# CENTERS FOR MEDICARE AND MEDICAID SERVICES

*Decision of the Administrator*

| **In the case of:** | **Claim for:** |
|---|---|
| **Hospital San Francisco, Inc.**<br><br>**Provider**<br><br>**vs.**<br><br>**Cooperativa de Seguros de Vida de Puerto Rico**<br><br>**Intermediary** | **Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 9/30/96**<br><br>**PRRB Dec. No. 2003-D57**<br>**Dated: September 12, 2003** |

This case is before the Administrator, Centers for Medicare and Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in §1878(f)(1) of the Social Security Act (Act). The parties were notified of the Administrator's intent to review this case. Accordingly, this decision is now before the Administrator for final agency review.

## ISSUE AND BOARD'S DECISION

The issue before the Board was whether the Intermediary's adjustment to bad debts was proper. The Provider is an acute care general hospital located in Rio Piedras, Puerto Rico. The Intermediary determined that $224,141 of Provider's claimed bad debts were not allowable, and made an adjustment accordingly. The Intermediary identified $137,863 of the $224,141 disallowance as a "statistical sample adjustment."[1] The Provider appealed the bad debt disallowance attributed to the "statistical sample adjustment" to the Board.[2]

[1] Although not at issue in this case, the Administrator notes that the remaining $86,278 of the $224,141 bad debt disallowance, which was not attributed to the statistical sample adjustment, was not protested by the Provider and was proper.

[2] The Provider disputes $136,723.60 of the $137,863 statistical sample adjustment. The remaining $1139.40 represented bad debts that the Intermediary examined

The Board held that $136,723.60 of the Intermediary's "statistical sample adjustment" was improper. The Board explained that the Intermediary failed to substantiate the statistical validity of its sample or present evidence that it properly entered data or used the proper disk when conducting the sample. The Board also found that the computer disk utilized by the Intermediary in the sample, contained inapplicable data to the Provider.

The Board continued that there was no evidence that the sample size chosen by the Intermediary was representative of the universe. Moreover, the Intermediary's exhibit, entitled "Sample Size Estimator," that it claimed was from the Office of the Inspector General sampling program, contained virtually no rationale about how the sampling program was created or applied. The exhibit also contained a caveat that as sample sizes were the result of mathematical formulas as opposed to management objectives, sample sizes may need to be increased. The Board also noted that a proper sample was not used, as prior to defining the universe, the Intermediary removed claims that were disallowed through a selective audit of accounts.

## DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, and exhibits. Under §1861(v)(1)(a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included…." The section does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters.

The principles set forth in the Social Security Act are reflected and further explained in the regulations. One of the underlying principles set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e. Medicare prohibits cross-subsidization of costs. This principle is reflected at 42 C.F.R. §413.9(c), which provides that the determination of reasonable cost must be based on costs related to the care of Medicare

---

and identified as unallowable during its sampling test of the Provider's bad debt claim. The Provider did not dispute those disallowances.

beneficiaries. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.

With respect to the conditions for payment, §1815(a) of the Act states that Medicare payments will not be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider for the particular cost period at issue. The Secretary has implemented this provision in the regulations at 42 C.F.R. §§413.20 and 413.24 which require providers to maintain financial and statistical records sufficient for an accurate determination of program costs.

Consistent with this principle, 42 C.F.R §413.80 (a) provides that bad debts, which are deductions in a provider's revenue, are generally not included as "allowable costs" under Medicare. However, §413.80(a) further states that bad debts attributable to the deductible and coinsurance amounts of Medicare beneficiaries are reimbursed under the Medicare program. The regulation at 42 C.F.R. §413.80(b)(1) defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services." "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.

The regulation at 42 C.F.R. §413.80 (d) further explains that to ensure that the cost of Medicare services are not borne by others, the costs attributable to the Medicare deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Providers may be reimbursed for the bad debts derived from uncollectible deductibles and coinsurance amounts under circumstances set forth at paragraph (e). The regulation at 42 C.F.R. §413.80(e) states that to be allowable, a bad debt must meet the following criteria:

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.

In addition to regulations, CMS issued program guidelines on bad debts. The Provider Reimbursement Manual (P.R.M.) §310 defines a reasonable collection effort, and specifically requires that "[t]he 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." Section 312 of the P.R.M. explains that

individuals who are Medicaid eligible as either categorically or medically needy may be automatically deemed indigent. However, §312.C requires that: "The provider must determine that no source other than the patient would be legally responsible for the patients medical bills. Finally, §312 also states that "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 [reasonable collection effort] procedures.

The Medicare Intermediary Manual (M.I.M.), Part 4, Audit Procedures, §4499, Exhibit 15 describes the specific audit procedure for claimed bad debts. Step 15.01 of the Exhibit dictates that an auditor review the provider's policies and procedures to obtain an understanding of the method used to determine bad debts, bad debt collection effort, and the method used to record the recovery of bad debts previously written off. After reviewing bad debt policies and procedures, the auditor should determine that only uncollectible deductible and coinsurance amounts are included in the calculation of reimbursable bad debts. The remaining steps of the exhibit outline the specific steps that the auditor should follow in its audit which include the method of sampling. These steps instruct intermediaries to utilize sampling methods in their audits.

The CMS Guidelines beginning at MIM §4112 assist intermediaries in complying with Government Auditing Standards which are issued by the Comptroller General of the United States. MIM §4112.4B states that evidence obtained during an audit must be sufficient to support the auditor's "conclusions, adjustments, and recommendations." Evidence must also be valid, reliable and have a logical relationship to the issue/subject under review. The MIM §4112.4B(1) indicates that "sampling" is recognized as a category of evidence to "ensure the propriety of costs claimed." Section 4112.4B(1)(e)[3] provides audit guidelines to Intermediaries for performing sampling and defines sampling as "the application of an audit procedure to less than 100 percent of the items within an account balance or class of transactions to evaluate some characteristic of the balance or class."

