PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2006-D58

PROVIDER -
Wilmington Treatment Center
Wilmington, North Carolina

Provider No.: 34-0168

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Cahaba Safeguard Administrators, LLC

DATE OF HEARING -
November 15, 2005

Cost Reporting Period Ended -
September 30, 1999

CASE NO.: 03-0895

INDEX

ISSUE:

Whether the Intermediary's disallowance of Medicare bad debts claimed by the Provider was justified.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program provides health insurance to aged and disabled persons. 42 U.S.C. §§1395-1395cc. The Secretary of the Department of Health and Human Services (Secretary) is authorized to promulgate regulations prescribing the health care services covered by the program and the methods of determining payments for those services. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with the program's administration. CMS has entered into contracts with insurance companies known as fiscal intermediaries to maintain the program's payment and audit functions. Intermediaries determine payment amounts due providers of health care services (e.g., hospitals, skilled nursing facilities, and home health agencies) under Medicare law and interpretative guidelines issued by CMS.

At the close of its fiscal year, each provider submits a cost report to its intermediary showing the costs it incurred during the period and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and notifies the Provider in a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's determination may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Under the Medicare statute, a provider is entitled to claim as a reimbursable cost "bad debts" attributable to amounts unpaid by beneficiaries for Medicare deductibles and coinsurance amounts for the Medicare patients it services. 42 C.F.R. §413.80. This appeal involves the Intermediary's denial of the Provider's bad debt claim.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Wilmington Treatment Center (Provider) is a 27-bed rehabilitation hospital located in Wilmington, North Carolina, that specializes in treating patients with alcoholism and substance abuse conditions. The Provider claimed $91,535 in Part A and $21,826 in Part B Medicare bad debts on its fiscal year ended September 30, 1999 cost report. Cahaba Safeguard Administrators (Intermediary) performed a limited desk review of the Provider's 9/30/99 cost report and asked the Provider to submit documentation to support a sample of bad debt accounts chosen by the Intermediary as well as the write-off dates

for all inpatient and outpatient bad debts reported on its Medicare bad debt log[1]. When this information was not received prior to the final settlement of the cost report, all of the bad debts claimed by the Provider were disallowed. The adjustment resulted in a reduction of Medicare reimbursement of approximately $68,017.

In October 2002, approximately two weeks after the NPR was issued, the Provider submitted the requested documentation. It also submitted a revised bad debt log totaling $110,462, $2,899 less than the original bad debts claimed. The revised bad debt log included the requested write-off dates and consisted of three separate listings for inpatient, day treatment and outpatient services. The Intermediary's original sample only included Medicare Part B claims from the day treatment and outpatient listings. Inpatient Medicare Part A bad debts were not sampled; however, the Intermediary did review the write-off dates to ensure accounts were not written off prior to 120 days from the date the first bill was mailed to the beneficiary.

Upon review of the new documentation, the Intermediary found that 8 of the 29 accounts in the sample were written off in the prior year, FYE 1998, and therefore were improperly included in the FYE 1999 accounts.[2] The Intermediary also applied a Medicare guideline in PRM 15-1 §310.2. It allows a provider to "deem" a debt uncollectible if, after reasonable and customary attempts to collect a bill, the debt remains unpaid after 120 days from the date "the first bill is mailed to the beneficiary." The Intermediary found that:

1. 21 of 29 accounts were written off prior to 120 days between the date of the first bill and the write off date,
2. the date of the first bill shown on the log submitted did not correspond to the date of an actual billing statement, and
3. 26 of 29 accounts had a first bill date prior to patients' admittance date.

The Intermediary notified the Provider in May 2003 that because the error rate exceeded 20%, all the bad debts claimed were disallowed and, if the Provider requested any further review, it would have to furnish documentation to support all the bad debts, not just those in the sample.

The Provider did not respond until September 2005 when it submitted additional documentation in support of only the sample of accounts, not 100% of the accounts as the Intermediary had indicated it would require. The Intermediary nevertheless reviewed the documentation, noting that several of the patients in the sample had been determined by the Provider to be indigent. The Intermediary found the documentation of indigence to be insufficient and so continued to disallow the bad debt claim.

The Provider appealed the original audit adjustment to the Board and met the jurisdictional requirements of 42 C.F.R §§405.1835-405.1841. The Provider was represented by Robert E. Wanerman, Esquire, of Epstein, Becker & Green, P.C. The

[1] Intermediary's position paper, exhibit I-21.
[2] Tr. pg. 91

Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider asserts that the claimed bad debts were appropriately reported in accordance with the existing Medicare regulations and manual provisions, and that the Intermediary's adjustment should be reversed based on those authorities. The Provider further claims that the explanation offered by the Intermediary for the appealed adjustment would unfairly penalize the Provider by imposing obligations on it that are not mandated under any Medicare regulations or manual provision and are more restrictive than those authorities.

