PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D11

PROVIDER –
HCA 2001 Outpatient Therapy Bad Debts Group

Provider Nos.: Various - See Appendix 1

vs.

INTERMEDIARY -
Wisconsin Physicians Service

DATE OF HEARING -
May 5, 2009

Cost Reporting Periods Ended - Various - See Appendix 1

CASE NO.: 04-0228G

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ISSUE:

Whether the various Intermediaries properly disallowed reimbursement to the Providers for uncollected coinsurance and deductible amounts relating to outpatient therapy services claimed as bad debt during the Providers' respective cost-reporting years ending in 2001.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due providers 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 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 and 413.24.

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. §§405.1835-405.1837.

Section 4541(a)(2) of the Balanced Budget Act of 1997, Public law 105-33, (BBA) requires payment under a prospective payment system for outpatient rehabilitation services furnished on or after January 1, 1999. The issue in this appeal involves the proper treatment of bad debts arising from the uncollectible deductibles and coinsurance amounts for outpatient therapy services provided to Medicare beneficiaries and billed under a fee-based reimbursement system.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hospital Corporation of America ("HCA"), a health service company, owned and operated the Provider hospitals comprising this group appeal.[1] On their cost reports for the fiscal periods ending in 2001, the Providers claimed as protested amounts bad debts for the uncollectible coinsurance and deductibles arising from outpatient therapy services furnished to Medicare beneficiaries. The fiscal intermediaries disallowed the entire amount of Medicare Part B bad

[1] See Appendix 1 for a listing of the Providers.

debts claimed because the services were paid under the Medicare fee schedule payment methodology. The Provider filed a timely appeal with the Provider Reimbursement Review Board ("the Board") and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. Wisconsin Physicians Service Insurance Corp. ("Intermediary") has been designated as the lead Intermediary for this group appeal.

A hearing was held before the Board on May 5, 2009. The parties appeared telephonically. The Providers were represented by Hope Levy-Biehl, Esq. from the law firm of Hooper, Lundy & Bookman. The Intermediary was represented by Marshall Treat, Specialist Cost Report Appeals, Wisconsin Physicians Service Insurance Corp.

PARTIES' STIPULATIONS:

The parties stipulated to the following facts material to this decision[2]:

1. The Providers are all general acute care hospitals that furnish, among other things, outpatient therapy services to Medicare beneficiaries.

2. During their collective fiscal years ending in 2001 ("FY 2001"), the Providers, despite engaging in reasonable collection efforts, were unable to collect certain Medicare coinsurance and deductible obligations from Medicare beneficiaries who received outpatient therapy services from the Providers.

3. The Providers claimed as protested amounts these uncollected coinsurance and deductible amounts as bad debt on their Medicare cost reports for FY 2001.[3]

4. Through various audit adjustments, the Providers' respective intermediaries disallowed the claimed bad debts related to outpatient therapy services.

5. The Providers timely appealed these adjustments and created this Common Issue Related Party ("CIRP") group appeal.

6. There are no outstanding jurisdictional issues impacting this group appeal at this time.

7. The sole issue in this appeal is whether the various intermediaries properly disallowed reimbursement to the Providers for uncollected coinsurance and deductible amounts relating to outpatient therapy services claimed as bad debt during the Providers (sic) respective cost reporting years ending in FY 2001.

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[2] Joint Stipulation dated April 23, 2009.

[3] It was the Providers' policy during FY 2001 to include on the protested items line of the cost report those bad debts attributed to outpatient therapy services. Because the exact amount of bad debt attributable to outpatient therapy services was difficult, if not impossible to determine, the Providers estimated the portion of the unpaid coinsurance or deductible amount attributable to outpatient therapy services. In a few limited circumstances, individual hospitals did not follow this policy and did not include bad debts attributed to outpatient therapy services as protested items. HCA believes that all of its hospitals that have had their bad debt adjusted for FY 2001 based on this outpatient therapy bad debt issue are included as providers within this group appeal.

8. The Parties agree that this is a legal issue and as such, intend to proceed with a hearing in this case based on legal arguments and without presenting witnesses.

9. The Parties agree that the hearing in this case can proceed most efficiently and economically if conducted via telephone. The Parties will formally request a telephonic hearing in this appeal by separate letter to the PRRB.

