PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2007-D18

PROVIDER -
Mesquite Community Hospital
Mesquite, Texas

Provider No.: 45-0688

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Highmark Medicare Services

DATE OF HEARING -
July 12, 2006

Cost Reporting Period Ended -
May 31, 2000

CASE NO.: 02-2080

INDEX

ISSUE:

Whether the Intermediary's determination of allowable Medicare bad debts based upon collection effort was proper.

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 was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. 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 administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

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

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Under the Medicare statute, regulations, and policy, a provider is entitled to claim as a reimbursable cost "bad debts" attributable to amounts unpaid by beneficiaries for deductible and coinsurance amounts arising from services furnished to Medicare patients. This appeal involves the Intermediary's denial of the Provider's bad debt claim.

Mesquite Community Hospital (Provider) is located in Mesquite, Texas and is an acute care hospital with a psychiatric subprovider distinct part unit and a hospital-based skilled nursing facility. The dispute in this case involves whether the Intermediary properly disallowed all bad debts claimed for Medicare accounts that were written off after 120 days from the date of the first bill, but remained in the possession of a collection agency.[1]

[1] Specifically, this case involves two legal sub-issues. The first sub-issue is whether the bad debts at issue are allowable pursuant to the substantive authority addressing bad debts ((42 C.F.R.§413.80(e)) and the implementing Provider Reimbursement Manual

For the fiscal year at issue, the Provider's collection policy for all bad debt accounts, including Medicare patients, was to pursue in-house collection efforts for a period of ninety (90) days and then, if the account remained uncollected, to forward the account to an outside collection agency for further collection efforts. After one hundred and twenty (120) days from the date of the first bill had elapsed the Provider would then write off any remaining balance on the account to bad debts. This procedure was followed regardless of whether the account remained in the collection agency's possession. Accounts older then 120 days were considered by the Provider to have met the criterion that there was no likelihood of recovery at any time in the future. (42 C.F.R. §413.80(e))

Initially, the Intermediary disallowed all of the Provider's bad debts claimed on the cost report on the basis that the Provider failed to submit adequate documentation to support its claim. Subsequent to the disallowance, the Provider submitted additional supporting documentation to the Intermediary for review and testing. However, the Intermediary noted significant issues with the documentation provided, such as discrepancies in write-off dates, that rendered it unacceptable, so the disallowance remained unchanged.

The Provider filed a timely appeal to the Board pursuant to 42 C.F.R. §§405.1835-1841 and met the jurisdictional requirements of those regulations. The Provider was represented by Kristin L. DeGroat, Esq., of Campbell Wilson. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of Blue Cross Blue Shield Association.[2]

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary improperly disallowed all of its bad debts. In accordance with P.R.M. §§308 and 310.2, the bad debts were properly written off as worthless and uncollectible after a 120-day collection effort. According to sound business judgment applied by hospital management, such accounts were considered to have met the criterion that there was no likelihood of recovery at any time in the future. The Provider distinguishes this case from the factual circumstances present in Battle Creek Health System,[3] upon which the Intermediary relies. The Provider points to the following two facts as support for its position that sound business judgment dictated that after 120 days the accounts still listed with the collection agency were deemed worthless:

(P.R.M.) provisions at Chapter 3). The second sub-issue is whether the bad debts are allowable pursuant to the "Omnibus Budget Reconciliation Act (OBRA) Moratorium" (OBRA of 1987, Section 4008(c) of Pub.L. No. 100-203, amended by §8402 of the Technical and Miscellaneous Revenue Act of 1988, Pub.L. No. 100-647, and §6023 of OBRA '89, Pub. L. No. 101-239).

[2] Subsequent to the filing of all exhibits and submission, Highmark Medicare Services became the Provider's assigned Imtermediary.

[3] Battle Creek Health System/Mercy General Health Partners v. Blue Cross Blue Shield Assn., United Government Services, LLC, PRRB Case No. 2004 D-40 (September 16, 2004) rev'd CMS Admr. (November 12, 2004) aff'd, 423 F.Supp. 2d 755 (W.D. MI, March 30, 2006).

