. The manual provision requires only that the collection effort for Medicare and non-Medicare patients be similar. There is no requirement that a provider must exactly follow its collection procedure, either written or assumed, as long as the collection effort is similar for all classes of payors.

The Provider indicated that its billing was timely because it charged for coinsurance on the bills at the time of its incurrence and then carried the charge forward on the bill until it was written off as uncollectible.[21] Debts were brought forward on subsequent bills for at least 120 days and by sending final notices. During the entire process, the Provider made every effort to have the beneficiary or responsible party pay the bill.[22]

The Provider points out that the Intermediary even denied bad debts for its indigent patients. CMS Pub. 15-1 § 312 states that: "Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." The rule states that, once indigence is determined and the Provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying collection procedures. Therefore, the Intermediary improperly applied its across-the-board denial of bad debts for patients identified as indigent on the bad debt summaries.

The Provider notes that the Intermediary was concerned about whether the collection letters had actually been sent to the beneficiaries. These letters had been placed in beneficiary mail boxes at the facility. Evidence of their delivery and the effectiveness of the collection effort is demonstrated by the large amount of the bad debts collected a result of this effort.

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[21] Provider's Final Position Paper at 2.
[22] Id.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it properly disallowed the Provider's bad debts because the customary debt collection procedures under the regulation and manual were not being followed.

The Intermediary notes that the regulations at 42 C.F.R. §§ 413.80(e)(3) and (4) require that the debt was actually uncollectible when claimed as worthless and that sound business judgment established that there was no likelihood of recovery at any time in the future. In order for a debt to be uncollectible, CMS Pub. 15-1 § 310 requires that a reasonable collection effort must be made. It specifically states:

> 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.**

CMS Pub. 15-1 § 310 (emphasis added).

The Intermediary notes that the documented collection efforts were years after the dates of service and that there were gaps in the collection effort. Thus, the documentation does not support a prompt and continuous collection effort. In the statements sent to patients with charges and balances, patients were not advised of the deductible and coinsurance amounts or the patients' responsibility to pay these amounts. There is also no record of any telephone calls to patients. Based on this record, the Intermediary asserts that the Provider's collection efforts were not genuine but merely token efforts.

The Intermediary also refers to The Arlington Hospital v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Virginia, CMS Administrator, July 8, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,724 at 55,885,[23] which stated that "[t]he provider's collection effort should be documented in the patient's file by copies of bill(s), **follow up letters, reports of telephone and personal contacts**, etc." (emphasis added). The Intermediary alleges that the Provider did not follow these procedures in this case.

The Intermediary contends that the Provider failed to meet its documentation requirements set forth at 42 C.F.R. § 413.24. Several facts support this contention:

1. The Provider did not submit a bad debt list with its 1997 cost report.
2. The list eventually supplied did not tie to the claimed bad debts.

[23] Intermediary Exhibit I-15.

3. The date of the patient's first bill as listed on the bad debt list was the date of the first bill sent to the intermediary for payment, rather than the date the patient was notified of a liability for the payment of deductible and coinsurance amounts.
4. The documented collection efforts were not in compliance with the Provider's written collection procedures.[24]
5. The Provider failed to offset bad debt recoveries against the claimed bad debt amounts as required by CMS Pub. 15-1 § 316.[25]

The Intermediary concludes that the Provider did have the documentation necessary to allow the bad debts.[26]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and Program instructions, the parties' contentions and the evidence presented, finds and concludes that the Intermediary properly disallowed the Provider's bad debts.

The Board notes that bad debts associated with deductible and coinsurance amounts may be claimed by providers if they meet the requirements of the regulation at 42 C.F.R. § 413.80(e). To be allowable, a bad debt must meet the following criteria:

> (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.

42 C.F.R. § 413.80(e).

The Board notes that the basis of the Intermediary's disallowance is that the Provider did not meet the second criteria, i.e., that the Provider failed to establish that it made a reasonable collection effort. For the reasons indicated below, the Board agrees with the Intermediary's determination.

The requirements of a reasonable collection effort are explained in CMS Pub. 15-1 § 310. See Intermediary's Contentions, supra. The manual requires that a provider's collection effort for Medicare bad debts be similar to that for non-Medicare patients, that the activities include issuance of a bill on or shortly after discharge or death of the

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[24] Intermediary Exhibit I-16.
[25] Intermediary Exhibit I-17.
[26] See Intermediary Exhibits I-19-I-35.

beneficiary, and that it should include other actions such as subsequent billing, collection letters and telephone calls or personal contacts. CMS Pub. 15-1 § 310.A. The guidelines further provide that "[t]he provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc." CMS Pub. 15-1 § 310.B.

