PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2001-D5

PROVIDER -
Hemet Valley Medical Center
Hemet, California

Provider No. 05-0390

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of California

DATE OF HEARING-
July 27, 2000

Cost Reporting Period Ended -
June 30, 1994

CASE NO. 97-0693

INDEX

ISSUE:

Was the Intermediary=s determination of inpatient and outpatient Medicare bad debts proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hemet Valley Medical Center (AProvider@) is a general, short term district hospital located in Hemet, California. The Provider is one of three hospitals operated by Valley Health System, a local California hospital district. In its Medicare cost report for the fiscal year ended (AFYE@) June 30, 1994, the fiscal year under appeal, the Provider claimed Medicare bad debts in the amount of $108,908, consisting of $80,318 for inpatients and $28,590 for outpatients. The Provider claimed the bad debts under the 120-day guideline set forth in ' 310.2 of the Provider Reimbursement Manual (AHCFA Pub. 15-1"), which is the same methodology it used to claim the Medicare bad debts in prior fiscal years. In accordance with the manual guideline, the Provider made attempts to collect on an account, and after the account had aged at least 120 days from the date the first bill was sent to the patient, the Provider claimed the unpaid amount on its Medicare cost report for that year. Most of the Medicare bad debts claimed by the Provider for the FYEs June 30, 1986 through June 30, 1993 had been disallowed by Blue Cross of California (AIntermediary@) during the course of its audit of the respective cost reports.

In addition to its in-house collection efforts, the Provider utilized collection agencies as part of its attempt to collect past due accounts. During the first half of 1994, the Provider was informed by the Intermediary that bad debts referred to a collection agency would only be allowed as a Medicare bad debt when those accounts were returned from the collection agency to the Provider. In light of this requirement, the Provider prepared a bad debt log showing all of the Medicare bad debts that had been returned by its collection agencies in the FYE June 30, 1994.[1] The Provider presented this listing to the Intermediary during the course of the Intermediary=s audit of the FYE June 30, 1994 cost report, and requested that these bad debts be allowed in that cost reporting period. This bad debt listing showed inpatient Medicare bad debts of $375,856.78, and outpatient Medicare bad debts of $98,819.83, for a total of $474,676.61. This amount was subsequently reduced by the Provider to adjust for $12,488.16 of non-covered services, and to account for $42,642 of Medicare bad debts allowed in prior years.[2] Accordingly, the Provider is seeking the allowance of Medicare bad debts in the amount of $419,546.45 for the FYE June 30, 1994.

During the hearing before the Provider Reimbursement Review Board (ABoard@), the Board requested that the Provider address the amount at issue in this appeal ($474,676.61-Unadjusted Listing) rather

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[1] See Provider Exhibit P-13. **Note**: This listing was submitted as Exhibit F in the Provider=s initial position paper.

[2] See Provider Exhibits P-14 and P-15.

than the $108,908 of Medicare bad debts claimed in the filed cost report for the FYE June 30, 1994. In response to this request, the Provider states that the Board addressed a similar situation in its decision in Santa Marta Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 97-D16, December 5, 1996, HCFA Admin. Decl=d. Rev., Medicare and Medicaid Guide (CCH) & 44,937 (ASanta Marta@). Prior to the hearing in that case, the provider submitted a detailed bad debt log which reflected a revised claim of $76,217 in Medicare Part B bad debts in contrast to its original claim of $28,472 in Medicare Part A bad debts. The Board in Santa Marta rejected the intermediary=s contention that the amount of bad debts in controversy was limited to the amount originally claimed and disallowed. The Board reasoned that the provider had appealed the intermediary=s determination of the correct amount of bad debts, and had met the jurisdictional requirements of the statute and regulations. The Board held that the revised bad debt listing recategorized and identified additional bad debts, which was analogous to adding a new issue to the appeal prior to the hearing under 42 C.F.R. ' 405.1841. Accordingly, the Board concluded that the amount in controversy was not limited to the provider=s original claim and the intermediary=s audit adjustment. Under the governing law and reasoning applied by the Board in Santa Marta, the Provider contends that the entire amount of $474, 676.61 is properly before the Board in the instant case.

The Intermediary disallowed the Provider=s bad debts on the basis that the Provider=s bad debt listing indicated that the bad debt accounts were ten years old and prior, and that the Provider had no indication that these were claimed in prior years.[3] The Provider, dissatisfied with the Intermediary=s adjustments to its cost report and refusal to allow the bad debts returned from the collection agencies in the FYE June 30, 1994, appealed the Medicare bad debts determination to the Board and has met the jurisdictional requirements of 42 C.F.R. '' 405.1835-.1841. All other issues appealed by the Provider were resolved by the parties prior to the hearing. The Provider was represented by Jeffrey R. Bates, Esquire, of Foley & Lardner. The Intermediary=s representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER=S CONTENTIONS:

The Provider contends that it is entitled to reimbursement for the Medicare bad debts that were returned by its collection agencies during the FYE June 30, 1994. The bad debts listed on the reports from its two collection agencies met the four criteria set forth in 42 C.F.R. ' 413.80 (e) in that: (1) The debts were related to covered services and derived from deductible and coinsurance amounts; (2) Reasonable in-house collection efforts were undertaken before the accounts were sent to a collection agency; (3) The debts were actually uncollectible and were returned from the collection agencies as worthless; and (4) Sound business judgement established that there was no likelihood of recovery in the future.

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[3] See Provider Exhibit P-5.

The Provider notes that, in its Medicare cost reports for prior years and the 1994 fiscal year in contention, it claimed Medicare bad debts under the 120-day guideline in HCFA Pub. 15-1 ' 310.2. However, the Intermediary instituted a new policy whereby it would allow bad debts that had been sent to a collection agency only when they were returned by the collection agency to the Provider as uncollectible.[4] In response to the Intermediary=s change in policy, the Provider contends that the bad debt listings submitted to the Intermediary should have been allowed since they were returned from the collection agencies for the year in question. In prior fiscal years, the Intermediary disallowed the bad debts claimed because they had been sent to a collection agency, and the collection agency had not yet returned the bad debts to the Provider. Accordingly, the Provider believes that it is now being disadvantaged by the Intermediary=s policy change because the Intermediary still refuses to allow the bad debts even though the collection agencies returned them in the FYE June 30, 1994.

The Provider points out that the Intermediary has never contended that the bad debts were claimed prematurely and that there was a likelihood of future recovery. Instead, the Intermediary contends that the bad debts are Atoo old@ and became uncollectible prior to the FYE June 30, 1994. The Provider notes that the Intermediary is unable to cite any regulation, manual provision or other guidance setting forth a limit on the time that a bad debt can be at the collection agency. In the instant case, the collection agencies only notified the Provider when they collected on an account in order to obtain their collection fee. The collection agencies did not return unpaid accounts to the Provider as there was no reason for them to do so. The Provider further notes that the Health Care Financing Administration (AHCFA@) has recognized in a program memorandum that Aa debt referred to a collection agency can sometimes be considered as pending indefinitely - i.e., for as long as the collection agency retains the claim and does not return it to the provider or actually inform the provider that it is uncollectible.@[5] Consequently, bad debts that had been sent to a collection agency would necessarily be older when claimed because of the time needed for the collection agency to attempt to collect the accounts before they could be claimed and allowed for Medicare reimbursement purposes.

The Provider notes that one of the original justifications given by the Intermediary for its disallowance of the Medicare bad debts was that the Provider had no indication that the bad debts were claimed in prior years. The Provider interprets this as evidencing a concern on the Intermediary=s part that the Provider not be reimbursed twice for the same bad debts. The Provider asserts that under its proposed methodology, there is no risk of double payment. If the Board agrees that the amounts on Exhibit P-13 are allowable Medicare bad debts in the FYE June 30, 1994, those amounts should be reduced by the amount of Medicare bad debts allowed by the Intermediary in prior years. The Provider proposes an offset of $42,462, which represents the bad debts that were allowed by the Intermediary for FYE June 30, 1986 through FYE June 30, 1993, with the exception of FYE June 30, 1989 and FYE June 30,

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[4] See Provider Exhibits P-1, P-2, P-3 and P-10.

[5] See Provider Exhibit P-3.

1993.[6] This offset prevents any possibility that the Medicare program would be paying the Provider twice for the same bad debts. As to the Intermediary=s conclusion that the bad debts at issue must have become worthless in prior years, the Provider suggests that this argument is nothing more than guesses and assumptions on the part of the Intermediary, and is not supported by the evidence presented at the hearing with respect to the Provider=s bad debt collection practices. Further, this is also inconsistent with the Intermediary=s allowance of the bad debts that were returned by the collection agencies in the FYEs June 30, 1989 and June 30, 1993. The documentation relied upon by the Intermediary in those years is similar to the documentation submitted by the Provider to support its claim for the FYE June 30, 1994. The Provider also notes that the Intermediary is currently allowing bad debts claimed in later cost reporting periods based on the return of bad debts from the collection agencies.

As to the Intermediary=s claim that the contract between the Provider and one of its collection agencies contained certain limitations on collection efforts for Medicare bad debts that it did not have for non-Medicare bad debts,[7] the Provider contends that this contract language does not by itself establish that different collection efforts were used for Medicare bad debts. The Provider notes that the Intermediary=s witness acknowledged that the Intermediary did not know whether the collection agency=s efforts to collect Medicare bad debts were different in practice than its efforts to collect non-Medicare bad debts.[8]

Finally, the Provider argues that the Intermediary=s failure to allow the Medicare bad debts results in impermissible cost shifting in direct violation of the statutory provisions of 42 U.S.C. ' 1395x(v)(1)(A), and the general cost reimbursement principles set forth in 42 C.F.R. ' 413.5. This prohibition is specifically addressed in the bad debt regulation at 42 C.F.R. ' 413.80(d) which states that Medicare reimburses providers for unpaid Medicare deductibles and copayments A[t]o assure that such covered service costs are not borne by others.@ The Provider believes the evidence presented clearly demonstrates that it attempted to collect the deductible and coinsurance amounts from the beneficiaries prior to claiming them as Medicare bad debts, and that all of its unpaid accounts were turned over to a collection agency for additional collection efforts. Further, the Intermediary acknowledged that its disallowance of bad debts related to Medicare services results in cost shifting.[9] Pursuant to the prohibition against cost shifting and the Intermediary=s inconsistent application policy regarding the allowability of bad debts, the Provider concludes that the Board should reverse the Intermediary=s determination and allow bad debts in the amount of $419,546 in the Provider=s cost report for the FYE June 30, 1994.

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6 See Provider Exhibits P-14 and P-15.

7 See Intermediary Exhibit I-2.

8 Tr. at 132-136.

9 Tr. at 150-152.

INTERMEDIARY=S CONTENTIONS:

The Intermediary contends that it properly disallowed the Medicare bad debts claimed by the Provider in accordance with the specific reimbursement policy set forth under the Medicare program. The regulations at 42 C.F.R. ' 413.80 establish the requirements and criteria for the allowability of Medicare bad debts as follows:

> (d) Requirements for Medicare. Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, costs of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services rendered to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductible and coinsurance amounts could 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 that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not allowable costs.
>
> (e) Criteria for allowable bad debt. A bad debt 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.

42 C.F. R. ' 413.80(d) and (e).

Pursuant to the regulatory criteria, the primary requirement for the allowability of Medicare bad debts related to uncollected deductible and coinsurance amounts for covered services is that a provider must make a reasonable collection effort. Generally, this requires prompt and effective collection efforts with Medicare bad debts being handled the same as debts due from other payors. While the use of a collection agency is not a specific requirement, a provider must refer Medicare bad debts to a collection agency if it uses an agency to pursue non-Medicare patient accounts. The manual provisions at HCFA Pub. 15-1 ' 310 state the following with respect to a reasonable collection effort:

> 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 the 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.
>
> 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 Alike 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.
>
> 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 contacts, etc.

The Intermediary acknowledges that the use of a collection agency for Medicare bad debts has been a point of special controversy. In the instant case, the factor that appears to be driving the issue in dispute is a policy statement relating to the use of collection agencies, and the point in time when a bad debt can be claimed.[10] Pursuant to HCFA=s policy statement, if a provider referred accounts to a collection agency, they would not be considered worthless until the agency returned the account to the provider. It is at that point that there is no likelihood of recovery at any time in the future. The Intermediary believes this general statement reflects sound policy. By tracking a collection agency=s efforts and the return of accounts to the provider, an intermediary can ascertain that the collection agency is making a reasonable effort to collect, and can also establish a specific point in time when any reasonable pursuit is over. Otherwise, a provider can send a Medicare account to a collection agency to satisfy a technical reimbursement requirement, but the collection agency is not making a reasonable effort to collect or is not making an effort comparable to other patient accounts. The Intermediary argues that the Provider=s Medicare bad debts claimed for the FYE June 30, 1994 was an effort to take advantage of the above discussed policy change, and to resurrect a bad debt claim that had long since lapsed.

The Intermediary points out that the amount of Medicare bad debts claimed by the Provider and its current position on this matter have shifted since the filing of its Medicare cost report for the FYE June 30, 1994. The original Medicare bad debts claimed on the cost report were based on the 120-day rule and consisted of inpatient bad debts of $96,326 and outpatient bad debts of $34,446.[11] The fact that the bad debts were sent out to a collection agency was not part of the initial claim. During the Intermediary=s audit of the cost report, the Provider totally changed its theory on the amount of its bad debts claim. Alleging that communication of the Intermediary=s position that it was premature to claim bad debts that were referred to a collection agency until the agency affirmatively returned the account, the Provider reconsidered its original claim and substantially increased the dollar value to reflect a total bad debt claim of $474,671.61. This increase resulted from a contact with collection agencies used by the Provider, and a request that they provide a listing of Medicare bad debts that were shown as open.[12] This revised listing of Medicare bad debts, which consisted of a 105 page printout with approximately 1,750 line items, was presented to the Intermediary for consideration during the audit of the Provider=s cost report. The individual line items were described by the Provider as accounts returned by the collection agencies at various times during the FYE June 30, 1994 where no further collection activity would take place.

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[10] See Provider Exhibits P-1, P-2 and P-3.

[11] See Provider Exhibit P-5/Intermediary Exhibit I-1. - Original amounts claimed included Medicare/Medicaid crossover bad debts which are no longer an issue in this case.

[12] See Provider Exhibit P-13.

The Intermediary states that its reaction to the Provider=s revised bad debts claim was somewhat reflexive and, thus, the relevant workpapers and audit adjustment report included the following explanation:

> To adjust the Medi/Medi crossover bad debts claimed to agree with the Providers= bad debt listing & related supporting documentation. To disallow the Medicare bad debts (Part A & B) claimed since the bad debt accounts are 10 years old & prior and that provider had no indication that these were claimed in prior years.

In response to the Intermediary=s audit adjustment, the Provider offers various solutions and arguments which the Intermediary believes do not address the fundamental problems at issue. As to the concern that the bad debts may have been claimed and paid in prior years, the Provider suggests that this can be resolved by offsetting the bad debt amounts allowed in prior years against the new 1994 claim. Regarding the age of the bad debts claimed, the Provider argues that this factor is of no significance for two reasons: (1) The accounts were not returned by the collection agencies until fiscal year 1994 and that is the reimbursement trigger under the Anew@ Intermediary policy; and (2) There is no discrete requirement as to when a bad debt must be claimed in relation to the service date. While the Intermediary believes that the Provider=s offset approach may cure the potential duplication problem, it believes the age of the bad debts claimed presents a more serious dilemma. Based on a sample analysis of the Provider=s bad debts listing derived from the accounts returned by the collection agencies, the Intermediary prepared the following aging schedule based on the service dates of the Medicare patients listed:

Fiscal Year Ended	Percentages
June 30, 1986	16.5%
June 30, 1987	7.0%
June 30, 1988	15.3%
June 30, 1989	20.0%
June 30, 1990	10.6%
June 30, 1991	15.3%
June 30, 1992	12.9%
June 30, 1993	2.4%
June 30, 1994	-
	100.0%

While the Intermediary admits that its analysis is not scientifically valid, the Provider has not challenged the accuracy of the percentages. The Intermediary believes the analysis is usable, and that the age of the bad debts when coupled with other factors is an adequate predicate for defeating the Provider=s claim. The analysis shows that the services representing the bad debts claimed for the FYE June 30,

1994 were fairly evenly dispersed between 1986 and 1992, with a small amount in 1993 (2.4%) and none in 1994.

The Intermediary contends that an objective view of Provider=s revised bad debts claim cannot be sustained based on the age of the patient accounts and the time limit for claiming bad debts under existing Medicare policy. The regulation at 42 C.F.R. ' 413.80 (f) specifies the following:

> (f) Charging of bad debts and bad debt recoveries. 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. . . .