1) The Provider was realizing an approximate collection rate of 5% on Medicare accounts and approximately 8% on all accounts in total (Exhibit P-9) so sound business judgment indicated that its accounts were most likely uncollectible and, therefore worthless at that point. If any future collections were received from the patient, they would be treated as a recovery of bad debt in the year of collection. Thus, the Provider would not be receiving the benefit of the bad debt twice (payment made by Medicare and then by the patient), and Medicare would not be cross-subsidizing non-Medicare patients.

2) Based in part on this low collection rate, the Provider, terminated its contract with the outside collection agency during FY 2001 and brought all collection efforts in-house (Exhibit P-10).[4]

The Provider contends that no authority prohibits writing off an account which remains in the collection agency's possession. Also, P.R.M. §316 recognizes that there are instances in which collections may be made on accounts previously deemed uncollectible.

Notwithstanding its position that it is entitled to reimbursement pursuant to the substantive Medicare regulations and policy applicable to bad debts, the Provider believes that it is also entitled to reimbursement for the bad debts based upon the OBRA '87 and '89 Moratorium provisions. The Provider explains that neither it nor the Intermediary[5] has been able to locate the relevant pre-August 1987 audit workpapers which would indicate whether the previously assigned Intermediary disallowed bad debts written off after 120 days even though the accounts were still maintained by an outside collection agency. The Provider does note, however, that for fiscal years ending 1995 through 1999 the Intermediary made no bad debt disallowances on the basis that the accounts remained in the collection agency's possession.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider failed to comply with 42 C.F.R. §413.80(e) because it was still pursuing collection efforts through an external collection agency. The Intermediary claims that the Provider failed to obtain reports from the collection agency to determine which accounts were uncollectible or to ascertain on which accounts the collection agency was making collections. Likewise, the rate of return that the Provider cites to support that it used sound business judgment when deciding that the bad debts were worthless is misleading, as the Provider did not differentiate accounts by age. Also, the Intermediary asserts that a lack of effort by the collection agency may have

[4] The Provider also claims that the CMS Memorandum to Regional Administrators dated June 11, 1990 (Provider Ex. 11), and P.R.M. Part II, Chapter 11 (Transmittal 5, September 12, 2003) (Provider Exhibit 12) further support its position.

[5] Prior to September 1997, the Provider's Intermediary was Aetna Insurance Company. As of October 1, 1997, Care First of Maryland became the replacement Intermediary and settled the cost reports for fiscal years 1995 through 2001. After fiscal year 2001, Mutual of Omaha became the Provider's Intermediary.

contributed to the low rate of return.

Additionally, the Intermediary argues that the Provider has not established that it qualifies for relief under the OBRA 87 Moratorium provisions. It asserts that the Provider has not submitted any documentation or evidence to support its assertion that prior to August 1, 1987, it claimed reimbursement from Medicare for bad debts that were still being pursued by a collection agency and that CMS/FI accepted this policy. Furthermore, the fact that the Intermediary allowed the Provider to claim reimbursement for accounts in the collection agency's possession for fiscal years ending 1995 through 1999 does not bind the Intermediary to continue to allow a provider to be reimbursed contrary to the regulations.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions and the evidence submitted, the Board finds that the Provider is entitled to reimbursement for the bad debts at issue.

The Intermediary's position is based on the fact that no tangible evidence exists that the collection agency ceased its collection activities and returned the accounts to the Provider. The Board notes that the Intermediary never questioned that the bad debts claimed by the Provider are related to covered services, that the debts were attributable to deductibles and co-insurance amounts, or whether reasonable collection efforts were made.

The regulations at 42 C.F.R. §413.80(a)[6] provide that bad debts attributable to Medicare deductible and coinsurance amounts are reimbursed under the Medicare program. Bad debts are defined at 42 C.F.R. §413.80(b)(1) as:

> [A]mounts 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 regulation at 42 C.F.R. §413.80(d) states that payment for deductibles and coinsurance amounts is the responsibility of the beneficiaries. However, since the reasonable cost principle at 42 U.S.C. §1395(x)(v)(1)(A) prohibits cross-subsidization, the Medicare program recognizes that the inability of providers to collect deductibles and coinsurance amounts from Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not Medicare beneficiaries. Therefore, to prevent such cross-subsidization, Medicare reimburses providers for allowable bad debts.

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[6] The bad debt regulations have been redesignated at 42 C.F.R. §413.89 (69 FR 49254, Aug. 11, 2004).

