# CENTERS FOR MEDICARE AND MEDICAID SERVICES
*Decision of the Administrator*

| **In the case of:** | **Claim for:** |
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| **Doctors Hospital** | **Provider Reimbursement for Cost Reporting Period(s):** |
| **Provider** | **June 30, 2004** |
| **vs.** | |
| **BlueCross BlueShield Association/ CGS Administrators, LLC** | **Review of: PRRB Dec. No. 2012-D18 Dated: July 18, 2012** |
| **Intermediary** | |

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in Section 1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. 1395oo(f)). The Intermediary submitted comments requesting reversal of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Provider submitted comments, requesting affirmation of the Board's decision. CMS' Chronic Care Policy Group submitted comments, requesting reversal of the Board's decision. Accordingly, this case is now before the Administrator for final administrative review.

## ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary improperly disallowed Medicare bad debt expense; specifically, did it improperly disallow those claims from the sample review where the Provider was unable to produce all of the documentation from the patient file utilized to substantiate the indigence determination.[1]

[1] The Provider and the Intermediary entered into a stipulation of facts. Transcript of Oral Hearing (Tr.) at 8. Involved in this case is a sample by the Intermediary of 42 inpatient bad debt claims of which 9 were denied because of a lack of

The Board, reversing the Intermediary's adjustment, held that Intermediary improperly adjusted the Provider's bad debt claims. The Board found that the Provider's bad debt identification process was operationally consistent with its bad debt policy; produced documentation adequate to support claims as bad debts; and was in compliance with Medicare law and program policy requirements. The Board noted that section 312 of the Provider Reimbursement Manual (PRM). interprets the bad debt regulatory provision to allow a hospital to forego collection activity where it can establish that a patient was indigent and sets forth the guidelines for providers to use in establishing indigence.

In this case, the Board found that the Provider's bad debt policies and procedures are contained in its "Department Policy" — entitled "HCAP Policy/Charity Application Process." The Board noted that the Provider's policy makes use of the HCAP/Charity application which collects certain financial information and is intended to identify patients who need financial assistance and to assist such patients in qualifying for governmental reimbursement. The Board also found that the Provider's policy expressly recognizes that other forms of proof, such as verbal declarations, are necessary and acceptable means to prove income for purposes of bed debt write-off and reimbursement. The Board concluded that the application in combination with the Provider's documented practices meets the requirements of section 312 of the PRM.

In addition, for each of the bad debts at issue, the Board determined that, while the actual HCAP application that was used in the indigence determination could not be located, the Provider produced back-up information in the patient account notes to substantiate its determination of indigence and that this back-up information also complied with its policy. The Board also noted that during the time at issue, the Provider's bad debt policies and practices were contemporaneously reviewed by the Providers' independent auditor, who verified that the bad debt policies and practices were adequate and produced sufficient documentation. The Board found the Provider complied with all the regulatory and manual provisions to support its bad debt claims. Thus, the Board concluded that the Intermediary's requirement for specific supporting documentation is improper and unsupported by the governing law and manual provisions.

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documentation of indigence status. Likewise, this case involves 42 outpatient claims of which 3 were denied because of a lack of documentation of indigence status. The Administrator notes that bad debts for uncollected deductibles and coinsurance amounts relating to outpatient services that are reimbursed under a fee schedule payment are not allowable for Medicare cost reporting purposes. A total of three claims among the impatient and outpatient claims sampled by the Intermediary were denied "for other reasons" which the Provider does not dispute.

SUMMARY OF COMMENTS

The Intermediary submitted comments, requesting reversal of the Board's decision. In this case, the Intermediary pointed out that some of the accounts lacked documentation that patients indeed qualified as indigent. The Intermediary noted that the section 310 of the PRM clearly requires that the Provider's collection effort should be documented in the patient file. However, the Intermediary asserted that the documentation did not exist. Thus, the Provider failed to meet the documentation requirements set forth in Medicare law and policy.

The Provider submitted comments, requesting affirmation of the Board's decision. The Provider argued that the Board properly held that its claimed bad debts were appropriate and that the Board correctly applied the regulatory provision at 42 C.F.R. §413.89 and sections 310 and 312 of the PRM. The Provider claimed that its bad debt policy met the PRM's requirements and, consistent with that policy, it maintained documentation relative to the bad debt accounts to confirm that the indigency determination was made, by what means the determination was made, and to substantiate the indigency decision. However, the Provider asserted that the Intermediary improperly imposed a specific documentation requirement while ignoring the Provider's available documentation.