The record contains a copy of the Provider's policies and procedures with respect to collection of bad debts.[27] The Provider's policy indicates that a collection notebook will be maintained on each past due amount in which all actions - written, verbal or "no answer," must be documented, dated and signed in the collection progress record.[28] The policy provides that a telephone call will be made within 6 days after the due date of the bill.[29] Then it provides that a form letter will be sent if payment is not received by the next billing date.[30] If payment is not received within an additional two weeks, the administrator is informed and is to call the responsible party.[31] The next step is for a final letter to be sent threatening legal intervention and, finally, discharge proceedings or legal action for collection will be initiated.[32] Although the policy indicates that it pertains to private pay patients, the Provider indicated that it engaged in a similar effort for its Medicare patients, albeit with somewhat longer time lines for undertaking follow-up.[33] The Intermediary did not identify any specific problems with the bad debt policy; rather, its concerns related to the failure of the Provider to document that it followed its policies.[34]

The Board notes that on August 26 and 27, 2002, the Intermediary conducted an onsite audit of the bad debts claimed, sampling the patient files maintained by the Provider. The Intermediary indicated that it copied all available data maintained by the Provider, analyzed it and placed it in the record.[35] A summary of the Intermediary's findings was presented in a letter to the Provider on September 13, 2002.[36] The Intermediary's letter listed a number of problems with the documentation: no audit trail of timely collection activity; no first bill notifying the patient that Medicare coinsurance was their responsibility; only fill-in-the-blank collection letters issued 6 to 18 months after the date of patient service; form letters to collect bad debts after they had been written off in the FYE 1997 cost report; and monthly billing of all unpaid balances in a single bill.[37]

The Board has reviewed the documentation in the record and found that the Provider did identify coinsurance on a monthly bill to its patients; however, subsequent bills only recorded a previously unpaid balance without further breakdown. The Board also found

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[27] Intermediary Exhibit I-16.
[28] Id. at No. 1.
[29] Id. at No. 3.
[30] Id. at No. 4.
[31] Id. at No. 5.
[32] Id. at Nos. 6 and 7.
[33] Tr. at 76-83.
[34] Tr. at 288-289.
[35] See Intermediary Exhibits I-19-35.
[36] Intermediary Exhibit I-14.
[37] Id.

that most of the files contained a form letter that requested payment for coinsurance but that this form letter was sent long after the date of service. The Board views this minimal notification to Medicare beneficiaries as unlikely to clearly and consistently inform them of the nature of their bill and their responsibility to pay it. And finally, the Board found that the Provider did conduct what it referred to as a final "sweep" for bad debts by sending out three form letters in November 1997, January 1998 and March 1998, but that this was long after the date of service. The Board acknowledges this final sweep generated a substantial portion of bad debt recovery; however, the Board believes that the Provider's success at bad debt recovery would have been even greater had it been more contemporaneous with the services. Based on the record, the Board finds that the Provider did not carry out its debt collection policies or other activities that would constitute a genuine collection effort.

The Board notes that the Provider asserted at the hearing that it had additional documentation of contemporaneous debt collection activity, such as telephone contacts, that was available to the Intermediary at the time of the audit.[38] The Board, however, only found one instance in the record of a telephone log indicating that contact had been made to collect an account and that this account pertained to one of the Provider's private patients.[39] Considering the importance of such documentation to this case, the Board is unpersuaded by the mere assertion that such documentation exists.

The Board also observes that it was unclear whether the Provider could tie the bad debts to the remittance advices (RAs) or the RAs to any amounts that were recovered. Furthermore, it is unclear if partial payment for bills was credited to coinsurance or to other outstanding bills which were commingled in the billing. The Board notes, however, that the Intermediary did not base its disallowance on these concerns.

Finally, the Board notes that the Provider indicated that it should be allowed to claim bad debts for its patients that its records show were eligible for Medicaid. However, the Board finds that the Provider has not met the requirements of CMS Pub. 15-1 § 312 concerning documentation of indigence. The Board notes that the Provider admitted that it did not have the requisite information to determine whether its Medicare patients were eligible for Medicaid at the time they incurred the debts for coinsurance.[40]

In summary , the Board finds that the Provider did not submit adequate documentation to support its claim that it engaged in a reasonable collection effort.

DECISION AND ORDER:

The Intermediary's adjustment disallowing the Provider's bad debts was proper. The Intermediary's adjustment is affirmed.

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[38] See Tr. at 79-80 and 111.
[39] See Provider Exhibit IV at 1.
[40] Tr. at 181-182.

Board Members Participating:

Suzanne Cochran, Esquire
Dr. Gary Blodgett
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA

DATE: September 30, 2003

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman