PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D30

PROVIDER –
Forest Hospital
Des Plaines, Illinois

Provider No.: 14-4036

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services - Illinois

DATE OF HEARING –
June 14, 2007

Cost Reporting Periods Ended -
October 31, 1998 and
October 31, 1999

CASE NOs.: 02-0050 and 02-0615

INDEX

ISSUES:

1. Whether the Intermediary properly adjusted Medicare bad debts.

2. Whether the Intermediary properly adjusted the Provider's treatment of asset re-lifing.

3. Whether the Intermediary properly adjusted public relations and marketing expenses.

4. Whether the Intermediary properly adjusted officers' life insurance and wind down expenses. (Fiscal year ended (FYE) 10/31/99 only)

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 portion 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:

Forest Hospital (Provider) was a for-profit corporation organized under the laws of the state of Illinois that sold its operations on October 1, 1999. The facility had 180 beds and was located in Des Plaines, Illinois during the cost reporting periods under appeal. The Provider's cost report for 1998 claimed reimbursement for asset relifing, public relations/marketing expenses and bad debt expenses. The Provider's 1999 cost report included amounts for these same cost categories and also requested reimbursement for

officers' life insurance expenses and wind down expenses. National Government Services - Illinois (Intermediary) reviewed the Provider's cost reports and issued a Notice of Program Reimbursement for 1998 on June 14, 2001 and for 1999 on September 24, 2001 that offset the amounts claimed for the cost categories enumerated above.

The Provider appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider was represented by Chris E. Rossman, Esq., of Foley & Lardner, LLP. The Intermediary was represented by James R. Grimes, Esq., of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

Issue 1: Medicare Bad Debts (1998 and 1999)

Facts: The Provider claimed reimbursement for deductible and co-insurance amounts that were uncollectible from Medicare beneficiaries in 1998 and 1999. The Intermediary chose a sample of the bad debts during its audit and subsequently disallowed a portion of the amounts claimed because the Provider failed to adequately document its collection efforts. The parties submitted the issue for mediation, held discussions and exchanged information that all failed to produce any adjustment to the Intermediary's disallowance. The Provider requested that the Board move forward and schedule a hearing to address the issue. On December 28, 2006, the Board scheduled the issue for hearing on June 14, 2007. In the interim, the Board maintained its routine case tracking efforts and contacted the Provider several times to determine the status of the case. The Board was advised that information was being exchanged and that efforts toward resolution were under way. On June 6, 2007 the Provider's representative advised the Board that he had just received a substantial amount of data from the hospital which was critical to support the Provider's bad debt claim and, because the data was so voluminous, a postponement of the hearing was necessary to allow the Intermediary time for its review. On June 8, 2007 the Board conducted a pre-hearing conference to discuss the material and the need for a postponement. At the conference, the Board questioned the propriety of admitting data which, despite being fundamental to the Provider's claim, had just been made available to the Intermediary, and the Chairman of the Board made a preliminary ruling refusing to admit the additional data into evidence. The Board offered the Provider the opportunity to appear as scheduled on June 14th to show cause why the information should be admitted into the proceedings and argue the merits of the bad debt issue. The Board indicated that it would determine the admissibility of the information prior to considering the issue on its merits.

Background: The Medicare program reimburses providers for unrecovered costs attributable to bad debts resulting from deductible and coinsurance amounts which are uncollectible from Medicare beneficiaries. 42 CFR §413.80(e) established the criteria that must be met for bad debts to be reimbursable under the Medicare program:

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.

CMS Pub 15-1, §310 defines a reasonable collection effort as follows:

> 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….

§310 at Paragraph B further requires that:

> The provider's collection efforts should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

Medicare regulations also require that specific record keeping standards be met to secure reimbursement under the program. 42 C.F.R. §413.24 (c) states in relevant part:

> Adequate cost information must be obtained from the provider's records to support payments made for services rendered to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization. . . .