The Chronic Care Policy Group submitted comments, requesting reversal of the Board's decision. The Group noted the Provider's argument that comprehensive notes from its accounting system and data provided are consistent with Medicare bad debt policy. However, the Group argued that section 312 of the PRM clearly requires that a patient's indigence must be determined by the provider, not be the patient, i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence. The Group asserted that the Provider's sole use of notes from telephone conversations places reliance on the patient's oral declaration of the inability to pay and cannot be considered proof of indigence. Further, the Group pointed out that Provider's Exhibits P-3 and P4 show accounts written off to "HCAP Bad Debt" "Courtesy Allowance," and "Charity Bad Debt." The Group argued that pursuant to section 328 of the PRM, the Provider cannot claim the accounts for HCAP charity and then include the accounts as Medicare bad debt on the cost report for Medicare reimbursement. Finally, referring to the case of Harris County Hospital District v. Shalala[2], the Group maintained that the

[2] *See* 1995 WL 519990 (5th Cir. (Tex.)).

Administrator's decision reversing the Board in that case reflects the correction interpretation of section 312 of the PRM.

## DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Section 1861(v)(1)(A) of the Social Security Act requires that providers of services to Medicare beneficiaries are to be reimbursed the reasonable cost of those services. Reasonable cost is defined as the "the cost actually incurred, excluding therefrom 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 …" Id. This section does not specifically address the determination of reasonable cost, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable costs. 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. These principles are reflected and further explained in the regulations. The regulations at 42 CFR §413.9(c) provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries.

Further, section 1815(a) of the Social Security Act provides that: "no such payments shall 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 under this part for the period with respect to which the amounts are being paid or any prior period."

Consistent with the statute, 42 CFR 413.20 and 413.24" set forth the general documentation and accounting requirements. As noted above, the regulations at 42 CFR 413.20 and 413.24 require that providers maintain adequate financial records and statistical data for the accurate determination of costs reimbursable under Medicare. The process of determining such reimbursable costs involves the review of data available from the provider's usually-maintained accounts to arrive at the proper payment amounts for services to beneficiaries.

Specifically, the regulation at 42 CFR 413.24 sets forth the requirement that cost data and cost finding be adequate. That regulation provides, in part:

> Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.
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> …
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> Adequate cost information must be obtained from the provider's records to support payments made 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. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization

At the center of Medicare's cost reimbursement principles is the rule against cross-subsidization. The regulatory provision at 42 C.F.R. 413.89(d) states:

> The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts, which remain unpaid, are added to the Medicare share of allowable costs.[3]

Consequently, Providers may receive reimbursement for accounts claimed as Medicare bad debt, if they certain criteria. The regulation at 42 C.F.R. 413.89 (2004)[4] provides the principles and criteria for claiming Medicare bad debts. Sections (a) and (b) of that regulation provide the following:

> (a) *Principle*. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable cost; however, except for anesthetists' services described under paragraph (h) of this section, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the program.

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[4] Redesignated from 42 C.F.R. 413.80 pursuant to 69 *Fed. Reg.* 49254 (Aug. 11, 2004).

> (b) *Definitions*--(1) *Bad debts*. 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.
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> (2) *Charity allowances*. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient. Cost of free care (uncompensated services) furnished under a Hill-Burton obligation are considered as charity allowances.
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> (3) *Courtesy allowances*. Courtesy allowances indicate a reduction in charges in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances.

Further, the regulation at 42 C.F.R. §413.89(e) sets forth the specific criteria a provider must meet to claim a Medicare bad debt:

> (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.

Under the Secretary's interpretive authority, the PRM has been issued to clarify these regulatory provisions. Section 310 of the PRM elaborates on the burden of providers with regard to the collection efforts they must engage to demonstrate that an account for which reimbursement is sought is in fact a bad debt. Section 310B of the PRM specifically dictates, "<u>The Provider's collection effort should be documented in the patient's file.</u>" (Emphasis added).

Moreover, relevant to this case, section 312 of the PRM addresses the indigent or medically indigent patients. Such amounts are includable in allowable bad debts provided that the requirements of section 312 are met. That provision of the PRM provides that:

In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. 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 by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of 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.[5]

[5] The Administrator notes that the introductory paragraphs and paragraphs B. and D. uses the word "should", while paragraph A. and C. uses the word "must" However, "should" is "the past of shall" and "expresses an obligation and originated from the old English "owed""was obligated to" hence the interchangeable usage of the two words. The Merrian-Webster Collegiate Dictionary (1st ed. 2003) at 1153.
*See also* http://www.merianwebster.com/dictionary/should The word "shall" likewise means "will have to""must". *Id* at 1143.

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.

Thus, since Medicare's inception, providers have been required to maintain and furnish contemporaneous, adequate documentation capable of verification, on audit, to support their claimed costs, including bad debt costs.