PARTIES' CONTENTIONS:

The Providers contend that there was no Medicare statute, regulation or manual provision in effect during the Providers' FY 2001 that exempted from bad debt reimbursement unpaid coinsurance and deductible amounts relating to outpatient therapy services.[4] Further, the Providers contend that neither CMS nor the Intermediaries were able to furnish any evidence demonstrating that one factor incorporated into the fee schedule methodology was reimbursement to providers for bad debt.[5] Absent such evidence, the adjustments at issue in this appeal violate Medicare's longstanding anti-cross subsidization principle and cannot be upheld.

The Intermediary contends that it was appropriate to disallow the Providers' claimed bad debt related to the outpatient therapy services because such services were reimbursed under the Medicare Physician Fee Schedule. The Intermediary asserts that following the enactment of the Balanced Budget Act of 1997, Medicare reimbursement for outpatient therapy services was changed from a reasonable cost basis to a reasonable charge basis or the Medicare Physician Fee Schedule payment methodology.[6] The Intermediary asserts no change in the law or regulation was required based on CMS' longstanding policy in disallowing reimbursement of bad debts when services are reimbursed under the Medicare Physician Fee Schedule.

The Intermediary contends this policy was upheld by the CMS Administrator's reversal of two PRRB decisions.[7] *Extendicare 99 Uncollected Coinsurance and Deductibles Dual Eligible Group v. Blue Cross/Blue Shield Association/United Government Service, LLC-WI,* PRRB Dec No. 2006-D36 (July 21, 2006) Medicare & Medicaid Guide (CCH) ¶81,542, *rev'd,* CMS Administrator (September 12, 2006), Medicare & Medicaid Guide (CCH) ¶81,604 (*Extendicare*). *Glenwood Park, Inc. v. BlueCross BlueShield Association/United Government Services, LLC,* PRRB Dec. No. 2006-D57, Medicare & Medicaid Guide ¶81,614 (September 28, 2006) *rev'd* CMS Administrator (November 20, 2006) Medicare & Medicaid Guide (CCH) ¶81,626. (*Glenwood Park*). In these cases the CMS Administrator found that the Intermediary properly disallowed bad debt associated with unpaid deductible and coinsurance amounts involving outpatient therapy services.

The Intermediary also noted that *Extendicare* was upheld by the federal district court. *See Abington Crest Nursing and Rehabilitation Center v. Leavitt*, 541 F. Supp. 2d 99 (D.D.C. 2007) March 28, 2008) (holding that bad debt reimbursement provisions in the regulations were not applicable to services for which Medicare payment was based on reasonable charges or a fee

[4]Transcript (Tr.) at 16 - 17; Providers' Post-Hearing Brief at 4.
[5] Tr. at 21; 61-66; Provider's Post-Hearing Brief at 4; Providers' Exhibit P-27 at 2.
[6] Tr. at 36; Intermediary's Post-hearing Brief at 6.
[7] Intermediary's Post-hearing Brief at 7.

schedule methodology), *aff'd*, 575 F. 3d 717 (D.C.Cir. 2009). The Intermediary argued that the Court's ruling confirmed CMS' longstanding policy to disallow bad debts when payment is made under a Medicare fee schedule.[8]

In response, the Providers urge that the Board reject the deferential analysis in *Abington Crest* for several reasons.[9] First, the bad debt regulation in effect during FY 2001 was not ambiguous, since neither the bad debt statute nor the bad debt regulation stated that bad debt reimbursement was unavailable to services paid pursuant to a fee schedule. Second, the Court erred in finding that the anti-cross subsidization principle is only applicable to certain prospectively determined payment systems, namely those with prospective rates calculated based on costs, not charges. This position, unsupported in the governing statutes and regulations and not pronounced informally until years after the cost reporting period at issue in this appeal, cannot be used to support the disallowance of outpatient therapy bad debt in this case. Third, the Court erred in accepting CMS' assertion, without any factual support, that the Medicare physician fee schedule included reimbursement for bad debt. Indeed, in response to the Providers' discovery request, CMS has been unable to support that the physician fee schedule includes reimbursement to physicians or other providers for uncollected coinsurance and deductible amounts.[10] If the Court in *Abington Crest* had the benefit of the discovery the Providers received in this case, it would have seen that CMS can offer no factual support for the assertion that Medicare fee schedule payment reimburse providers for the cost of unreimbursed deductible and coinsurance amounts.