42 C.F.R. §413.20(d)(1) states in pertinent part:

> The provider must furnish such information to the intermediary as may be necessary (i) to assure proper payment by the program . . . (ii) to receive program payments, and (iii) to satisfy program overpayment determinations.

In addition, Part II of the Board's instructions sets the discovery and disclosure standards that must be met for participation before the Board. At its Section B.IV b, Part II requires that position papers ". . . contain all documentary evidence and corroboration for the positions taken . . ."

Provider's Contentions: The Provider contends that it ceased all operations in 1999 and, consequently, the supplemental information supporting the bad debt claim was not readily available. The Provider argues that access to records was limited and that, upon discovery of the information, a prompt dissemination was made to the Intermediary. The Provider acknowledges that due to the late dissemination, the Intermediary did not have adequate time to review the data in advance of the hearing. However, the Provider argues that its dissemination was made promptly upon its discovery and that the regulations and the Board's instructions encourage the full exchange of information germane to the dispute. Accordingly, the additional bad debt information should be allowed into evidence and, once admitted, will demonstrate the Provider's compliance with 42 C.F.R. §413.80(e) and support the bad debts claimed.

Intermediary's Contentions: The Intermediary contends that it made frequent requests for bad debt information dating back as far as 2003. The Intermediary's requests included requests for proof of collection efforts, documentation of financial hardship and the accounting records that would establish the timing of the billings and write-offs. Although the requests were ongoing and repetitive, the Intermediary contends that it received no information from the date of the NPR until the Provider supplied the data on June 8, 2007. While the Intermediary states that it reviewed the data prior to the hearing, it could not determine if it was responsive to any of its earlier requests or if it supported the costs that were claimed by the Provider.

Issue 2: Asset Re-lifing (1998 and 1999)

Facts: The Provider sold its facility effective October 1, 1999. For fiscal years 1998 and 1999, the Provider attempted to recover additional depreciation and submitted a positive A-8 adjustment on its cost report to incorporate a "re-lifing" of its assets. The Provider's adjustments were based upon calculations that took all fully depreciated assets and re-assigned the same original life to them over again. The Provider limited its re-lifing exercise to fully depreciated assets and used the original cost of the asset to calculate depreciation. For assets that were not fully depreciated, the Provider claimed depreciation using the accelerated depreciation method used by the Provider for tax purposes.

Background: 42 C.F.R. § 413.134 establishes the guidelines under which depreciation may be properly allowed under the Medicare program. The section addresses historical costs, useful life and methods of depreciation. 42 C.F.R. §413.134 (b)(7)(iii) entitled *"Changing useful life"* states:

> A change in the estimated useful life may be made if clear and convincing evidence justifies a redetermination of the useful life used by the provider. Such a change must be approved by the intermediary in writing, and the factors cited in paragraphs (b)(7) and (b)(7)(i) of this section are applicable in making such redeterminations of useful life. If the request is approved, the change is effective with the reporting period immediately following the period in which the provider's request is

submitted for approval.

42 C.F.R. §413.134(b)(7)(i) further states:

> In selecting a proper useful life for computing depreciation under the Medicare program, providers must use the useful life guidelines published by HCFA. If HCFA has not published applicable useful life guidelines, providers must use –
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> (A) The edition of the American Hospital Association useful life guidelines, as specified in HCFA Medicare program manuals; or
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> (B) A different useful life specifically requested by the provider and approved by the intermediary. . . .

The guidance at CMS Pub. 15-1 §114.B states how the basis for depreciation is determined for used assets when a provider enters the program and revises the useful life of an asset:

> When the useful life of an asset is revised, the adjusted historical cost is based on the historical cost reduced by the revised accumulated depreciation based on the new estimate of the asset's useful life. The revised depreciation may be determined on a straight-line basis regardless of the depreciation method used or in use by the provider. . . .

Provider's Contentions: The Provider contends that since Forest Hospital was sold, October 1, 1999 represents the last day of the useful life of the fixed assets of Forest Hospital. The Provider is therefore entitled to adjust the life of the assets in the manner contemplated on its as-filed cost report.

