PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2018-D23

PROVIDER–
Momence Meadows Nursing and Rehabilitation Center, LLC

Provider No.: 14-5713

vs.

MEDICARE CONTRACTOR –
National Government Services

HEARING DATE –
May 6, 2016

Cost Reporting Period Ended –
December 31, 2010

CASE NO.: 13-0043

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ISSUE STATEMENT

Whether the Medicare Administrative Contractor's ("Medicare Contractor's") adjustment that eliminated $183,879 of claimed Medicare reimbursable bad debts was proper and in accordance with Medicare regulations and the Centers for Medicare and Medicaid Services' ("CMS") Provider Reimbursement Manual (PRM)?[1]

DECISION

After considering the Medicare law and regulations and the evidence presented, the Provider Reimbursement Review Board ("Board") finds that Momence Meadows Nursing and Rehabilitation Center, LLC ("Momence" or "Provider") did not follow its collection policy for bad debt reimbursement for its fiscal year ending December 31, 2010 ("FY 2010") nor did they prove that their collection efforts were otherwise reasonable. Therefore, the Board affirms the Medicare Contractor's adjustment to the Provider's bad debt reimbursement.

INTRODUCTION

Momence is a 140 bed Medicare-certified long-term care facility, offering skilled and intermediate nursing care to residents of the community, located in Momence, Illinois.[2] Momence filed its Medicare cost report for the fiscal year ending on December 31, 2010 with a claim for Medicare bad debt reimbursement. Upon review, the Medicare Contractor disallowed some of the claimed bad debts.

The Provider filed a timely appeal and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-405.1840. The Board held a telephonic hearing on May 6, 2016. Daniel S. Gaafar, of Bradley & Associates, Inc. represented the Provider; Scott Berends, Esq., of Federal Specialized Services represented the Medicare Contractor, National Government Services.

STATEMENT OF THE FACTS AND RELEVANT LAW

The regulations at 42 C.F.R. § 413.89(e) and (f) (2010)[3] establish the following criteria for Medicare to reimburse a provider's bad debt. They include:

> (e) …
>
> > (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.

[1] Transcript ("Tr.") at 5-6.
[2] Tr. at 10.
[3] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

> (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.
>
> (f) The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

This regulation does not, however, define what a provider must do to engage in "reasonable collection efforts" or to establish that it has, indeed, made "reasonable collection efforts.[4] CMS Provider Reimbursement Manual, PRM 15-1 § 310, suggests a definition of reasonable collection efforts as:

> 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.

Section 310.1 further states:

> 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.

And, finally, Section 310.2 establishes:

> Presumption of Noncollectibility—If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

In the present case, the Medicare Contractor sampled twelve patients' files for whom Momence claimed as bad debts. Based on this review the Medicare Contractor determined that in eleven of the twelve cases, Momence failed to send the form collection letters, failed to document the patient was indigent and failed to document that the bad debt write-off had been approved

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[4] *District Health Partners v. Sebelius*, 932 F. Supp.2d 194, 200 (D.D.C. 2013); *GCI Health Care Centers, Inc. v. Thompson*, 209 F. Supp.2d 63, 69 (D.D.C. 2002).

consistent with the Provider's written collection policy. The Provider's written collection policy also required that it complete a "collection log" documenting that the required letters had been sent and that collection phone calls were made as outlined in the policy.[5] The Provider did not provide documentation that the collection logs were completed as defined in its policy. As a result, the Medicare Contractor disallowed $184,413 of the claimed $626,582 bad debt reimbursement.

Momence maintains that its established procedure to collect patient debts included sending out statements, collection letters and numerous phone calls to former patients. Momence witnesses testified that they did not believe that the Provider had to have a written collection policy, or that it must follow this policy, in order to comply with Medicare law.[6] The Provider believes the debts were written off in the period they were deemed worthless and can be claimed as Medicare bad debt having fulfilled all the requirements of 42 C.F.R § 413.89.[7] The Provider maintains that it had provided adequate documentation in the form of bad debt logs, copies of Medicare (*sic*) remittance advices, copies of 2010 patient account receivable ledgers, and copies of collection letters to the Medicare Contractor. This documentation was not provided to the Board due to concerns regarding patient confidentiality.[8]

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

Section 42 CFR § 413.89(e)(2) requires that a provider must be able to establish that reasonable collection efforts were made to collect the debt and subsection (3) requires that the debt was actually uncollectible when claimed as worthless. Although the regulation does not define what reasonable collection efforts must be, PRM Section 310 provides: 1) that a provider may use a collection agency in addition to and in lieu of the provider's collection efforts and 2) that "if after *reasonable and customary* attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."