Instead, the Providers urge the Board to follow the reasoning in *Dialysis Clinic, Inc. v Leavitt*, 518 F. Supp. 2d 197 (D.D.C 2007). In *Dialysis Clinic*, the District Court held that it is improper for CMS to limit bad debt reimbursement based on informal guidelines or policy statements not incorporated into the governing bad debt laws or regulations.[11] Consequently, in this case, the Board should adopt the reasoning from *Dialysis Clinic*, reject the informal agency policy pronouncements called upon by the Intermediary and instead, rely on the plain language of the bad debt regulation to find that during FY 2001, there was no prohibition against bad debt reimbursement for unpaid coinsurance and deductible amounts relating to outpatient therapy services reimbursed under a fee schedule.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions and the evidence contained in the record, the Board majority finds and concludes that the Intermediary's adjustment to the Providers' uncollectible deductibles and coinsurance amounts arising from outpatient therapy services paid under the Part B fee schedule were improper.

Section 1861(v)(1)(A)(i) of the Social Security Act articulates the principle against cross-subsidization and states that the cost for individuals covered by the Medicare program

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[8] Intermediary's Post-hearing Brief at 8.

[9] Tr. at 30-33; Providers' Post-Hearing Brief at 15-16.

[10] Providers' Exhibit P-27. This exhibit contains CMS' response dated April 15, 2009, to the Providers' subpoena duces tecum of July 25, 2007. CMS treated the request under the Freedom of Information Act. In its response, CMS advised that after a careful search it was unable to locate any records establishing that unpaid Medicare co-payments were included in computing the Medicare physician fee schedule amounts.

[11] Tr. at 25-30; Providers' Post-hearing Brief at 13-15.

must not be borne by individuals not covered by the program and the costs for individuals not covered by the program must not be borne by the program. In 1966, the Health Insurance Benefits Advisory Committee (HIBAC) initially recommended that Medicare cover the unpaid deductible and coinsurance amounts that arose in connection with the provision of covered services to beneficiaries in an effort to avoid the cross-subsidization that might occur if hospitals or other entities tried to recoup Medicare bad debts from other payors. The Secretary, by regulation, adopted the bad debt policy in accordance with the anti-cross-subsidization principle that is part of the definition of reasonable cost contained in section 1861(v) of the Act.

Prior to enactment of the BBA of 1997, payments for outpatient rehabilitation services were made using salary equivalent guidelines. The salary equivalency guidelines were a tool used to determine the reasonable cost of therapy services provided by practitioners other than physicians. The regulations at 42 C.F.R. §413.80 provided for reimbursement of bad debts and expressed as the rationale the statute's prohibition against cross-subsidization. It also established the standards under which bad debts would be reimbursed by the Medicare program. Subsequently, the cost based system was replaced by fee-based payment systems. CMS asserted that the physician fee schedule mechanism included all costs, including bad debt, and traditionally did not allow the recovery of bad debts for the services covered by those fee schedules.

Beginning with claims with dates of service on or after January 1, 1999, the BBA mandated that outpatient therapy services be paid under a prospective payment system. CMS further provided that the Medicare Physician Fee Schedule would be used as the prospective payment system for these services.

While the BBA effectively shifted payment for outpatient therapy services from reasonable cost to fee-based, it made no mention of the related bad debts, nor did CMS make any change to 42 C.F.R. §413.80. The Board majority considers these omissions significant. Congress specifically addressed the issue of Medicare bad debt in the BBA for a variety of services. These provisions illustrate that Congress was fully aware of the distinctions between cost-based and fee-based reimbursement at the time that it made the shift. The Congress fully understood that the bad debt regulation was derived from the policy against cross-subsidization articulated in Section 1861(v), and that there were no concomitant regulatory provisions addressing bad debts for Part B services. The Board majority concludes that if Congress had intended to alter treatment of bad debts under established principles, it would have done so in the statutes, as it did for physician assistants,[12] certified registered nurse anesthetists,[13] nurse practitioners and clinical nurse specialists,[14] and suppliers of durable medical equipment.[15] The Board majority finds that Congress' silence on bad debts demonstrates its intent that bad debt policy remain unchanged.

