PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D18

PROVIDER –
Doctors Hospital
Columbus, OH

Provider No.: 36-0152

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
CGS Administrators, LLC

DATE OF HEARING -
December 16, 2011

Cost Reporting Period Ended -
June 30, 2004

CASE NO.: 08-1404

INDEX

ISSUE:

Did the Intermediary properly disallow Medicare bad debt expense – specifically, did the Intermediary correctly disallow those claims from the sample review where the Provider was unable to produce all of the documentation from the patient file used to substantiate the indigency determination.[1]

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established by Title XVIII of the Social Security Act, as amended (Act),[2] to provide health insurance to the aged and disabled. The Centers for Medicare & 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 (FIs) and Medicare administrative contractors (MACs). FIs and MACs[3] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[4]

Providers are required to submit cost reports annually, with reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[5] The intermediary assigned to the provider reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR).[6] 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 receipt of the NPR.[7]

Medicare regulations governing bad debts are located in 42 C.F.R. § 413.89(a).[8] As a general rule, bad debts are deductions from revenue and are not to be included in allowable costs; however, to ensure that costs attributable to covered services furnished to Medicare beneficiaries are not borne by individuals who are not covered by the Medicare program, bad debts attributable to Medicare deductibles and coinsurance are reimbursable under the Medicare program if certain criteria are met.[9] In this regard, § 413.89(e) specifies that a bad debt must meet the following criteria to be allowable:

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[1] Stipulations of Fact (hereinafter Stips.) at ¶1; Transcript (hereinafter Tr.) at 5-6.
[2] 42 U.S.C. Ch 7, Subch. XVIII.
[3] FIs and MACs are hereinafter referred to as intermediaries.
[4] *See* §§ 1816 and 1874A of the Act, 42 U.S.C. § 1395h and § 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[5] *See* 42 C.F.R. § 413.20.
[6] *See* 42 C.F.R. § 405.1803.
[7] *See* § 1878(a) of the Act, 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 405.1837.
[8] Re-designated from 42 C.F.R. § 413.80 pursuant to 69 Fed. Reg. 49254 (Aug. 11, 2004). *See* Exhibit P-2.
[9] 42 C.F.R. §§ 413.89)(a) and (d).

(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 issued guidance on the application of these criteria in Chapter 3 of the Provider Reimbursement Manual, CMS Pub. 15, Part 1 ("PRM 15-1" or "Manual"). PRM 15-1 § 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four main criteria that must be satisfied in order for bad debts to be reimbursable by the Medicare program. PRM 15-1 § 310 provides the following guidance on the concept of "reasonable collection effort" which is part of the second criteria:

> 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.)
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> A. Collection Agencies. —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. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.
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> B. Documentation Required. —The provider's collection effort should be documented in the patient's file by copies of the

bill(s), follow-up letters, reports of telephone and personal contact, etc.[10]

PRM 15-1 § 312 allows a hospital to reasonably forego Medicare deductible and coinsurance collection activity where it can establish that the Medicare beneficiary patient was indigent. Specifically, PRM 15-1 § 312 provides the following guidance for establishing indigence:

A. The patient's indigence must be determined by the provider, not the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of his indigence;

B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

C. 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; and

D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

The dispute in this case involves the application of § 312 to the provider's debt collection and write-off policies.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Doctors Hospital is located in Columbus, Ohio. The State of Ohio has a statewide hospital program called the Hospital Care Assurance Program (HCAP) that fulfills Ohio's Medicaid obligation to provide Medicaid disproportionate share funding to Ohio hospitals which provide care to indigent patients. As part of HCAP, all general and acute care hospitals in Ohio are required to "provide, without charge to the individual, basic, medically necessary hospital-level services" for patients who is not a Medicaid recipient and whose income is at or below the Federal poverty level.[11] HCAP then provides a payment to hospitals for providing uncompensated or charity care to low-income and uninsured individuals. Further, effective for Medicaid Cost Reports filed for cost reporting periods ending during or after Ohio's state fiscal

[10] (Underline in original.)
[11] Ohio Administrative Code 5101:3-2-07.17.

year 2003, each hospital is required to have an independent certified public accountant verify the uncompensated care data reported on Schedule F of the Ohio Medicaid cost report.[12]

For its fiscal year 2004, the Provider claimed approximately $210,000 for Medicare bad debts on its cost report based upon its debt collection policies and its actual collection activities throughout the fiscal year. National Government Services, Inc. (now CGS Administrators and hereafter Intermediary) conducted a review of the Provider's collection and write-off policies and selected a sample from the Provider's Medicare bad debt claims.

