# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D25

**PROVIDER –**
Select Specialty '05 Medicare Dual Eligible Bad Debts Group

Provider No.: Various (See Appendix I)

**vs.**

**INTERMEDIARY –**
Wisconsin Physicians Service

**DATE OF HEARING -**
December 3, 2008

Cost Reporting Period Ended -
Various (See Appendix I)

**CASE NO.:** 08-0251G

**INDEX**

ISSUE:

Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in the Medicaid program.

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 to organizations 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.

The Medicare program reimburses providers for bad debts resulting from deductible and coinsurance amounts charged to Medicare beneficiaries. 42 C.F.R. §413.89(e) requires that bad debts 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.

CMS Pub. 15-1, Provider Reimbursement Manual Part I ("PRM-I") §308 restates these requirements, while PRM-I §310 addresses the concept of "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. The provider's collection effort may include using or threatening to use court action to obtain payment. (See §312 for indigent or medically indigent patients.)

PRM-I §312 states that, "providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively." For such beneficiaries, the debt may be deemed uncollectible without applying the collection procedures outlined in §310.

This section goes on to reference PRM-I §322 to address Medicare bad debts under State Welfare Programs. Section 322, states in pertinent part:

> Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. For example, a State which covers hospital care for only 30 days for Medicaid recipients is not obligated (unless made part of the State title XIX plan) to pay all or part of the Medicare coinsurance from the 61st day on. For services that are within the scope of the title XIX plan, States continue to be obligated to pay the full deductible and coinsurance for categorically needy persons for most services, but can impose some cost sharing under the plan on medically needy persons as long as the amount paid is related to the individual's income or resources.
>
> Where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of §312 or, if applicable, §310 are met.

PRM II §1102.3L, offers implementing guidance for debt collection activities and specifically addressed crossover bad debts (bad debts relating to beneficiaries dually eligible for both Medicare and Medicaid). It states in relevant part:

> [e]vidence of a debt arising from Medicare/Medicaid crossovers may include a copy of the Medicaid remittance showing the crossover claim and resulting Medicaid payment or non-payment. However, it may not be necessary for a provider to actually bill the Medicaid program to establish a

> Medicare crossover bad debt where the provider can establish that Medicaid is not responsible for payment. In lieu of billing the Medicaid program, the provider must furnish documentation of:
>
> - Medicaid eligibility at the time services were rendered (via valid Medicaid eligibility number), and
>
> - Nonpayment would have occurred if the crossover claim had actually been filed with Medicaid.

The dispute in this case involves the Provider's debt collection and write-off policies for Medicare/Medicaid dual eligible patients.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Select Medical Corporation owns and operates the Provider hospitals ("Providers") comprising this group appeal.[1] The Providers are Medicare-certified long-term acute care hospitals located in various states which did not participate in their respective state Medicaid programs. During the cost reporting periods at issue, the Providers claimed Medicare bad debts on their cost report for beneficiaries who were also eligible for Medicaid benefits under the applicable state's Medicaid program (i.e. dual eligible beneficiaries). Wisconsin Physicians Service Insurance Corporation ("Intermediary") disallowed all the bad debts based on the CMS must-bill policy, which requires providers to bill the state Medicaid program and receive a remittance advice (RA) before they can be reimbursed for Medicare bad debts.

The Providers filed a timely appeal with the Provider Reimbursement Review Board (Board) and have met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Providers were represented by Jason M. Healy, Esq. of ReedSmith LLP. The Intermediary was represented by Byron Lamprecht and Terry Gouger of Wisconsin Physicians Service Insurance Corporation.

PARTIES' STIPULATIONS:

At the hearing the parties agreed to the following facts[2]:

1. The Providers are Medicare certified long-term acute care hospitals located in various states operated by subsidiaries of Select.
2. The adjustments at issue relate to bad debts claimed in the Providers' fiscal year 2005 cost reports for patients that were dually eligible for both Medicare and Medicaid on their dates of service.