[12] Social Security Act (P.L. 74-271) § 1842(b).
[13] Social Security Act § 1833(1)(5)(C).
[14] Social Security Act § 1833(r)(1) and (2).
[15] Social Security Act §1834(a).

Furthermore, the Board majority finds that the existence of a proposed rule, which proposed to eliminate bad debts arising from any service provided under a fee schedule, offers substantive evidence that CMS was aware that existing regulations allowed bad debts for some fee-based services.[16] If CMS had believed that the bad debt policy articulated in 42 C.F.R. §413.80 applied only to cost reimbursed services, such a change would not have been necessary to propose. CMS' failure to finalize its proposed rule suggests that it considered but rejected the policy change.[17]

The Intermediary contends that CMS policy is reasonable and consistent with the law and regulations based on the ruling in *Abington Crest* decision. The Board finds the *Abington Crest* decision is flawed because the Court accepted the Secretary's assertion, without any factual support, that the ". . . physician fee schedule is based on the amount providers *charge* for services, which historically has taken into account the costs of uncollectible deductibles and coinsurance."[18] As established in this case, CMS has been unable to support that the physician fee schedule includes reimbursement to physicians or other providers for uncollected coinsurance and deductible amounts.[19] The Provider' subpoena duces tecum of July 25, 2007 requested ¶(3) all documentation, including but not limited to data files, letters, memoranda, notes, or any other writing establishing that unpaid Medicare co-payments were included in computing the Medicare physician fee schedule amounts under 42 U.S.C. §1395w-4(a) and 42 C.F.R. §414.20.[20]

CMS responded to that request as follows. Please note after a careful search of the Centers for Medicare and Medicaid Services (CMS) files, i.e., a search reasonably calculated to locate records responsive to your request and employing reasonable standards, we were unable to locate any records responsive to item 3 of your request.[21]

If the Court in *Abington Crest* had the benefit of discovery the Providers' had in this case, it would have seen that CMS can offer no factual support for the assertion that Medicare fee schedule payments reimburse providers for bad debt.

A review of the final rule implementing the Medicare Physician Fee Schedule also does not support CMS' assertion that fee schedule payments reimburse providers for bad debt.[22] In the final rule, CMS explained the formula used to determine payments made on a fee schedule. The payment amount for a particular service is developed as the product of three factors:

i. Relative value units for the service,
ii. Geographic Adjustment Factor (GAF) for the fee schedule area, and
iii. National uniform payment Conversion Factor (CF).

Simply stated, the payment amount for a specific service is the result of adjusting the Relative

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[16] 68 Fed. Reg. 6682 (proposed February 10, 2003).
[17] The Board notes that CMS ultimately modified the regulation at 42 C.F.R. § 413.89(i)(2007).
[18] *Abington Crest*, 541 at 108.
[19] Providers' Exhibit P-27 at 2.
[20] Provider Exhibit P-27.
[21] Id.
[22] 56 Fed Reg. 59502 (Nov. 25, 1991).

Value Unit (RVU) for the service obtained by the Geographic Adjustment Factor (GAF) that will weigh the RVU value to reflect the cost of resources in the service area. The three components of GAF are:

1) Physician work,
2) Practice expenses or overhead, such as rent, staff salaries, equipment, and supplies,
3) Professional liability insurance or malpractice costs.

The GAF is an index which reflects the relative practice expenses in an area compared to the national average. The purpose of the GAF is to measure "justifiable" geographic differences in physicians' costs of furnishing services. 56 Fed. Reg. 227,59511.

The issue of Medicare bad debts comes into focus here. It is improbable that the Medicare bad debts were isolated for inclusion under component in the GAF. Bad debts (on a per-unit basis) would not require adjustments relative to a national average. This presumption is confirmed in this case by virtue of CMS' response to the Providers' discovery request, acknowledging that they were unable to locate records that would establish inclusion of unpaid Medicare coinsurance amounts in the Medicare Physician Fee Schedule amounts.[23]

Once the RVU is adjusted for the fee schedule area, it is then converted to a dollar value by applying the national uniform payment Conversion Factor (CF) to the GAF adjusted RVU value. This becomes the payment rate for that particular medical service for that particular location.

Based on the foregoing, the Board majority believes the Medicare bad debts are not included in the physician fee schedules.