Intermediary's Contentions: The Intermediary contends that the Provider failed to comply with the regulation and instructions in applying for, or calculating, the re-lifing of hospital assets. The Intermediary argues that the Provider never requested or obtained the approval for re-lifing required by 42 C.F.R. §413.134 (b)(7)(iii) and offered no documentation to support its re-lifing methodology. Further, the Provider's methodology failed to follow the useful life guidelines required under 42 C.F.R. §413.134(b)(7)(i) or the instructions for the calculation of historical costs at CMS Pub. 15-1 §114.B. Accordingly, the Intermediary contends that the additional depreciation costs claimed by the Provider based upon its asset re-lifing calculations should be disallowed.

Issue 3: Public relations/marketing expenses (1998 and 1999)

Facts: The Provider recorded expenses for Public Relations and Marketing on its financial books and records in 1998 and 1999. The Provider listed these expenses on Worksheet A and grouped them for cost reporting purposes as part of the Administrative and General cost center. The Intermediary disallowed these expenses due to inadequate documentation to support their allowability.

Background: The regulations at 42 C.F.R. §413.20 and §413.24 set the record keeping standards that must be met in order for costs to be allowed by the Medicare program. Generally the regulations require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.[1]

Provider's Contentions: The Provider contends that it has adequate and sufficient documentation to support the allowability of the expenses at issue and argues that the Intermediary's offset of these expenses was inappropriate because the Intermediary made no request for documentation to support the expenses in question.

Intermediary's Contentions: The Intermediary contends that 42 C.F.R. §413.20 and §413.24 require that a provider supply auditable documentation to support claimed costs. The documentation must be sufficient and verifiable and include source information that serves as a check on the accuracy of the information presented. The Intermediary contends that it made its adjustment and its supporting rationale available to the Provider during the audit.[2] The Provider was aware of the adjustment but failed to supply any additional information that supported the claimed costs. Absent such documentation, the Intermediary argues that the costs must be disallowed.

Issue 4: Officers' life insurance and wind down expenses (1999)

Facts: In 1999, the Provider submitted two adjustments on Worksheet A-8 of its cost report for "Owners Life Insurance" and "Wind Down Expense." The Intermediary requested documentation in support of these costs but none has been furnished by the Provider. The Intermediary eliminated the costs from the settled cost report.

Background: CMS Pub. 15-1, Section 2130, entitled "Life Insurance Premiums" prescribes the standards under which cost claimed for life insurance may be allowable. CMS Pub. 15-1, Section 2176, entitled "Administrative Cost Incurred After Provider Terminates Participation in Program," sets the conditions under which termination and wind down expenses may be allowable. Both sections require the provider to maintain adequate documentation that supports the amounts claimed.

The regulations at 42 C.F.R. §413.20 and §413.24 set the record keeping standards that must be met in order for costs to be allowed by the Medicare program. Generally the regulations require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.[3]

Provider's Contentions: The Provider contends that it has adequate documentation to support the allowability of the expenses at issue but argues that the Intermediary made no request for documentation supporting the expenses. Accordingly, the Provider contends

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[1] See, Issue 1-Background for pertinent regulatory extracts.

[2] See, I-12 for the exit conference minutes for FYE 10/31/98. There was no formal exit conference for FYE 10/31/99, but a note in the Intermediary's 1999 position paper at Exhibit I-12 states that the Provider was given the adjustments and allowed time to respond to them.

[3] See Issue 1 - Background for pertinent regulatory excerpts.

that the Intermediary's adjustment is improper.