PARTIES' CONTENTIONS:

The Providers contend that CMS' must-bill policy is invalid for the following reasons[3]:

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[1] Intermediary's Exhibit I-1. See Appendix I for a listing of the Providers.
[2] Transcript (Tr.) at 13-15; Provider's Exhibit P-33 items 2 and 3.
[3] Transcript (Tr.) at 35-36.

(1) There is no statutory or regulatory authority for subjecting the Providers to CMS' must-bill policy;
(2) there was no reason for the Providers to comply with the must-bill policy as they are non-Medicaid –participating providers;
(3) the Intermediary's prior audit treatment and lack of prior notice to the Providers of a policy change; and
(4) even if the Providers had received prior notice, there was no ability for the Providers to comply with the must-bill policy because the state Medicaid programs will not process claims from non-participating providers and many of the states will not allow the Providers to enroll.

The Providers assert that there is no legal requirement that a hospital enroll in Medicaid as a condition of participation in the Medicare program or to obtain Medicare reimbursement for bad debt.[4] The Providers contend that the Intermediary began applying the must-bill policy in April 2007, when the Intermediary informed the Providers for the first time that the must-bill policy would be applied to non-Medicaid participating providers, and that bad debt claims without supporting RAs would be denied[5]. Prior to this date, the Providers contend that the Intermediary did not apply the must-bill policy to Medicare bad debt for non-Medicaid participating providers because the providers could not obtain an RA from the state.

The Providers acknowledge that CMS' must-bill policy was upheld in the 9th Circuit decision *Community Hospital of the Monterey Peninsula v. Thompson* 323 F.3d 782 (9th Cir. 2003) ("*Monterey Peninsula*")[6] in the context of providers which participate in and are thus able to bill their state Medicaid programs for dual eligible patients' cost sharing amounts.[7] The Providers contend, however, there is no authority addressing whether the must-bill policy can be applied to non-Medicaid participating providers that are unable to comply with its terms.

The Providers contend *Monterey Peninsula* is readily distinguishable from the facts in this case.[8] First, in *Monterey Peninsula* the Court found that the providers consistently claimed Medicare bad debt reimbursement without Medicaid RAs and were consistently denied Medicare reimbursement of that bad debt. The Providers believe the Court was persuaded by the fact that there was no evidence the Secretary had ever reimbursed crossover bad debt without a Medicaid RAs. In this case, the opposite is true. The Providers consistently claimed Medicare bad debt reimbursement for dual eligibles without Medicaid RA and were consistently reimbursed by Medicare for those bad debts in prior periods. Second, in *Monterey Peninsula*, the Court concluded that the Medicare prohibition on cost shifting was not violated because only the cost of billing a state Medicaid program was at issue. The Court found that the cost of the bad debt itself would have been paid by the Medi-Cal program if below the state ceiling or by Medicare if above it. However, in this case, the actual cost of the bad debt had been shifted to the Providers as a result of the Intermediary's denials because the states could not even process any billings from the Providers' and therefore neither Medicare nor the state Medicaid programs would ever

[4] Tr. at 31.
[5] Providers' Final Position Paper at 11 *cross referencing* Providers' Exhibit P-9 and Exhibit P-10 at 4.
[6] Providers' Exhibit P-23 contains a copy of the court decision.
[7] Providers' Final Position Paper at 10 and 14.
[8] Tr. at 22 and 23; Providers' Final Position Papers at 14; Providers' Post-Hearing Brief at 31.

pay those amounts. The Providers contend this amounts to a violation of Medicare's cost-shifting prohibition.

The Providers also assert that CMS has recognized some exceptions to its must-bill policy which are analogous to the instant case.[9] One exception is for community mental health centers (CMHCs) in California. The Secretary permits CMHCs to claim Medicare dual eligible bad debts without billing the state Medicaid agency because CMHCs are not licensed by the state and therefore cannot enroll in the state Medicaid program. A second exception to the must-bill policy applies to the Institutes for Mental Disease (IMDs). The Secretary allows IMD to claim Medicare dual eligible bad debts without billing the state Medicaid agency when services are provided to an individual ages 22 – 64 years old because the Medicaid statute and the regulations preclude payment for IMD services provided to patients in this age group.