Finally, the Board majority notes there is no distinction between a prospective payment rate determined by costs versus a prospective payment rate based on charges. Medicare has the responsibility to reimburse for services regardless of the payment methodology.

The bad debt policy was established through regulation. That regulation was derived from the policy against cross-subsidization articulated in Section 1861(v). The Board is bound by the Secretary's regulations. Absent a change in that regulation, either via a legislative change or through the rule-making process, the Board cannot modify or eliminate the Secretary's mandate, and the majority must conclude that 42 C.F.R. §413.80 remains the controlling authority for the payment of bad debts. The Board majority therefore concludes that the Intermediary's adjustment eliminating the application of 42 C.F.R. §413.80 and disallowing the Provider's bad debts arising from outpatient therapy services under the Part B fee schedule is improper.

DECISION AND ORDER:

The Intermediary's adjustment to the Provider's Medicare bad debts for uncollectible

[23] Providers' Exhibit P-27.

deductibles and coinsurance amounts arising from outpatient therapy services paid under the Part B fee schedule was improper. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, C.P.A (Dissenting)
Keith E. Braganza, C.P.A.
John G. Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: JANUARY 28, 2010

APPENDIX I

PROVIDER NAME	PROVIDER NUMBER	COST REPORTING PERIOD ENDED
Regional Medical Center of San Jose	05-0125	12/31/2001
West Hills Regional Medical Center	05-0481	12/31/2001
Los Robles Regional Medical Center	05-0549	12/31/2001
Rose Medical Center	06-0032	12/31/2001
Swedish Medical Center	06-0034	9/30/2001
North Suburban Medical Center	06-0065	12/31/2001
Medical Center of Auroa	06-0100	12/31/2001
Spalding Rehab Hospital	06-3027	10/31/2001
Cedars Medical Center	10-0009	12/31/2001

PROVIDER NAME	PROVIDER NUMBER	COST REPORTING PERIOD ENDED
East Pointe Hospital	10-0107	8/31/2001
Medical Center of Osceola	10-0110	12/31/2001
Aventura Hospital and Medical Center	10-0131	12/31/2001
Lake City Medical Center	10-0156	10/31/2001
Doctors Hospital of Sarasota	10-0166	12/31/2001
Plantation General Hospital	10-0167	8/31/2001
Memorial Hospital of Jacksonville	10-0179	12/31/2001
Northwest Regional Hospital	10-0189	12/31/2001
Kendall Regional Medical Center	10-0209	12/31/2001
Ocala Regional Medical Center	10-0212	8/31/2001

PROVIDER NAME	PROVIDER NUMBER	COST REPORTING PERIOD ENDED
Southwest Florida Regional Medical Center	10-0220	12/31/2001
Fawcett Memorial Hospital	10-0236	12/31/2001
Northside Hospital	10-0238	9/30/2001
Edward White Hospital	10-0239	12/31/2001
Brandon Regional Hospital	10-0243	12/31/2001
Lawnwood Medical Center Hospital	10-0246	9/30/2001
South Bay Hospital	10-0259	8/31/2001
Medical Center of Port St. Lucie	10-0260	9/30/2001
Englewood Community Hospital	10-0267	12/31/2001
Gulf Coast Hospital	10-0279	12/31/2001

PROVIDER NAME	PROVIDER NUMBER	COST REPORTING PERIOD ENDED
Emory Peachtree Regional Hospital	11-0020	12/31/2001
Emory Cartersville Medical Center	11-0030	9/30/2001
Polk General Hospital	11-0120	9/30/2001
Emory Dunwoody Medical Center	11-0172	12/31/2001
Emory Parkway Medical Center	11-0179	12/31/2001
Doctors Hospital of Columbus	11-0186	12/31/2001
Emory Eastside Medical Center	11-0192	8/31/2001
Hughston Sports Medicine Hospital	11-0200	9/30/2001
West Valley Medical Center	13-0014	9/30/2001
Eastern Idaho Regional Medical Center	13-0018	9/30/2001

PROVIDER NAME	PROVIDER NUMBER	COST REPORTING PERIOD ENDED
Terre Haute Regional Hospital	15-0046	8/31/2001
Wesley Medical Center	17-0123	12/31/2001
Tulane University Hospital	19-0176	12/31/2001
Lakeview Regional Medical Center	19-0177	12/31/2001
North Monroe Hospital	19-0197	12/31/2001
Lakeland Medical Center	19-0200	12/31/2001
Garden Park Community Hospital	25-0123	9/30/2001
Garden Park Community Hospital	25-0123	12/31/2001
Research Medical Center	26-0026	12/31/2001
Mountain View Hospital	29-0039	12/31/2001