The Intermediary's policy review confirmed that the Provider utilized the Ohio HCAP/Charity application for indigency determinations. The Intermediary requested the Ohio HCAP/Charity applications for all of the accounts that it selected in its sample of eighty-four accounts. However, the Provider was unable to provide the application for twelve of the accounts in the sample. The Intermediary considered the lack of this documentation to be inconsistent with the Provider's own policy as well as the Medicare program requirements in PRM 15-1 §312. Accordingly, the Intermediary extrapolated the results of its sample to the universe of claimed bad debts resulting in a disallowance of approximately $61,000.

The Provider disputes the Intermediary's findings and adjustment. There is no dispute that 42 CFR § 413.89 and PRM 15-1 §§ 308, 310 and 312 are the controlling guidance for bad debts. The dispute centers on the application of this guidance to determine uncollectibility.

The Provider timely appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 – 405.1840. The Provider was represented by James F. Flynn, Esq., of Bricker and Eckler, LLP. The Intermediary was represented by James R. Grimes, Esq., of the BlueCross BlueShield Association.

THE PARTIES' STIPULATIONS OF FACT:

Paragraphs 2 and 5 to 12 of the Stipulations of Fact contain the following facts stipulated by the parties:

> 2. At the time of the audit and issuance of the September 12, 2007 Notice of Program Reimbursement for the cost report at issue in this appeal, the fiscal intermediary was National Government Services, Inc. Since then, the term "fiscal intermediary" has been replaced with "Medicare Administrative Contractor." As of October 17, 2011, National Government Services, Inc. was replaced as the Medicare Administrative Contractor responsible for Jurisdiction 15, which includes Ohio, by Cigna Government Services. . . .
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> 5. In auditing Provider's bad debts, the Intermediary requested supporting documentation for a sample of claims to review. The Intermediary identified a sample of 42 inpatient claims and

[12] Ohio Administrative Code 5101:3-2-23(A)(5).

a sample of 42 outpatient claims. The Intermediary's work papers for the review of the inpatient claims sample are contained at Provider Exhibit P-9. The Intermediary's work papers for the review of the outpatient claims sample are contained at Provider Exhibit P-11.

6. The Intermediary's work papers for the review of the testing of the support documentation for the inpatient claims sample are contained at Provider Exhibit P-8. Excerpts of these same work papers are also included at Intermediary Exhibit I-3.

7. The Intermediary's work papers for the review of the testing of the support documentation for the outpatient claims sample are contained at Provider Exhibit P-10. Excerpts of these same work papers are also included at Intermediary Exhibit I-3.

8. From the sample of 42 inpatient claims reviewed, the Intermediary disallowed 9 claims all for the same reason: "no indigency documentation". A tenth claim (Record 207) was disallowed for another reason and the Provider is not contesting this disallowance. The Provider is disputing the disallowances for the inpatient claims summarized on Provider Exhibit P-19.

9. From the sample of 42 inpatient [*sic* outpatient] claims reviewed, the Intermediary disallowed 3 claims all for the same reason: "no indigency documentation". Two other claims (Record 610 and Record 646) were disallowed for other reasons and the Provider is not disputing these disallowances. The Provider is disputing the disallowances for the outpatient claims summarized on Provider Exhibit P-20.

10. In each of the claims disallowed for "no indigency documentation," the only documents not provided that caused the disallowance were a copy of the patient's "HCAP/Charity Care/Financial Aid Application" and certain other documentation from the patient file used to substantiate the indigence determination. Examples of what this application looks like are included as Provider Exhibit P-7 and pages 1, 2, 4, 5, 7, 8, 10 and 11 of Intermediary Exhibit I-7.

11. In each of the disallowed claims, the Provider did provide the Intermediary with documentation relating to the indigence determination in the form of patient account histories. The patient account histories for the disallowed claims are contained at Provider Exhibit P-15, P-16, P-17 and P-18.

12. Provider Exhibit P-7 is identical to pages 7 and 8 of Intermediary Exhibit I-7.

PROVIDER'S CONTENTIONS:

The Provider contends that the documentation furnished to the Intermediary was sufficient to establish that the bad debt expense is allowable under the Medicare program. The Provider argues that that the Intermediary previously examined its collection policies and found that they met the criteria for establishing bad debts prescribed under 42 C.F.R. § 413.89(d). Section VII of the Provider's HCAP/Charity Application Policy (the Policy)[13] provides that, for the purpose of writing off bad debts, proof of patient income may be documented either through a physical application or by notes in the Provider's computer system regarding verbal declarations by patients of their income during a phone conversation with a representative of the provider. The verbal declarations are acceptable upon validation by a Provider representative. The Policy expressly recognizes that other forms of proof are necessary and acceptable means to prove income for purposes of bad debt write-off and reimbursement especially when hard copy proof is not available. The Provider asserts that it supplied the HCAP Charity Applications for most accounts and furnished comprehensive notes from its accounting system for the remainder. The Provider contends that its collection efforts were consistent with its policy and provided the data necessary to establish the bad debt.