The Intermediary asserts that its original disallowance of the bad debts claimed on the cost report was due to the lack of response to its initial documentation request for the write-off date for each bad debt account included on the log.

With regard to the revised bad debt log and additional documentation, the Intermediary contends that the error rate in the sampled accounts was so high that all bad debts had to be disallowed. Its justification for disallowing a majority of the accounts selected for testing (21 of 29) was that the debts were written off prematurely. PRM 15-1 §310.2 permits a provider to "deem" a debt uncollectible if, after reasonable and customary attempts to collect a bill, the debt remains unpaid after 120 days from the date "the first bill is mailed to the beneficiary." The Provider's log indicated a first bill date at least 120 days prior to the write-off which also corresponded to the date in the patient's account file "follow up notes." The Intermediary denied the claims, however, based on what it believed was contradictory evidence: there was no written billing statement sent on that date, a fact that the Provider does not dispute, and in several instances the first bill dates preceded the patients' admission to the facility.

The Provider explained that the facility had written procedures for handling patient bad debts for all payor tyes. These procedures required that when a patient was admitted to the facility, within 48 hours he or she would meet with a financial counselor who would interview the patient, focusing on the patient's income, resources, bills, expenses, and other factors that are indicators of the patient's disposable income and ability to pay. In some cases, the interview would involve the patient and a family member or other individual, but due to privacy laws, communication with others was possible only if the patient gave consent to do so. The information collected during the interviews was documented on a Financial Information Sheet.

The Provider asserts that although the patient interview covers several key indicators of a patient's ability to pay, it also reflects an understanding that the Provider's patient population consists of individuals with serious psychiatric problems, and that some of them may not have knowledge about their finances. The Provider notes that in select cases, credit reports are obtained for patients even though this is not a requirement under Medicare regulations or even of its own procedures. At the close of interview process,

the Provider makes an attempt to obtain a deposit from the patient or to set up a payment plan with the patient. The Provider claims that after the patient is discharged, if payment has not been received, the Provider sends a series of three letters at preset intervals requesting payment. If payment is still not received, the account is referred to collection. At that point, if it is established that the patient is indigent, further collection effort may then be waived.

The Provider notes that in some cases patients that lacked the ability to make any out-of-pocket payments were treated, and that its determination of "no ability to pay" was sometimes based on information collected during the admission interview coupled with the staff's experience with their patient population.[3] If these patients did not have insurance or any ability to pay, the cost of their care was administratively written off prior to the onset of treatment pursuant to the Executive Director's approval, and no collection effort was made.

The Provider discussed the first bill date it listed on the bad debt log at length during the hearing and claimed that the Intermediary's denial of bad debts with a first bill date prior to the admit date was due to a lack of understanding. The Provider explained that in most instances, patients are transferred to the partial hospitalization program, or day treatment program, directly from the inpatient setting of the Provider. Therefore, the bad debt log reflects a first bill date that precedes the date that the patient was admitted to the day treatment program or to the outpatient setting. However, the Provider claims that since the patient's ability to pay remains unchanged when he or she transfers from the inpatient setting, it is appropriate to use the date of the initial interview with the patient prior to entering the inpatient setting as the date of first bill. The Intermediary asserts that this practice is improper because it was impossible for the Provider to know the amount owed by the patient prior to admittance; therefore, there was no true amount due to bill the patient. The Provider responds that upon admission of a patient for treatment, the facility does have an estimate of the coinsurance/deductibles that a patient will incur; therefore, the discussion of the amount due with the patient and attempts to obtain a deposit or make a payment plan does constitute the "first bill" to a patient. The Provider therefore asserts that the Intermediary's disallowance of bad debts due to the first bill being before the transfer date to partial hospitalization lacks merit and should not be considered.

