PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2008-D32

PROVIDER -
Port Huron Hospital
Port Huron, MI

Provider No.: 23-0216

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, LLC - WI

DATE OF HEARING -
January 10, 2008

Cost Reporting Periods Ended -
June 30, 2000 and June 30, 2001

CASE NOs.: 03-0778 and 04-0914

INDEX

ISSUES:

1. Whether the Provider was required to submit a claim to the Michigan Medicaid program and to obtain a Medicaid remittance advice in order to receive Medicare reimbursement for Part B bad debts relating to services furnished to patients dually eligible for Medicare and Medicaid.

2. Whether the sampling methodology used by the Intermediary for determining the Provider's entitlement to bad debt payment for the fiscal year ended 6/30/2000 was proper. (CN: 03-0778 only)

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Medicare program reimburses providers for bad debts resulting from deductible and coinsurance amounts which are uncollectible from Medicare Beneficiaries. 42 C.F.R. §413.80(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.

The procedures constituting "reasonable collection efforts" are outlined in CMS Provider Reimbursement Manual (PRM) 15-1, section 310. The section incorporates PRM 15-1, section 312 for the determination of indigent or medially indigent patients. Section 312, states in pertinent part:

> 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, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:

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 indigency;

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 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

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.

> Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures.

CMS PRM 15-2, section 1102.3L, offers implementing guidance for debt collection activities and specifically addressed crossover bad debts. It states in relevant part:

> Evidence 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:
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> - 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:

Port Huron Hospital (Provider) is a not-for-profit, acute care hospital located in Port Huron, Michigan. In fiscal 2000 and 2001, the Provider claimed Medicare bad debts for deductible and coinsurance amounts not paid by a state Medicaid program with a payment crossover ceiling.[1] The Provider established that certain patients were eligible for Medicaid at the time of service and that Medicaid would not have made a payment had the crossover claim been billed, but the Provider never actually billed the State for the deductible and coinsurance amounts. National Government Services (Intermediary) challenged the propriety of writing off those amounts in the absence of billing the State for each patient and receiving contemporaneous documentation of a payment or denial. The Provider also challenged the reliability of the sampling methodology employed by the Intermediary to determine its bad debt adjustments. There is no dispute that 42 C.F.R. §413.80 and PRM 15-1, §§308, 310, 312 and 322 are the controlling guidance for bad debts. The bad debt reimbursement dispute centers on whether there was an absolute requirement that the Provider bill the Michigan 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 dispute regarding the Intermediary's sampling methodology involves whether the sample was representative of the population sampled.

The Provider ultimately appealed both disputes to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835 - 405.1841. The Provider was represented by Kenneth R. Marcus, Esquire, Honigman, Miller Schwartz and Cohn, L.L.P. The Intermediary was represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

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[1] The Term "crossover ceiling" means that a state Medicaid program is not required to pay the Medicare copayment or deductible for a dual eligible patient if the Medicare program has paid a provider the amount that the Medicaid program would have paid for the services provided to an eligible recipient other than a Medicare beneficiary. See, 42 U.S.C. 1396a(n)(2).

PARTIES' CONTENTIONS:

Issue 1: Must Bill Requirement

Provider's Contentions: The Provider contends that the amounts in dispute meet the criteria established at 42 C.F.R. §413.80 and should be reimbursed as Medicare bad debts. The Provider argues that all of the accounts claimed relate to deductible and coinsurance amounts for covered services. The Provider argues further that it verified the beneficiaries' eligibility under the Michigan Medicaid program and that under the plan, the amounts outstanding would not be paid. The Provider argues that its verification efforts constituted a reasonable collection effort that established no likelihood of recovery and, given that low likelihood, sound business judgment precluded further pursuit of costly, additional collection efforts.

The Provider also argues that its write-off methodology is in full compliance with the procedures constituting "reasonable collection efforts" that are presented in PRM 15-1, section 312. Section 312 states, in relevant part: "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." Section 312C further 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." Section 312 concludes: "Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures." The Provider contends that its individual examination of each patient's Medicaid status established that Medicaid had no liability, and the patient was indigent. Once indigence was determined, the Provider contends that it properly wrote off coinsurance amounts.

The Provider further contends that the courts addressed CMS' must bill policy in Community Hospital of Monterey Peninsula v. Thompson.[2] Although CMS argued that reasonable collections efforts within the meaning of section 1102.3L of PRM 15-II involves billing anyone responsible for payment, the Court concluded that ". . . the text of §1102.3L is not subject to the interpretation that the Secretary seeks to give it." The Court concluded that ". . . the author of §1102.3L thought it permissible '[i]n lieu of billing the Medicaid program, [for a] provider [to] furnish documentation of . . . Medicaid eligibility . . . and [the][n]on-payment that would have occurred if the crossover claim had actually been filed with Medicaid. . . .' "[3] The Provider argues that it complied with the intent of the manual provision and furnished such information. Accordingly, the Provider contends that it is entitled to claim the related bad debts.