The Provider also challenges the Intermediary's determination that only the HCAP application is sufficient evidence to establish the bad debt under the requirements of PRMS 15-1 §§ 310 and 312. The Provider contends that the PRM does not provide documentation requirements for proof of indigency. Rather, the PRM provides guidelines and possible methods of satisfying the regulations. Further, the PRM does not have the effect of substantive law or regulation but, rather is interpretive in nature.[14]

The Provider argues that, while PRM 15-1 § 312 prescribes the guidelines for the determination of patient indigency, only two of its four elements must be performed to establish indigency. Specifically a provider must determine indigency and must determine that only the patient is legally responsible for the medical bill in question. The Provider argues that it satisfied both of the mandatory requirements of § 312. The Provider made its determination of indigency in accordance with its Policy, through substantive financial discussions with the patient as recorded in the account notes. Further, the Provider did not merely rely on the assertions of the patient, but verified that the patients in question were solely responsible for the payment of their medical bills. The Provider argues that its indigency determinations accommodate § 312 and that the Intermediary's attempts to require additional information are unsupported by § 312.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider has not met the following burden of documentation delineated in 42 CFR §413.24(c):

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[13] Exhibit P-5.

[14] *See Harris County Hosp. Dist. V. Shalala*, 863 F. Supp. 404, 409 (S.D.Tex., 1994), *aff'd* 64 F.3d. 220 (5th Cir. 1995).

> Adequate cost information must be obtained from the provider's records to support payments for services furnished 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.

Further, PRM 15-1 § 312(A) states: "[t]he patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence." The Intermediary argues that, absent the completed HCAP application, the Provider's use of notes from telephones conversations places reliance on the representations of the patients and does not constitute an independent verification of the patient's circumstances and that this practice is inconsistent with § 312. As a result, the Intermediary contends that the Provider has not provided documentation that is adequate under §413.24(c) to permit bad debt recognition under the Medicare program.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions and stipulations, and the evidence presented at the hearing. Set forth below are the Board's findings and conclusions.

42 CFR § 413.89(a) provides that bad debts attributable to the deductible and coinsurance amounts of Medicare beneficiaries are reimbursable under the Medicare program. Bad debts are defined at 42 CFR § 413.89(b)(1) as:

> Bad debts are amounts 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.

42 CFR § 413.89(d) states that payment for deductibles and coinsurance amounts are the responsibility of the relevant Medicare beneficiary. However, in recognition of the reasonable costs principle at § 1861(v)(1)(A) of the Act which prohibits cross subsidization, § 413.89(d) states that the inability of Providers to collect deductibles and coinsurance amounts from the Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not beneficiaries and that, to prevent such cross-subsidization, the Medicare program reimburses Providers for allowable bad debts.

Providers may receive reimbursement for Medicare bad debt, if they meet all of the criteria set forth in 42 CFR § 413.89(e). The criteria require:

(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.

PRM 15-1 § 312 interprets the regulation to allow a hospital to reasonably forego collection activity where it can establish that the patient was indigent and sets forth the "guidelines" for providers to use in establishing indigence:

> A. The patient's indigence must be determined by the provider, not the patient: i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of his indigence;
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> B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuation circumstances that would affect the determination of the patient's indigence;
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> C. The provider must determine that no other source other than the patient would be legally responsible for the patient's medical bill, e.g., title XIX, local welfare agency and guardian; and
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> D. The patient's file should contain, documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Significantly, paragraphs A and C are written using the auxiliary verb "must" while paragraphs B and D are written using the auxiliary verb "should."

The issue before the Board concerns the Provider's methods for determining indigency and requires an examination of the bad debt policies and practices in place within the Provider's operations.

The Provider's bad debt policy is encapsulated in its Department Policy entitled "HCAP/Charity Application Process" (hereafter "the Policy").[15] The Policy makes use of the HCAP /Charity application which collects certain financial information, including but not limited to, income, expenses, assets, and family size.[16] The HCAP application is intended to identify patients who need help paying their hospital bills and assist them in qualifying for Government reimbursement programs or free care plans. Section VII of the Policy specifies that, for purposes of writing off a bad debt, proof of patient income may be documented either through the physical application or by notes in the Provider's computer system regarding verbal declarations by patient of their income during phone conversations with a representative of the provider. The Policy expressly recognizes that other forms of proof, such as verbal declarations, are necessary and acceptable means to prove income for purposes of bad debt write-off and reimbursement, especially when

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[15] Exhibit P-5.
[16] *See* Tr. at 84.

hard-copy proof is unavailable. The Policy requires verbal declarations to be validated by the signature of a Provider representative.