The Providers argue that the rationale for CMHCs and IMDs are applicable in this case because despite numerous attempts, many states do not recognize long-term acute care hospitals[10] and therefore ,will not enroll the Providers' hospitals in Medicaid.

Finally the Providers contend that they submitted sample bills in many states. In each case, the state would not process the claims of a non-Medicaid participating provider and would not issue RAs.[11] As a result, the Providers contend they were forced to bear the costs of allowable Medicare bad debts, in violation of Medicare's statutory prohibition on cost shifting.[12]

In sum, the Providers assert that the must-bill policy's absolute requirement that the Provider bill the state Medicaid program and receive a Medicaid remittance advice (RA) prior to claiming Medicare bad debts is legally invalid. Because it fails to recognize the non-Medicaid participating providers, it amounts to a violation of Medicare's statutory prohibition against cost-shifting.

The Intermediary contends that its adjustment of the Providers' bad debts was in accordance with CMS' must-bill policy. It maintains that the Providers' method of writing off bad debts for dual-eligible patients without billing the State does not constitute a reasonable collection effort as contemplated by the regulations at 42 C.F.R. § 413.89(e) or the Manual provisions at PRM-I §308 and 312.[13] The Intermediary contends that the must-bill policy is a reasonable interpretation of the regulation that has been upheld by the courts in *Monterey Peninsula.*[14]

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[9] Tr. at 27-30; Providers' Final Position Paper at 17; Providers' Post-hearing Brief at 33-35; *Defendant's Memorandum in Reply to Plaintiffs' Opposition to Defendant's Motion for Summary Judgment* at 9, fn. 5, *Community Hospital of Monterey v. Thompson*, 2001 U.S. Dist. LEXIS 16938 (N.D. Cal. October 11, 2001) (No. C 01 00142 VRW). (Providers' Exhibit P-14)

[10] Providers' Exhibits P3 through P-7. These exhibits consist of written confirmation for the Medicaid programs of New Jersey, Pennsylvania, Arkansas, North Carolina and Delaware denying the Providers' participation in the Medicaid program because the program does not cover long-term acute care hospitals. Provider Post Hearing Brief at 8, fns. 7 and 9 responding to the Board question that the Medicaid program in the state of Arkansas and Delaware do not recognize long-term acute care hospitals.

[11] Providers' Exhibit P-34. The exhibit was submitted in response to Board inquiry and consists of state responses to sample billing exercise for Arkansas, Colorado and Louisiana.

[12] Tr. at 30 and 31.

[13] Intermediary's Position Paper at 5; Tr. at 38-40.

[14] *Id.*

The Intermediary further asserts that the Provider was properly notified of the must-bill policy by virtue of the Medicare newsletters issued by the Intermediary on October 15, 2003 and October 1, 2004.[15]

The Intermediary asserts that the Providers' contention that non-Medicaid participating providers are precluded from complying with the conditions of the must-bill policy by circumstances beyond their control is an implausible excuse.[16] It states the Providers are merely trying to frame the situation as impossible in order to divert attention away from a more plausible reason why the Providers do not want Medicaid certification. The Intermediary alleges the Providers are simply seeking to recover reduced reimbursement resulting solely from their own decision not obtain Medicaid certification.

Finally, the Intermediary contends that §1905(p) (3) of the Social Security Act imposes cost-sharing of Medicare deductibles and coinsurance for qualified beneficiaries on each and every state.[17] As such, the state bears liability for some portion of the coinsurance and deductible amounts for services rendered to dually eligible beneficiaries. However, the Providers have made a conscious decision not to pursue this source and/or available remedy. As such, the Providers have failed to establish that reasonable collection efforts were employed as required under 42 C.F.R. § 413.89(e), and that the debt was actually uncollectible when claimed as worthless.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions the evidence presented the Board finds and concludes as follows:

The primary issue before the Board is whether there was an absolute requirement that the Provider bill the state Medicaid program and receive a Medicaid remittance advice (RA) prior to claiming unpaid deductible and coinsurance amounts as bad debts for Medicare/Medicaid dual eligible patients. The Board examined the regulations at 42 C.F.R. §413.89 and the program guidance at PRM-I §§308, 310, 312, and 322 that govern the recognition of Medicare bad debts. The Board examination included the newsletters and agency alerts cited by the parties in their respective presentations.