Intermediary's Contentions: The Intermediary contends that the Provider's method for writing off Medicare/Medicaid crossover bad debts does not constitute reasonable

[2] Community Hospital of Monterey Peninsula v. Thompson, U.S. Court of Appeals for the Ninth Circuit, No. 02-15115, March 18, 2003. (Provider Exhibit 15).
[3] Id. p. 14 of 18.

collections efforts as contemplated by the regulations at 42 C.F.R. §413.80(e) or the manual provisions at CMS Pub. 15-1 §308. The Provider's policy of calculating what the State would pay rather than submitting a bill for each patient fails to validate the requirement that "no source other than the patient would be legally responsible for the patient's medical bills."[4] The Intermediary argues further that the "must bill" policy is a reasonable reading of the regulation that has been upheld by the CMS Administrator[5] and the Ninth Circuit Court of Appeals.[6]

The Intermediary also contends that the Provider received notification of the policy in a "Medicare Memo" (Memo) that was published on March 11, 1999.[7] The Memo recommended the type of documentation that providers should keep to evidence cross-over bad debts. The Intermediary contends that the Memo provides appropriate notice of both the billing and documentation requirements.

Issue 2: Sampling Methodology

Provider's Contentions: The Provider contends that the Intermediary's bad debt sampling methodology did not distinguish between Medicare/Medicaid crossover accounts and Medicare only accounts. The Provider argues that the sample should have been stratified and separate samples selected to properly reflect the characteristics of each account type and that, absent such stratification, the Intermediary's sample is not representative of the universe of bad debt accounts.

Intermediary's Contentions: The Intermediary acknowledges that it did not stratify its audit sample. However, the Intermediary argues that the Provider offered no regulation, instruction or statistical sampling standard to support its contention that the sample was not proper. The Intermediary contends that, absent substantial evidence that the sampling method was improper, the sample and its results should be considered proper.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

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

Issue 1: Must Bill Requirement

The primary issue placed before the Board is whether a finding of uncollectibilty on a debt owed by a patient who is dually eligible for Medicare and Medicaid must be supported by individual billing to the State. The Board examined the regulations at 42 C.F.R. §413.80 and the program guidance at PRM 15-I, sections 308, 310, 312, and 322

[4] PRM 15-1§312C.
[5] See, California Hospitals Bad Debts Group v. Blue Cross/Blue Shield of California, CMS Administrator Decision, Oct. 31,2000, PRRB Dec. No. 00-D80; affirmed sub nom.
[6] Community Hospital of Monterey Peninsula v. Thompson, supra.
[7] Intermediary Exhibit I-3.

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. §413.80 and the program guidance at PRM 15-I, Section 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 if the debt was actually uncollectible. PRM 15-I, section 310 sets the parameters for establishing reasonable collection efforts. However, the section specifically refers to section 312 for indigent and or medically indigent patients and, by its own terms, is inapplicable to the determination of reasonable collection efforts for indigent patients. Section 312 states in pertinent part:

> 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 paragraph appears to establish that Medicaid eligible beneficiaries are indigent and that the 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 the guideline suggests that it imposes a universal requirement to collect the debt from responsible third parties. That requirement appears applicable but for the use of "otherwise" in the first paragraph which effectively makes the application of 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 must be established by a billing.

PRM 15-I, section 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 Section 312. Section 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 discussed earlier, the Board could find no billing requirement in Sections 310 or 312. Accordingly, the Board concludes that no billing requirement is imposed by either the regulations or the manual.

The Intermediary relies on its Medicare Memo (Memo) dated March 11, 1999, as evidence of a "must bill" requirement. The Board's examination of the Memo indicated that its "must bill' language is clear for fiscal years ending December 1995 and after. However, the Memo is the only evidence in the record that such a billing was required during the fiscal periods under consideration. The requirement, although explicit, is unsupported by an appropriate statutory or regulatory base and is, therefore, insufficient to impose an additional major requirement for reimbursement. Nevertheless, the Memo clearly requires that such billings be made even through they are futile and the provider can otherwise demonstrate that there is no reasonable expectation of payment and the debt was worthless when it was claimed. The billing policy goes well beyond the requirements of the regulation and manual provisions and requires the Provider to do something that is futile. Accordingly, the Board must conclude that the application of the "must bill" policy to outstanding deductible and coinsurance amounts due from dually eligible beneficiaries is improper.

Issue 2: Sampling Methodology

Prior to the hearing, the parties developed a joint stipulation under which the Intermediary agreed to increase the Provider's Medicare bad debts. The Board considers the stipulation appropriate to apply to the circumstances of the sampling issue for FYE 6/30/2000.

DECISION AND ORDER:

Issue 1: Must Bill Requirement

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 outstanding deductible and coinsurance amounts due from dually eligible beneficiaries is improper. The Intermediary's adjustment is reversed.

Issue 2: Sampling Methodology

The joint stipulation of the parties maybe implemented to resolve the issue.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Elaine Crews Powell, C.P.A.

Yvette C. Hayes
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: August 11, 2008