The representative's validation signature is supported by a comprehensive data collection program that includes a "30 day due diligence" during which the provider representative conducts phone campaigns and generates letters to the patient that solicit the hard copy documentation to support their income statements.[17] The program also makes use of collection agencies referrals, and a final attempt by a third party administrator to secure any missing income information.[18] The Provider relied for all internally performed patient indigency determinations on its application. The application in combination with the provider's documented practices meets all of the requirements of PRM 15-1 § 312 and, to this end, was approved by the Intermediary during its audit process as sufficient documentation.

At the hearing, the Board determined that the Intermediary does not dispute or challenge that the Provider's internal policies used to arrive at a bad debt determination comply with Medicare bad debt rules or that such policies were in place during the period under audit.[19] Rather, the Intermediary limited its review to a verification that a hard copy HCAP application existed for each bad debt determination.[20] Consistent with this limited review, the Intermediary considered those accounts for which the hard copy HCAP application was not available as "errors" and made an adjustment to the Providers bad debts for these "errors."[21] The Board can find no evidence that the Intermediary considered other documentation offered by the Provider in support of the bad debt prior to the disallowance of these bad debts. The Board can find no supporting basis in the regulation or the PRM that permits the Intermediary to require a specific form of documentation to support bad debt and, thereby, to exclude from consideration other supporting documentation to determine bad debts.

For each of the twelve bad debts at issue, the record reflects that: (1) the Provider documented in the patient account notes that an indigence determination was made and the method by which such indigence determination was made (*i.e.*, the Provider completed an HCAP application for each patient and made an indigence determination based on such application); and (2) while the actual HCAP application that was used in the indigence determination could not be located, the Provider produced, consistent with its policy, copies of backup information in the patient account notes to substantiate the determination.[22] Specifically, the Board finds that this backup documentation complied with the Provider's policy which specified that "Each write off will be supported by [among other things] . . . [the] Charity application and/or notes from computer system documenting conversation via phone."

Further, the Board finds that it also complied with PRM 15-1 § 312 specification that "[t]he patient's file *should* contain, documentation of the method by which indigence was determined

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[17] Tr. at 31-32.
[18] *Id.* at 55-65.
[19] *Id.* at 108-110.
[20] *Id.*
[21] Intermediary Final Position Paper at 5.
[22] *See* Tr. at 36-53, 109-110; Exhibits P-15 to P-18 and P-22. *See also* Post Hearing Brief of Provider at 6-10.

in addition to all backup information to substantiate the determination." [23] The Provider did what it was asked to do. The Provider developed an internal policy to comply with this requirement and, consistent with this internal policy, the Provider maintained documentation relative to the bad debt accounts at issue to confirm that an indigence determination was made and the method by which the indigence determination was made as well as documentation to substantiate that determination. Similarly, at the hearing, the Board determined that, during the time at issue, the Provider's bad debt policies and practices were the subject of a then-contemporaneous review by the Provider's independent auditor, Ernst & Young, LLP.[24] The auditor verified that the Provider's bad debt policies and practices were in place and operational during the period under review by the Intermediary. The auditor further concluded that the Provider's policies and practices produced adequate documentation for the Provider's uncompensated care data elements.

Accordingly, the Board concludes that the Provider's bad debt identification process was operationally consistent with the Provider's policy and producing documentation that was adequate to support the Provider's bad debt claims in compliance with 42 C.F.R. § 413.89 and PRM 15-1 § 312. The Intermediary's requirement for specific supporting documentation is unsupported by 42 C.F.R. § 413.89 and PRM 15-1 § 312. Further, the Intermediary's refusal to consider the other available supporting documentation that the Provider maintained in the individual patient's files is improper.

DECISION AND ORDER:

The Intermediary improperly disallowed the Provider's claimed Medicare bad debts. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: JUL 18 2012

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[23] *See Baptist Healthcare Sys. v. Sebelius*, 646 F. Supp. 2d 28, 33-34 (D.D.C. 2009); *Harris County Hosp. Dist. v. Shalala*, 863 F. Supp. 404, 409-410 (S.D. Tex 1994), aff'd 64 F.3d 220 (5th Cir. 1995). *See also Shalala v. St. Paul Ramsey Med. Ctr.*, 50 F.3d 522, 528-529 (8th Cir. 1995).

[24] Exhibit P-23.