42 C.F.R. ' 413.80 (f).

The regulatory requirement is reiterated in HCFA Pub. 15-1 as follows:

> Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable bad debts must be related to specific amounts which have been determined to be uncollectible.

HCFA Pub. 15-1 ' 314.

The Intermediary reasons that, in order for the Provider=s 1994 bad debts claim to comply with the above authorities, the Provider must ask for the acceptance of the proposition that its collection agencies actively pursued all accounts for two to nine years, and then made a decision sometime after July 1, 1993 that further efforts would be useless. The Intermediary=s conclusion based upon common sense, experience with the collection process, and review of the timing and minimal amounts of collection success is that the accounts claimed by the Provider were objectively worthless long before July 1, 1993. Based on its review of the Provider=s bad debts listing, the Intermediary observed that some recovery was made by the collection agencies on 8.2 percent of the debts. Further analysis of this minimal collection success revealed that any recovery that was made was in close proximity to the service date.

The Intermediary contends that Medicare policy puts a limit on when a bad debt can be claimed and when a claim becomes stale. Accordingly, it is the Intermediary=s position that the presence of all old claims on the 1994 Medicare bad debts list logically resulted from an over due effort to follow up with the collection agency on long dead accounts, rather than the collection agencies= affirmative decision to give up on specific accounts on the dates referenced. If a collection agency is utilized, a timely claim will help insure that the creditor is monitoring the collection activities. If the collection agency=s results are minimal (under 10 percent in the instant case), a provider will understand why and make a decision as to

whether a change of agency is needed, or whether more effort is needed or given to the patient population. The Intermediary notes that the testimony of the Provider=s witness clearly shows that the Provider was not monitoring the activities of the collection agencies.[13] Whereas the agreement with one of the Provider=s collection agencies called for extensive reporting,[14] the record demonstrates that the Provider never enforced this requirement. The Intermediary further notes that, when section 5(I) of the agreement is read in context with the agency=s other collection procedures set forth in sections 5(A) to 5(K), the only conclusion is that restraints were put on the collection of Medicare accounts that were not applicable to other debtors.

In summary, the Intermediary believes that all that can be derived from the Provider=s Medicare bad debt listing of accounts returned by its collection agencies during the FYE June 30, 1994 is that the collection results for Medicare patients were minimal. Whether that outcome resulted from a level of collection effort that was different for Medicare versus non-Medicare patients is an open question. However, the question is secondary to the primary consideration of whether the Provider=s collection agencies actually pursued the Medicare bad debt accounts identified in Provider Exhibit P-13 until some point in the FYE June 30, 1994. An objective view of the facts can lead only to the conclusion that collection activity ceased long before the Provider contacted its collection agencies to obtain an account listing to support a revised Medicare bad debt theory. The Intermediary notes that a review of prior year claims and disallowances makes the fact patently obvious that the revised fiscal year 1994 Medicare bad debts claim was nothing more than a reiteration of prior efforts that failed.[15] The Provider has not established any basis for allowing additional Medicare inpatient and outpatient bad debts, and the old bad debts claimed in the FYE June 30, 1994 should not be allowed under a new theory. The Intermediary concludes that its determination was proper, and that the Board should deny the Medicare bad debts claimed by the Provider.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

   '1395x(v)(1)(A) - Reasonable Cost

2. Regulations - 42 C.F.R:

   '' 405.1835-.1841 - Board Jurisdiction

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[13] Tr. at 78.

[14] See Intermediary Exhibit I-2 (Section 1B).

[15] See Intermediary Posthearing Exhibit A-(Requested by the Board at Tr. 100).

' 413.5 - Cost Reimbursement: General

' 413.80 et seq. - Bad Debts, Charity, and Courtesy Allowances

3. Program Instructions - Provider Reimbursement Manual, Part I(HCFA Pub.15-1):

'310 - Reasonable Collection Effort

'310.2 - Presumption of Non-collectibility

'314 - Accounting Period for Bad Debts

4. Case Law:

Santa Marta Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 97-D16, December 5, 1996, HCFA Admin. Decíd Rev., Medicare and Medicaid Guide (CCH) &44,937.