Providers may receive reimbursement for Medicare bad debts if they meet all of the criteria set forth in 42 C.F.R. §413.80(e).[7] The criteria require that:

> (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 P.R.M. at §310.A further explains:

> A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. . . .

Section 310.2 of the P.R.M. further provides:

> 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 beneficiary, the debt may be deemed uncollectible.

Section 316 of the P.R.M. continues:

> Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period. Treatment of such recoveries under the program is designed to achieve the same effect upon reimbursement as in the case where the amount was uncollectible.
>
> Where the provider was reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period.

The Board has consistently held that where a provider satisfies all four criteria of 42 C.F.R. §413.80(e), any presumptions regarding collectibilty or uncollectibility are

[7] P.R.M. §308 contains identical language.

necessarily moot, and the bad debt must be reimbursed.[8] The Board finds that the term "uncollectible," within the meaning of the regulation, means that no payments have been received or are expected to be made on an account based upon the provider's experience and sound business judgment. Additionally, the Board finds no explicit legal requirement that collection efforts must cease before accounts can be deemed uncollectible.

The Board finds that the Provider's practice of performing in-house collection activities for a period of 90 days and then forwarding the accounts to a collection agency for an additional period, and subsequently writing off the account balance to bad debts meets the requirements of both the controlling Medicare regulations and the P.R.M. The Provider has demonstrated that it used sound business judgment to establish that there was no likelihood of recovery at any time in the future before deeming a debt to be worthless.

The Board is unable to reconcile the Intermediary's position with P.R.M. §310.A and §310.2 which, respectively, permit the utilization of a collection agency and presume that a debt that is unpaid for over 120 days may be deemed worthless. The mere "active" status of an account with an outside collection agency does not automatically constitute proof of value or collectibility.

A conclusive presumption of collectibility arising from an account's "open" or "active" status at a collection agency contradicts both the reality of the collection trade and the regulations that the Board is entrusted to enforce. Providers may not control the decision-making process of their outside collection agencies. Thus, an account that is actually worthless and uncollectible could languish as an "open" or "active" account with an outside collection agency indefinitely. Equally important, the position urged by the Intermediary would encourage, if not mandate, that the Provider promptly request the return of accounts assigned to an outside collection agency, despite the fact that utilizing a collection agency does not typically result in costs for the Provider. Furthermore, CMS is not disadvantaged by this procedure, because if the Provider recovers funds from previously written off bad debts, such recovery will reduce allowable bad debts in the period of recovery.

The Board concludes that providers may continue to pursue collection activities with respect to debts that have been deemed uncollectible for Medicare reimbursement purposes. To hold otherwise would violate Medicare's prohibition on cross-subsidization by requiring a non-beneficiary (here, the Provider) to bear the cost of Medicare covered services.[9] Accordingly, the Board finds that the Provider is entitled to reimbursement for the bad debts at issue.

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[8] See Dameron Hospital, PRRB Dec. No. 2006 D-16, (February 17, 2006).; Sutter Merced Medical Center PRRB Dec. No. 2006 D-56 (September 27, 2006). The Board also notes that while its rationale and analysis is congruent with these cases, Mesquite Community Hospital, as opposed to the providers in the referenced cases, sent its accounts to the collection agency prior to considering them uncollectible.

[9] 42 U.S.C. 1395x(v)(1)(a); 42 C.F.R. §413.80.

With regard to the Provider's position that it is entitled to recovery based on the OBRA Moratorium, the Board concludes that the Provider would not qualify.

Amending the moratorium it had imposed two years earlier on regulatory changes to the bad debt collection rules, Congress provided in §6023 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239 (Dec. 19, 1989):

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

The Board notes that the evidence in the record is inconclusive as to what the Intermediary accepted before August 1, 1987. The workpapers within the record do not affirmatively establish the Provider's collection efforts during the relevant timeframe. Likewise, the Provider's collection policies do not provide a detailed explanation of the collection agency's handling of bad debts, and they do not describe the Provider's interactions with the agency or clarify when debts in the possession of a collection agency may be written off. Therefore, the bad debts in issue would not qualify for reimbursement under the Moratorium provisions.

DECISION AND ORDER:

The Provider properly claimed Medicare bad debts even though the accounts were still with the collection agency. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

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

DATE: February 16, 2007

FOR THE BOARD:

Suzanne Cochran

Chairperson