Intermediary's Contentions: The Intermediary contends that 42 C.F.R. §413.20 and §413.24 require that a provider supply auditable documentation to support claimed costs. The Intermediary contends that it made its adjustment and its supporting rationale available to the Provider at the audit exit conference.[4] The Provider was aware of the adjustment but failed to supply additional information to support these costs. In addition, the Intermediary's workpapers indicate that it did request additional documentation. See, Exhibit I-5, page 2. Absent such documentation, the Intermediary argues that the costs claimed could not be evaluated under the requirements of CMS Pub. 15-1, §§2130 and 2176 and were properly disallowed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions, the testimony offered at the hearing and the evidence included in the record, the Board finds and concludes as follows:

Issue 1: Bad Debts

The issue presented for the Board's consideration requires a two tier analysis of the facts and circumstances surrounding the bad debts claimed by the Provider. The first involves the admissibility of the data offered into evidence that was unavailable until June 8, 2007. The second involves the merits of the claim for bad debt reimbursement based upon the evidence admitted.

Admissibility of June 8th data: At the hearing, the Board confirmed the chain of events that led up to its preliminary finding that the data offered on June 8th was inadmissible:[5]

1. The Provider filed final position papers on December 1, 2006 which acknowledged that Medicare bad debts must be supported by adequate documentation, but it provided no supporting documentation for the claim.

2. The Board notified the parties on December 28, 2006 that it had scheduled the cases for hearing on June 14, 2007.

3. The Provider furnished no additional supporting documentation in the 6 months between the December 28th Notice of Hearing and the June 8th pre-hearing conference.

The Provider did not dispute the chain of events. Rather, the Provider contended that 1998 and 1999 were the last years of the Provider's existence and that information contained in the June 8th supplemental bad debt information was not known to the

[4] See footnote number 2.
[5] Transcript, pp. 10-12.

Provider's representative until 6/4/2007.[6] Provider argues that it disseminated the information promptly upon its discovery of the information. The Provider further argued that the regulations encourage the full exchange of information germane to the dispute and, accordingly, the additional bad debt information should be allowed into evidence.

Testimony at the hearing indicated that the supplemental information had been supplied to the Provider's former consultant in March, 2002 [7] and had been continuously available since.[8] However, the witness could not confirm that the documentation was ever transmitted to the Intermediary.[9] Further, no additional attempts to secure the information were initiated by the Provider until May 21, 2007,[10] despite continuing attempts by the Intermediary to secure the data.[11]

The Board finds no justification for the delay in supplying the data to the Intermediary. The evidence established that the records were readily available to the owner. Despite multiple routine requests by the Intermediary, the data was not furnished until 6 days before the hearing – a time so late that it undermines the hearing process. The Board's instructions anticipate that all documentary evidence shall accompany the Provider's final position paper but usually allows liberal supplemental documentation. However, the documentation at issue here is the very foundation and heart of the case. Its absence from the filings until just 6 days before the hearing effectively denies substantive notice of the Provider's case to the Intermediary and, consequently, does not afford the Intermediary a reasonable opportunity to prepare for the Provider's case. Accordingly, the Board considers the late submission of the data a violation of due process and will not admit it into evidence.

Merits of the claim for bad debt reimbursement: 42 C.F.R. §413.80(e) and CMS Pub. 15-1, §310 establish the criteria and documentation standards that must be met for bad debts to be reimbursable under the Medicare program. The standards require that the provider's collection efforts be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone contact, etc. Further, 42 C.F.R. §413.20(d)(1) and 42 C.F.R.§413.24(c) require that auditable, verifiable documentation that assures proper payment by the program be made available for review. The Provider offered no admissible documentation supporting its Medicare bad debts claim and did not meet the collective documentation responsibilities set by the regulations. Accordingly, the Board concludes that the Intermediary's adjustments were proper.