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties= contentions, evidence presented, testimony elicited at the hearing, and post-hearing briefs, finds and concludes as follows:

Upon analysis of the complete record presented by the parties in this case, the Board finds that the main issue to be decided concerns the timeliness of the bad debt accounts associated with the collection agencies= listings that were furnished by the Provider to the Intermediary for FYE June 30, 1994. In response to the Intermediary=s requirement that bad debts referred to a collection agency would only be allowed as Medicare bad debts when those accounts were returned from the collection agency, the Provider presented its bad debts listings to the Intermediary and requested that these returned bad debts be allowed in the 1994 cost reporting period. The Intermediary denied the entire amount of the bad debts claimed by the Provider based on its determination that the accounts were Atoo old.@ However, the Board finds that there is no timeliness provision under the bad debt regulations at 42 C.F.R ' 413.80 et seq. as to when bad debt accounts must be returned by a collection agency.

In response to the Board=s request for a break down of the claimed bad debts by the year in which they were referred to the collection agency, the Provider submitted the following schedule with its post-hearing brief which identified the claimed bad debts by the year of the bad debt date:[16]

[16] See Provider Exhibit P-20.

Medicare Bad Debts Shown on Bad Debt Log
(Provider Exhibit P-13) Sorted by Year of Bad Debt Date

	Amount		
Year	Inpatient	Outpatient	Total
FYE 6/30/86	$ 7,574.18	$ 1,412.54	$ 8,986.72
FYE 6/30/87	35,771.23	6,150.63	41,921.86
FYE 6/30/88	34,711.86	5,117.57	39,829.43
FYE 6/30/89	47,692.94	12,212.67	59,905.61
FYE 6/30/90	26,947.45	8,504.74	35,452.19
FYE 6/30/91	99,687.22	26,295.77	125,982.99
FYE 6/30/92	76,044.19	26,174.35	102,218.54
FYE 6/30/93	43,381.92	11,653.52	55,035.44
FYE 6/30/94	1,714.05	79.59	1,793.64
TOTALS	$373,525.04	$97,601.38	$471,126.42[17]

The Board notes that the Intermediary=s witness testified that several of the Provider=s bad debt settlements in prior years relied upon collection agency listings similar to the listing prepared for the FYE June 30, 1994.[18] Further, the Intermediary is currently allowing bad debts claimed in the Provider=s cost reports for later years based on the return of the bad debts from the collection agency.[19] Since there is evidence in the record that the Provider=s bad debts listings from its collection agencies are being routinely utilized by the Intermediary for the settlement of bad debts claimed by the Provider, the Board believes that the same recognition must be given to the bad debts listings submitted for the FYE June 30, 1994.

Based on the evidence presented, the Board finds that the only bad debt accounts returned by the collection agencies during the year in contention which were not previously considered by the Intermediary in the settlement of the Provider=s bad debts claimed in prior years pertain to the FYEs June 30, 1993 and 1994. Accordingly, the Board concludes that the Provider is entitled to reimbursement for Medicare bad debts in the amount of $56, 829.08 for the FYE June 30, 1994. This

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[17] The Provider noted that there is a variance of $3,552.39 between this analysis and the total amount of $474,678.81 reflected on Provider Exhibit P-13. Amounts reported exclude Medicare - Medicaid crossover bad debts.

[18] Tr. at 157-159.

[19] Tr. at 60.

amount consists of the bad debt accounts that were referred to a collection agency during FYE June 30, 1993 ($55,035.44) and FYE June 30, 1994 ($1,793.64), and were returned to the Provider during the FYE June 30, 1994 as uncollectible bad debts that did not warrant further collection efforts. The Board finds the Intermediary=s total disallowance of the entire amount of Medicare bad debts claimed by the Provider for the FYE June 30, 1994 to be unsupported by the evidence presented, and inconsistent with the proper application of the bad debt policy set forth under the Medicare program.

DECISION AND ORDER:

The Intermediary=s determination of inpatient and outpatient Medicare bad debts was not proper. The Intermediary=s determination is modified to allow the Provider Medicare bad debts in the amount of $56,829.08 for the FYE Jun 30, 1994.

Board Members Participating

Irvin W. Kues
Henry C. Wessman, Esquire
Martin W. Hoover, Esquire
Charles R. Barker
Stanley J. Sokolove

Date of Decision: December 04, 2000

FOR THE BOARD

Irvin W. Kues
Chairman