PROVIDER NAME	PROVIDER NUMBER	COST REPORTING PERIOD ENDED
OU Medical Center	37-0093	8/31/2001
Edmond Regional Medical Center	37-0148	12/31/2001
Colleton Regional Hospital	42-0030	12/31/2001
Skyline Medical Center	44-0006	11/30/2001
Grandview Medical Center	44-0064	12/31/2001
Summit Medical Center	44-0150	12/31/2001
Centennial Medical Center	44-0161	12/31/2001
Hendersonville Hospital	44-0194	8/31/2001
Bayshore Medical Center	45-0097	12/31/2001
Las Palmas Medical Center	45-0107	12/31/2001

PROVIDER NAME	PROVIDER NUMBER	COST REPORTING PERIOD ENDED
Conroe Regional Medical Center	45-0222	12/31/2001
North Central Medical Center	45-0403	8/31/2001
Mainland Medical Center	45-0530	12/31/2001
North Bay Hospital	45-0605	12/31/2001
Clear Lake Regional Medical Center	45-0617	12/31/2001
Denton Regional Medical Center	45-0634	12/31/2001
West Houston Medical Center	45-0644	12/31/2001
Del Sol Medical Center	45-0646	12/31/2001
Rio Grande Regional Hospital	45-0711	9/30/2001
Kingwood Plaza Hospital	45-0775	9/30/2001

PROVIDER NAME	PROVIDER NUMBER	COST REPORTING PERIOD ENDED
Methodist Ambulatory Surgery Hospital	45-0780	12/31/2001
Texas Orthopedic Hospital	45-0804	12/31/2001
Las Colinas Medical Center	45-0822	12/31/2001
Mountain View Hospital	46-0013	8/31/2001
Lewis-Gale Hospital	49-0048	12/31/2001
Retreat Hospital	49-0071	12/31/2001
Chippenham/Johnston-Willis Hospital	49-0112	8/31/2001

Dissenting Opinion of Michael D. Richards

The majority found that the Provider is entitled to claim reimbursement for bad debts related to deductible and coinsurance amounts for Part B therapy service paid under a fee schedule. I respectfully dissent.

In reviewing this case I asked two different questions. First, does a Law, Regulation, or CMS ruling bind the Board?[24] Second, is the CMS interpretation of the law reasonable?

There are two distinct areas of law applicable to this case. First there is the law related directly to the payment for Medicare bad debts. The relevant statute is found at §1861(v)(1)(A) of the Social Security Act (SSA). In this section entitled, "Reasonable Cost," it states in relevant part:

> The necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs….

Even though this statute does not directly speak to Medicare bad debt reimbursement, the language has been incorporated into the bad debt regulation at 42 C.F.R. §413.80(d) as follows:

> *Requirements for Medicare.* Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for by others than beneficiaries are not to be borne by the Medicare program.

The second area of law is found at SSA §1834(k). This section sets up the required method for payments for the outpatient therapy services in this case, and states in relevant part:

> (k) PAYMENT FOR OUTPATIENT THERAPY SERVICES AND COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—
> (1) IN GENERAL.—With respect to services described in section 1833(a)(8) or 1833 (a)(9) for which payment is determined under this subsection, the payment basis shall be—
> (A) for services furnished during 1998, the amount determined under paragraph (2); or
> (B)for services furnished during a subsequent year, 80 percent of the lesser of—
> (i) the actual charge for the service, or
> (ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.
> (2) PAYMENT IN 1998 BASED UPON ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of –
> (A) the charges imposed for the services, or
> (B) the adjusted reasonable costs (as defined in paragraph (4) for the

[24] See, 42 C.F.R. §405.1867.