Based on the Board's examination of the regulation at 42 C.F.R. §413.89 and the program guidance at PRM-I §308, it finds that neither contained a requirement to bill. Rather, the sections require that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM-I §310 provides guidance on establishing reasonable collection efforts. However, the section by its own terms, is inapplicable to the determination of reasonable collection efforts for indigent patients and specifically refers to §312 for guidance as to indigent and or medically indigent patients. Section 312 states in pertinent part:

[15] Intermediary Position Paper at 6; Tr. at 41-42, Intermediary's Exhibits I-3 and I-4.
[16] Intermediary Position Paper at 6 - 7; Tr. at 40-41.
[17] Intermediary Position Paper at 7; Tr. at 42-43.

> Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, (emphasis added) the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines. . .

The plain language of the above section establishes that Medicaid eligible beneficiaries are deemed indigent and that a provider is not required to take further steps to prove their indigence. However, the language of subsections A through D of §312 is convoluted. Subsection C states:

> The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian . . .

A common sense reading of this guideline suggests that it imposes a universal requirement to collect the debt from responsible third parties. That requirement appears applicable except for the use of the term "otherwise" used in the first paragraph which effectively makes subsections A through D applicable to situations other than Medicare/Medicaid dual eligible beneficiaries. Further, the duty demanded by subsection C to collect from responsible third parties still does not rise to a specific billing requirement. Nowhere does the language of the section support the conclusion that uncollectibity can only be established by submission of a bill and receipt of a remittance advice.

PRM-I §322 addresses "Medicare Bad Debts Under State Welfare Programs." The section requires that deductible and coinsurance amounts not covered by state title XIX plans may be claimed as Medicare bad debts if they meet the requirements of §312. PRM-I §322 states in pertinent part:

> Where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible and coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided the requirements of §312 or, if applicable, §310 are met.

As in Section 310 and 312, the Board could find no specific billing requirement in PRM-I §322. Accordingly, the Board concludes that no billing requirement is imposed by either the regulations or the Manual.

In this case, the Providers are Medicaid non-participating providers. The Board recognizes that there is no legal requirement that a Medicare-certified hospital enroll in Medicaid as a condition of participation in Medicare or to obtain Medicare reimbursement. Further, if a provider is not participating in Medicaid the Board finds Medicaid will not process bills that are submitted. For

these reasons, the Board finds the aforementioned Manual provisions on bad debt are not intended to apply to dual eligible bad debt claims of non-Medicaid participating providers.

The Board also notes CMS' must-bill policy requirement was issued to the intermediaries through a Joint Signature Memorandum (JSM) 370 dated August 10, 2004[18] and referenced in the Intermediary's Medicare Newsletter dated October 15, 2004.[19] The JSM is not an appropriate vehicle to set policy and therefore is given little weight.[20] Consequently, the Board finds the Intermediary changed its policy inappropriately because it disallowed bad debts based upon the JSM that should not be used as a means to convey new instructions or provide clarification of existing requirements to intermediaries. Moreover the Board finds that even if the JSM was an appropriate vehicle to change the must-bill policy, the Providers still prevail because the State is not legally responsible for paying the bad debts of Medicaid non-participating providers.