Also relevant to this case, section 328 of the PRM provides for the cost treatment for charity, courtesy, and thirdparty payer allowances which are not reimbursable Medicare costs:

> Charity, courtesy, and third-party payer allowances are not reimbursable Medicare costs. Charges related to services subject to these allowances should be recorded at the full amount charged to all patients, and the allowances should be appropriately shown in a revenue reduction account. The amount reflecting full charges must then be used as applicable to apportion costs and in determining customary charges for application of the lower of costs or charges provision.
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> Example - The provider entered into an agreement with a third-party payer to render services at 25 percent below charges. Accordingly, for an X-ray service with a charge of $40, the provider billed the third party payer $30. The charge of $40 would be used to apportion costs and the $10 allowance would be recorded in a revenue reduction account.

Applying the foregoing provisions of Act, the regulations and instructions to the facts in this case, the Administrator finds that the Intermediary properly determined that Medicare could not reimburse the uncollected accounts at issue in this case. The Administrator notes that this case involves whether, consistent with Medicare law and policy, the Provider maintained and furnished adequate documentation to support a determination of indigence in order that the claimed bad debts could be deemed uncollectible.

The Administrator finds that the burden of proof rests with the Provider to maintain and furnish contemporaneous and verifiable documentation. In this case, the Provider argued that the Intermediary improperly required a specific documentation requirement while ignoring the Provider's available documentation. The Provider claimed that its summary notes, computer generated and stored logs, were sufficient to document the indigence determination process. However, the Administrator finds that the Intermediary properly determined that the Provider

failed to maintain and furnish adequate documentation capable of verification as required the regulations to support the subject bad debts.

Further, contrary to the Provider's arguments, patient account histories, i.e., computer generated and stored logs do not constitute adequate documentation capable of verification as evidence of the Provider's indigence determination. The indigence determination process must be pursued and documented, maintained, and be capable of verification and cannot merely consist of a computer generated database print out.[6] Providers have a burden to follow certain procedures and to document those procedures in rendering indigence determinations for the deeming provision to apply.

In this instance, the Provider failed to meet the regulatory and policy guideline documentation requirements.[7]

Moreover, the record shows that certain patient accounts were claimed as HCAP bad debts, courtesy allowance, and charity bad debts.[8] As instructed by the regulation at 42 C.F.R. 413.89(a) and section 328 of the PRM, such accounts cannot be claimed as Medicare bad debt and are not reimbursable.

Finally, the Administrator notes that the Provider's claim that the backup notes to substantiate an indigence determination complied with its written policy and that these policies were in place and operational during the period under review by the Intermediary.[9] Even assuming the Provider's written policy met the necessary

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[6] The HCAP/charity care application as it was the basis for the indigency determination, was the appropriate evidence that the Provider properly documented the financial status of patients.

[7] Moreover, this requirement is not discretionary, as suggested by the Board and the district court in Harris County. The Administrator notes that the 5 th Circuit Court of Appeals, in reviewing the district court in that case, stated "we need not address the issue of whether the hospital complied with all Medicare regulations because violation of the OBRA provides sufficient basis for affirming the district court judgment in favor of the hospital. Thus, as the 5 th Circuit did not address whether the hospital in that case complied with Medicare regulations, including documentation requirements, the Administrator finds that this case is not persuasive. In addition, the Administrator notes that the Provider in this case is not located in the 5 th Circuit and, thus, this case is not controlling in this instance.

[8] *See, e.g.*, Provider Exhibits P-3, P-4 and P-15.

[9] The Provider does not appear to be arguing that the bad debt moratorium prohibits the disallowance and, therefore, as no argument or documentation was presented on that issue it will not be addressed here.

Medicare regulations and policy to support reimbursement as Medicare bad debts, the logs presented do not show that the Provider conformed to its own practice. The Policy states that:

> Each write off will be supported by the following documentation:
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> 1. Registration face sheet or system printout showing comparable information.
> 2. Copy of DA card or Medifax screen print.
> 3. Charity application and or notes from computer system documenting conversion via phone.
> 4. Proof of income such as pay stubs, tax returns etc. as listed previously.
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> This policy recognizes that hard-copy proof of income may not always be available or practical to obtain, such as when the patient is homeless, lives beyond central Ohio, is not literate, etc. Other reasons exist but these are just examples. Therefore verbal declarations of income are considered accepted when validated by the signature of a hospital representative. Such determinations can be made when accounts originally written off to bad debts are reviewed for HCAP or charity classification."

While the internal policy allows self- reported income verification that is done under limited circumstances, such circumstances are not documented here, and the write-off can still only be done when the bad debt is reviewed for HCAP or charity classification, the record of which were not maintained for these subject amounts in this case.

Consequently, the Administrator concludes that the Provider failed to maintain and furnish adequate documentation to support the claimed bad debts at issue.

## 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: 9/11/12

/s/
Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services