In this case, the record shows that the Intermediary used a statistical sampling software program developed by the Office of the Inspector General (OIG). The program requested that the Intermediary use a sample of nine random numbers from the universe size of 1099 and identified the random numbers that were to be used to identify patients to be selected for the sample. From this sample of nine, the Intermediary found three of the patients' billings sampled had errors in the collection efforts made by the Provider. The Intermediary found that, either there was partial indigency of the patient or the patient was not indigent, and that for

[3] See also CMS Transmittal No. A 92-5

both types of patient none of the required reasonable collection effort was made. The nine samples represented a total bad debt amount of $6,369. The three erroneous samples identified by the Intermediary represented a total bad debt claimed amount of $1,139. The Intermediary computed from these figures an error rate of approximately 18 percent. The 18 percent error rate was then applied to the total amount of bad debts claimed by the Provider ($765,000 less $86,278 that had been denied for other reasons). This resulted in a bad debt disallowance of $137,863, which the Provider appealed to the Board.

The Provider objected to the size of the sample of nine, approximately .8 percent of the entire universe, although the Provider did not dispute that three of the nine samples showed a lack of reasonable collection effort. Regarding the sample size, the Administrator notes that court cases addressing sampling make no mention of a statistical floor which auditor's must exceed in order to guarantee a provider's due process. Michigan Dept. of Education v. U.S. Department of Education, 875 F. 2d 196 (6th Cir. 1989) ("There is no case law that states how large a percentage of the entire universe must be sampled." Id. at 1206.); Ratanansen v. State of California,11 F. 3d 1467, 1472 (9th Cir. 1993) ("Indeed, the sample of 3.4 percent in the instant case exceeds that of the sample in Michigan where a random, stratified sample of .4 percent was used as a starting point for determining improper expenditures."); Webb v. Shalala, 49 F. Supp. 2d 1114 (W.D. AK. 1999) ("We do not believe there is a 'statistical floor.' ") Consequently, the Administrator finds that the sample size of .8 percent is not inherently inaccurate and does not otherwise deny the Provider due process in this case.

Moreover, the Provider submitted no rebuttal evidence demonstrating that the sampling represented an inaccurate estimate of the errors in the Provider's bad debt reasonable collection efforts. Consistent with general Medicare documentation rules of Section 1814 of the Act and the regulation at 42 CFR 413.9, 413.20 and 413.24, courts have concluded that it is not unreasonable to place the burden on the challenging party to present evidence to rebut the statistical sample.[4]

As noted by the court in Chaves County Home Health Service v. Sullivan, 931 F.2d 914 (D.C. 1991), in an effort to challenge the accuracy of the extrapolation, "a provider could separately present evidence of a different random sample from the universe of claims that yields a lower result of denials or prove that the projection is not a true estimate of the rate of denials in the nonsample universe. For instance, if a sampling projection estimated 100 percent denial in the non-sample universe, a provider could demonstrate that one or more of those

[4] See, e.g., State of Georgia v. Califano, 446 F. Supp. 404 (N. D. Ga. 1977); see also 5 USC 556(d).

unreviewed claims was proper…. The provider could always appeal the determination by establishing the validity of all or a sufficient number of its actual claims to demonstrate that the HHS projections is factually impossible of correctness." In this case, the Provider did none of the foregoing to disprove the accuracy of the Intermediary's sampling, nor did it otherwise submit any rebuttal evidence regarding the accuracy of the Intermediary's sampling estimate.

In addition, the Intermediary verified in its post-hearing brief that there was no duplication of the disallowances as the 18 percent extrapolation was applied to the adjusted bad debt claim of $756,000. The Intermediary also verified that none of the sampled cases which were used to develop the 18 percent extrapolation represented disallowances made for "other reasons"; e.g., as a result of prior year cases, desk review exceptions, the 120 day rule, etc. Consequently, the Administrator finds that the Intermediary has assured that its method does not result in any duplication of bad debts already disallowed

In sum, the Administrator finds that the Intermediary's actions were proper.[5] A review of record shows that the Provider did not demonstrate that the Intermediary's method involves an inherent bias in samples;[6] did not demonstrate that the Intermediary's findings with respect to the sampled patients' billings were inaccurate, and did not otherwise demonstrate by use of sampling or other means that the Intermediary's extrapolation was an inaccurate estimate. Accordingly, the Administrator reverses the Board's decision in this case.

---

[5] Even assuming arguendo, if the sample were found to be invalid, the Administrator disagrees with the Board that $136,723.60 would therefore be allowable. The proper remedy where a sampling is found to be invalid would be to remand the case for a statistically valid sampling to be conducted.

[6] See Intermediary Exhibit I-9. The sample diskette program supplied as Exhibit I-9 identifies the program as developed by OIG. The OIG is the investigative arm of HHS. The HHS OIG's audit focus is on HHS programs and operations and thus is more specific in focus than the General Accounting Office auditing standards. The Administrator finds that the use of the OIG program was appropriate in this case. Furthermore, while the program itself does not explain its methodology, the Provider did not point to any bias in the program that would indicate a flaw in the program, nor did the Provider allege, based on the sampled billings, that the Provider's documentation was not used by the Intermediary or was improperly inputted by the Intermediary.

## DECISION

The Board's decision is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 11/10/03

/s/
Leslie V. Norwalk, Esq.
Acting Deputy Administrator
Centers for Medicare & Medicaid Services