Next, the Board finds the Intermediary's reliance on Monterey Peninsula to be misplaced because the court did not deal with circumstances existing here that make billing impossible. *Monterey Peninsula* involved a Medicaid state plan that applied a payment ceiling which limited the amount of payment or resulted in no payment for coinsurance and deductibles. Because payments were small, the provider sought to use its own calculations showing the payment that would have been received from the state. It argued that the amounts it could potentially receive were so small they did not justify the expense of billing. The Court noted that while the existence of a ceiling might make the payment amount predictable, in many cases it would be unclear whether the state would pay and, if so, how much.[21] The Court found the Secretary was authorized to determine what supporting documentation will be required so long as it is not inconsistent with the statue and regulation, and is a reasonable implementation thereof. Under the circumstances presented in that case, the Court found that billing the state was the most straightforward and reliable way of determining whether, and, if so how much the state would pay. Therefore, it could not say the must-bill policy was inconsistent with the statute or regulations nor was it an unreasonable implementation of them. [22] The Court was also persuaded by the fact that there was no evidence in that case the Secretary had ever reimbursed crossover bad debt without an RA; the provider's requests were consistently denied. It also noted that PRRB cases had consistently denied reimbursement pursuant to the must-bill policy. [23] There is nothing in *Monterey Peninsula* to indicate the Court considered billing impossibility or, if those circumstances had been presented, the must-bill requirement would have been found to be a reasonable implementation of the regulation and manual provisions. In addition, the evidence

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[18] Providers' Exhibit P-9.

[19] Intermediary's Exhibit I-4 at 3.

[20] The Board recognizes that a JSM is not issued to the general public. CMS states its used by CMS to communicate internally with its contractors. It is used for the purpose of announcing a contract award; emergency alert, and/or a one-time request for information. A JSM is not to be used to convey new instructions or provide clarification of existing requirements that impact contractor operations. *See*, CMS Division of Change & Operations Management CMS/CMM/Medicare Contractor Management Group, *About Joint Signature Memorandums (JSMs) and Technical Direction Letters (TDLs)*, available at http://cmsnet.cms.hhs.gov/hpages/cmm/dcm/agoutjsm.htm (accessed September 2, 2009).

[21] 323 F.3d at 796.

[22] Id. at 793.

[23] Id. at 796.

showed that in this case, the Secretary allowed payment for crossover bad debts without RAs under the regulation and manuals prior to issuance of the JSM.

Finally, the Intermediary's "no-exception" application of the must-bill policy is unfounded, as CMS has recognized two exceptions to the policy.[24] Specifically, CMS has granted exceptions to CMHCs because these institutions are not licensed by the state and therefore cannot enroll in the state Medicaid program or have their Medicaid claims processed. CMS has also granted an exception to IMDs when the services are provided to an individual age 22 to 64 because the Medicaid statute precludes payment for services when provided to this age group. Consequently the state has no responsibility to pay the cost-sharing amounts associated with those services. The same rationale applies to the Providers in this appeal, as many states do not recognize long-term acute care hospitals and therefore will not enroll the Providers' hospitals in Medicaid. Under the same rationale the Secretary used for its exemptions to the must bill policy, hospitals that are not enrolled in Medicaid should also be exempt from the Intermediary's enforcement of the must-bill policy.

Based on the foregoing conclusions, the Board finds the Intermediary's application of the bad debt collections policy including the must-bill policy's absolute requirement that the Providers obtain a Medicaid remittance advice (RA) prior to claiming Medicare bad debts is unsupported by the applicable law, regulations and manual provisions, as it fails to recognize a non-Medicaid participating provider's inability to comply.

DECISION AND ORDER:

The Intermediary's must bill policy has no foundation in law and is beyond the requirements of the regulations and manual. Application of the must bill policy to dual-eligible bad debts when the Provider did not participate in Medicaid programs is improper. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: APRIL 13, 2010

[24] Providers' Exhibit P-14, *supra*, at 7.

**APPENDIX I**

| Provider No. | Provider Name | FYE |
|---|---|---|
| 08-2000 | Select Specialty Hospital- Wilmington<br>Wilmington, Newcastle, Delaware | 07/31/2005 |
| 19-2030 | Select Specialty Hospital- Jefferson Parish<br>Metairie, Jefferson, Louisiana | 08/31/2005 |
| 04-2006 | Select Specialty Hospital- Fort Smith<br>Fort Smith, Sebastian, Arkansas | 08/31/2005 |
| 06-2015 | Select Specialty Hospital- Denver<br>Denver, Denver, Colorado | 09/30/2005 |
| 10-2003 | Select Specialty Hospital- Orlando<br>Orlando, Orange, Florida | 12/31/2005 |