In several decisions the Board has interpreted this "reasonable and customary" language to require that a provider have a written debt collection policy to memorialize the process for its "collection effort", and that the provider follows its policy in the debt collection process.[9] While it is up to the provider to determine what its debt collection policies may be, the determination of these policies should reflect its sound business judgment. Further, as part of the cost report requirements providers must submit bad debt logs,[10] and as part of an audit Medicare contractors often request a copy of the provider's written collection policy and documentation that the policy was followed.

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[5] Medicare Contractor's Final Position Paper at 5-7. Transcript ("Tr") at 13-14. A copy of the Provider's written collection policy can be found at Medicare Contractor's Exhibit I-3 and Provider's Final Position Paper Exhibit P-1.
[6] Tr. at 61 and 113
[7] Provider's Final Position Paper at 4-5.
[8] Provider's Final Position Paper at 2-3.
[9] *Marian Health Center v. Blue Cross & Blue Shield*, PRRB Dec. 85-D110 (Sept. 23, 1985); *St. John Health 2004-2005 Bad Debt Moratorium CIRP Group v. National Govn't Services*, PRRB Dec. 2014-D19 (August 27, 2014)
[10] *See*: PRM 15-2, Ch. 11 § 1102.3 (2006):

"I. Bad Debts .-- . . .

A provider whose Medicare bad debts meet the above criteria should complete Exhibit 5 or submit internal schedules duplicating the documentation requested on Exhibit 5 to support bad debts claimed. If the provider claims bad debts for inpatient and outpatient services, complete a separate Exhibit 5 or internal schedules for each category."

Momence memorialized its written debt collection policy as exhibited in the record, to document the process that it would follow to ensure that its debt collection was reasonable and that the debts were worthless when written off. The Provider's policy required that the staff should "not wait until 30-45 day past due to start the collection effort" and that "collection calls should begin on the 11th day of the month."[11] Collection efforts would consist of three form letters and collection calls.[12] The Provider was to keep a log with all backup contact information that would be submitted to the Account Receivable department by the 15th day of each month.[13] The Provider was to also complete a bad debt form that would provide each patient's name, the date of the write off, the amount and the reason for the write off. The bad debt form was to be signed by the Administrator, the bookkeeper and the owner approving the write off.[14]

The Board finds that although Momence's debt collection policy likely was reasonable, Momence did not follow this policy. The evidence in the file demonstrates that Momence did not timely send collection letters. In the sample audited by the Medicare Contractor,[15] the Provider did not start sending collection letters on one patient until 59 days after the remittance advice when the collection policy stated the Provider was not to wait 30-45 days to begin the collection process.[16] For another patient the bad debt was written off before 120 days but the Provider continued to send letters to collect on the account.[17] Letters submitted into the record by the Medicare Contractor indicate that the Provider did not send out the letters as drafted in its policy, or that letters were followed up by phone calls to collect the debt.[18]

At the hearing the Provider's witnesses testified that they did not provide call logs, invoices, or bad debt forms signed by the owner, documenting the reason for the Medicare bad debt written off.[19] The Medicare Contractor in its post hearing brief stated that the Provider did not tender any additional documentation after the hearing other than what had been previously provided.[20]

PRM 15-1 § 310 states that the collection effort "includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party [refers to the person responsible for patient's financial obligations] which constitutes a genuine, rather than a token, collection effort". In this case it is clear that although the Provider did have a written debt collection policy, the Provider did not follow its own policy. The Board concludes that the Provider did not prove that its collection efforts were reasonable under the Medicare bad debt requirements and therefore the Medicare Contractor was proper in denying bad debt reimbursement to the Provider.

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[11] Exhibit I-3 Collection Log Instructions at 3.
[12] *Id.* at 4-6.
[13] *Id.at 3.*
[14] Exhibit I-3, Bad Debt and Bad Debt Form and Tr. at 38.
[15] Exhibit I-2.
[16] Exhibit I-3, Collection Log Instructions.
[17] *Id.*
[18] Exhibit I-3 and I-4.
[19] Tr. at 32, 36, 38 and 39.
[20] Medicare Contractor's Post Hearing Brief at 5 and 6.

DECISION

After considering the Medicare law and regulations, the evidence presented, and the parties' contentions, the Board finds, the Provider did not follow its collection policy for bad debt reimbursement for FY 2010 nor did they prove that their collection efforts were otherwise reasonable. Therefore, the Board affirms the Medicare Contractor's adjustment to the Provider's bad debt reimbursement.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A
Gregory Ziegler, C.P.A, CPC-A

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: February 12, 2018