> services, less 20 percent of the amount of the charges imposed for such services.
> (3) APPLICABLE FEE SCHEDULE AMOUNT.—In this subsection the term "applicable fee schedule amount" means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1848[25] for such services furnished during the year or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.
> (4) ADUSTED REASONABLE COSTS.—In paragraph (2), the term "adjusted reasonable costs" means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to services described in section 1833(a)(8)(B) (related to services provided by hospitals).
>
> (Footnote added)

While it is clear from the statute and regulation that Medicare bad debts are paid when a provider is cost reimbursed, it is also true that physicians paid on a fee schedule have not been reimbursed for Medicare bad debts. The statute clearly shows the change of payment methodologies for outpatient therapy services from adjusted reasonable costs to the lessor of charges or fee schedule amounts. However, there is nothing in the statute or the regulations that states that Medicare bad debts should be paid when a provider is reimbursed under a fee schedule. Therefore, we must try to determine what CMS' policy for Medicare bad debts was and whether it was consistent with the statute and regulation.

CMS' written policy regarding bad debts can be found in three different documents. First, in Exhibit I-8 to the Intermediary's final position paper there is a letter dated April 10, 2000 from HCFA, Region VI that states:

> Both the statute (§1861(v)(1)(A) and the regulation (42 C.F.R. §413.80) assume a cost based reimbursement system for the payment of bad debts. Allowing reimbursement for bad debts is a feature of the reasonable cost payment principles and, with little exception is not applicable to any other payment system. Medicare bad debts are recognizable for prospectively based payment systems only when those systems are based on cost data. Therefore, SNF outpatient therapy services reimbursed on a fee schedule, deductibles and coinsurance are not allowable Medicare bad debts.

Published three years later is CMS Pub. 13-3 §3653. The relevant section states:

> V. Bad Debts—There is no payment for bad debts (unrecovered costs attributable to uncollectible deductible and coinsurance arising from covered services to beneficiaries considered in calculating payment to providers reimbursed on the basis of reasonable cost) with respect to services paid under the Medicare physician fee schedule. Under a fee schedule, payment is not based on incurred

[25] Section 1848 of the Social Security Act is entitled "PAYMENT FOR PHYSICIANS' SERVICES."

> costs; rather payment is made based on a schedule for the specific service furnished. Whether a fee schedule has its basis in charges or is resource-based, the payment is not related to a specific provider's cost outlay for a service and does not embody the concept of unrecovered cost.
>
> Bad debts are allowable only to an entity to whom payment is made on the basis of reasonable cost.[26]

Finally, on February 10, 2003 CMS published a proposed change to the bad debt regulation that precluded reimbursement for the bad debts at issue in this case. The Final Rule adopting the proposal was published on December 1, 2007. The pertinent language added to 42 C.F.R. §413.89[27] was:

> (i) Exception bad debts arising from covered services paid under a reasonable charge-based methodology or a fee schedule are not reimbursable under the program.

CMS regarded the addition to the regulatory language as being consistent with longstanding policy and not a change in policy.

Nothing in evidence indicates that the Intermediary's adjustment was inconsistent with CMS' longstanding bad debt policy. The D. C. Circuit court in *Abington Crest Nursing and Rehabilitation Center v Leavit,* 575 F. 3d 717 (D.C. Cir. 2009) affirmed this longstanding policy.

The Providers' emphasis on CMS' not being able to support that the Medicare physician fee schedule included reimbursement for bad debt is not relevant to my decision. My dissent is based upon CMS' consistent policy of not paying bad debts to providers paid based on the physician fee schedule irrelevant to whether that fee schedule included bad debt costs or not.

The circumstances in this case differ from when a provider can prove through evidence that CMS has changed its policy. When a policy change occurs, the change is not effective until proper notice is given to providers. We find that there is no evidence that CMS changed it bad debt policy; therefore, the tardiness of the manual and regulation changes is of no consequence.

I find that the Board majority's conclusion that because the bad debt regulation at 42 C.F.R. §413.80 did not change, bad debts are still reimbursed, misses the pertinent point – the regulation and statute they rely on is not applicable to bad debts when a provider is not paid based on reasonable costs. I find nothing in the record to show that this has not always been CMS' policy.

I find that the Intermediary's disallowance of Medicare bad debts related to fee schedule payments is consistent with CMS' policy and that CMS' policy is not inconsistent with statute or regulation; therefore, the adjustment should be affirmed.

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[26] January 24, 2003, Intermediary Manual, Transmittal No. 1872; Intermediary Final Position Paper, Exhibit I-7.
[27] Id.

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Michael D. Richards, C.P.A.