Remaining Issues: At the hearing, the Provider submitted the three remaining issues for the Board's review/decision based upon the record as it existed.[12] The Board confirmed that the record was limited to the final position papers filed by the parties and that the Provider's position paper consisted of a four page narrative unaccompanied by any

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[6] Transcript, pp. 13-14.
[7] Transcript, p. 34.
[8] Transcript. p. 49
[9] Transcript, p. 40.
[10] Transcript, pp.54-55.
[11] Transcript, pp. 68-69.
[12] Transcript, p. 6.

exhibits or other supporting documentation.[13]

Issue 2: Asset Re-lifing

The Provider argued that it was entitled to adjust the life of its assets because the facility was sold on October 1, 1999 and that date represented the last day of the useful life of the assets for the Provider's use. The record contains no rationale or documentation in support of the Provider's argument. 42 C.F.R. §413.20(d)(1) and 42 C.F.R.§413.24(c) impose an affirmative obligation upon the Provider to supply auditable, verifiable documentation in support of its claimed Medicare costs. The Provider has not met that obligation and, accordingly, the Board finds that the Intermediary properly disallowed the costs claimed for asset re-lifing.

The Board notes that the narrative addressing the Provider's asset re-lifing methodology, which was included in the Intermediary's position paper, indicated that the methodology was inconsistent with the requirements of 42 C.F.R. §413.134(b)(7)(i) and the instructions at CMS Pub. 15-1 §114.B. However, the Board bases its findings on the absence of verifiable supporting documentation in the record.

Issue 3: Public relations/marketing expenses.

The Provider contends that it is entitled to reimbursement for these expenses because it has adequate documentation to support their allowability and argues that the Intermediary made no request for documentation supporting the expenses. The Board considers the Provider's argument invalid on its face. 42 C.F.R. §413.20(d)(1) states in pertinent part:

> The provider must furnish such information to the intermediary as may be necessary to –
>
> (i) Assure proper payment by the program. . .
> (ii) Receive program payments; and
> (iii) Satisfy program overpayment determinations.

The regulation clearly places the burden for developing and providing supporting information on the Provider. The regulation imposes no obligation on the Intermediary to solicit the information. There is nothing in the record that indicates that the Provider ever supplied the documentation. Accordingly, the Board finds that the Provider has not met the documentation standards imposed by the regulations and that the Intermediary's adjustments disallowing the cost claimed for public relations and marketing expenses were proper.

Issue 4: Officers' life insurance and wind down expenses

The Provider contends it is entitled to life insurance and wind down costs because it has adequate and sufficient documentation to support the allowability of the expenses for

[13] Transcript, pp. 88-89.

which the Intermediary made no request. As discussed earlier, the Board considers the Provider's argument invalid. 42 C.F.R. §413.20(d)(1) requires that the Provider furnish documentation to the Intermediary that supports its cost claims. The regulation imposes no obligation on the Intermediary to solicit such information. Nothing in the record indicates that the Provider ever supplied the documentation and, accordingly, the Board finds that the Provider has not met the documentation standards imposed by the regulations. The Board concludes that the Intermediary's adjustment disallowing officers' life insurance and wind down expenses was proper.

DECISION AND ORDER:

Issue 1: Bad Debts

Admissibility of June 8, 2007 data: The late submission of the data offered in support of Medicare bad debts does not afford the Intermediary a reasonable opportunity to prepare for the Provider's case and constitutes a violation of due process. The Board will not admit the data into evidence.

Merits of the claim for bad debt reimbursement: The Provider offered no admissible documentation supporting its Medicare bad debts claims and did not meet the collective documentation responsibilities set by 42 C.F.R. §413.20(d)(1) and 42 C.F.R. §413.24(c). The Intermediary's adjustments were proper.

Issue 2: Asset Re-lifing

The Provider has not met the affirmative duty imposed by 42 C.F.R. §413.20(d)(1) and 42 C.F.R. §413.24(c) to supply auditable, verifiable documentation in support of its claimed Medicare costs. The Intermediary properly disallowed the costs claimed for asset re-lifing.

Issue 3: Public relations/marketing expenses

The Provider has not met the documentation standards imposed by 42 C.F.R. §413.20(d)(1). The Intermediary's adjustments disallowing the costs claimed for public relations and marketing expenses were proper.

Issue 4: Officers' life insurance and wind down expenses

The Provider has not met the documentation standards imposed by 42 C.F.R. §413.20(d)(1). The Intermediary's adjustment disallowing officers' life insurance and wind down expenses was proper.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.
Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: June 5, 2008