With regard to the Provider's making determinations of indigence prior to the patient obtaining treatment, the Intermediary complains that the Provider's policies do not require a follow-up with the patient after the initial interview to determine if the patient's ability to pay has changed or if more accurate information is available once treatment is rendered. In addition, the Intermediary asserts that adequate documentation is not obtained from the patient during this interview process to document that a patient is truly indigent, since the Provider does not require that the patient provide proof of the expenses and income that are reported on the Financial Information Sheet. In addition, the Intermediary states that the Provider's own collection policies require that the Executive Director of the facility approve all determinations of indigence made by patient financial counselors during the in-take of a patient. The Intermediary notes, however,

[3] See Transcript, Page 17 and Provider Exhibit P-9

that each Patient Financial Information Sheet included in the record as support for the patient's indigence status does not have the Executive Director's signature of approval on the designated line, nor does it appear elsewhere in the documentation furnished.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes as follows:

42 C.F.R. §413.80(e) identifies the following criteria that must be met in order for a bad debt to be allowable:

> (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 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 Intermediary relied heavily on what it found to be a failure to meet the deeming provision; that is, the Provider failed to wait 120 days after the first billing before writing off the bad debt. The Board concludes that the Intermediary used the wrong standard by applying only the 120-day deeming provision. If the debts do not meet the deeming criteria, all the provider's collection efforts must nevertheless, be tested under the criteria set forth in 42 C.F.R. §413.80.

Although the Provider did not argue the impropriety of the sample, the sampling method used to review the bad debts does not appear to produce a statistically valid sample, in that it is not representative of each type of claim.

If a patient is indigent, a debt may be deemed uncollectible without applying collection procedures otherwise required. PRM 15-1 §312.[4] The Provider determined that a majority of the patients on its bad debt log were indigent. Several financial information forms used to document indigence for patients in the bad debt sample were included in the record, and the forms were discussed at length during the hearing. Ms. Virginia

[4] Intermediary Exhibit 20. "[T]he provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is . . . indigent . . ." Once indigence is determined and the provider concludes that the financial condition is not likely to improve, "the debt may be deemed uncollectible without applying the §310 procedures."

Powell, the Director of Finance for the Provider, testified that the Provider's bad debt policy required that an effort to be made to obtain the financial information required on the form as well as the Executive Director's signature of approval if an up-front administrative adjustment was to be done.[5] Upon review of the record, it was noted that none of the forms had been signed by the Executive Director to indicate that his approval had been obtained. When asked about the absence of the approval signature, Ms. Powell stated that the Executive Director's approval may have been somewhere else in the chart or that the approval may have been verbal. She agreed that none of the forms she reviewed in the record was signed by the Executive Director.[6]

The Provider argues that its bad debt policy does not explicitly require the Executive Director's signature on the form approving an up-front write-off of a patient's account when its intake counselor determined that the patient is indigent. The Board finds, however, that the Provider's policy, coupled with the signature line on the Financial Information Sheet for the Executive Director's approval,[7] anticipates that his signature must be on the form as proof that he reviewed the file and approved the write-off. The financial information forms submitted into evidence do not have the appropriate signature approving the up-front administrative write-offs due to a finding of patient indigence, and the Provider presented no other documentary evidence showing that the Executive Director approved any of these write-offs. Accordingly, the Board finds that the Provider did not follow its own bad debt write-off policy for indigent patients and, therefore, cannot now rely on that determination. [8]

With regard to the bad debts that were written off in a prior year but claimed on the current year cost report, the Board concludes that these bad debts are not allowable in 1999.

The Board concludes that all nine of the bad debts claimed for non-indigent patients as listed in Provider's Exhibit P-9 as "poor," "fair," or "good ability to pay" (ATP) and those listed as "ATP unknown" must be reviewed by the Intermediary to determine whether the Provider's collection effort was adequate in accordance with 42 C.F.R. §413.80(e).

DECISION AND ORDER:

The Intermediary's adjustment is modified. The disallowance of bad debts relating to indigent patients whose accounts were written off up front without approval of the Executive Director was proper. Likewise, the disallowance of the bad debts claimed for

[5] See transcript, pages 46-47.
[6] See transcript, pages54-55.
[7] See Intermediary's condensed final position paper, new Exhibit I-2, pg. 64.
[8] The transcript at pages 80 and 81 indicates that the patient account information included in the record at Exhibit I-2 was extracted by the Provider from the patient's files and supplied to the Intermediary. The Intermediary then may have only included a portion of those documents in their exhibits. Therefore, the documentation at I-2 does not necessarily reflect all of a patients file However, as the documents at I-2 were all that was submitted in the record for review by the Board and the Provider did not supply copies in support of their position, the Board's determination was based upon the information available to them.

accounts written off in FY 1998 but included in the FY 1999 cost report was proper. The Board hereby remands the bad debts related to non-indigent patients to the Intermediary for a determination of the adequacy of the Provider's collection effort.

BOARD MEMBERS PARTICIPATING

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: September 28, 2006

Suzanne Cochran
Chairperson