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Medicare Bad Debts — Providers Win One and Lose One in the Courts

Leslie Demaree Goldsmith
410-347-7333
ldgoldsmith@ober.com

Two courts, the United States District Court and the Court of Appeals for the District of Columbia, each recently issued a decision addressing a provider's right to Medicare bad debt reimbursement. The district court upheld a provider's right to Medicare reimbursement for bad debts even though the provider did not uniformly apply an asset test to determine its patients' indigence. The court of appeals disallowed bad debt reimbursement to skilled nursing home providers' related to therapy services paid pursuant to a fee schedule.

No Asset Test Need Be Applied

In *Baptist Healthcare System v. Sebelius*, DDC, No. 1:08-cv-00677-AW (Aug. 18, 2009), the hospital's bad debt policy required patients with debts greater than $800 to complete a financial disclosure form, including information related to both income and assets. Patients with bad debts under $800 did not need to complete the disclosure form. The intermediary disallowed all of the Medicare bad debts for the years at issue, cost reporting years 1999, 2000 and 2001, because the hospital did not perform an asset test for all indigent patients. The Provider Reimbursement Review Board (Board) reversed the intermediary's denial of bad debt costs, but the CMS Administrator reversed the Board's decision.

The district court, in turn, reversed the Administrator. The district court's decision turned on its determination of the meanings of "must" and "should" as those terms are used in section 312 of the Medicare Provider Reimbursement Manual (PRM). That section states that: "the provider *should* apply its customary methods for determining indigence"; "the patient's indigence *must* be determined by the provider"; "[t]he provider *should* take into account a patient's total resources which would include…assets [and] *should* take into account any extenuating circumstances"; "[t]he provider *must* determine that no source other than the patient would be legally responsible"; and the "patient's file *should* contain documentation…." PRM § 312 (emphasis added).

The court determined that the words "must" and "should" are not synonymous in the context of government regulations, manuals or everyday usage.

Donna J. Senft

Susan A. Turner

Associates

Kristin Cilento Carter

Joshua J. Freemire

Mark A. Stanley

Lisa D. Stevenson

Specifically, the court found that the two words do not carry the same meaning in the context of PRM § 312, and ruled that the provider was not required to apply the asset test to determine patient indigence. Accordingly, the Medicare bad debt costs could not be disallowed because the provider did not uniformly apply an asset test to all of its indigence determinations.

No Bad Debt Reimbursement for Costs Reimbursed Under a Fee Schedule

The court of appeals in *Abington Crest Nursing & Rehabilitation Center v. Sebelius*, D.C. Cir., No. 08-5120 (Aug. 4, 2009), upheld the denial of Medicare reimbursement for bad debt costs associated with therapy services. The providers, all skilled nursing facilities, claimed Medicare bad debt associated with unpaid deductible and coinsurance amounts for therapy services reimbursed under Medicare Part B based on a fee schedule during their 1999 fiscal year. Although the Board held that the intermediary had improperly denied the providers' bad debt costs, the CMS Administrator reversed. The district court affirmed the CMS Administrator's decision, and the court of appeals affirmed the district court's ruling. The court ruled that the Secretary's action did not violate the Medicare statute's prohibition against cross-subsidization, deferring to the Secretary's interpretation that the prohibition applies only to reasonable cost reimbursement and not to costs reimbursed under a reasonable charge or fee schedule methodology.

Ober|Kaler's Comments:

- While the district court's decision permitting a provider's claim for bad debt where no asset test was applied to determine patient indigence is helpful to providers, it is likely this decision will be appealed to the United States Court of Appeals for the District of Columbia Circuit. Providers with this fact pattern should be sure to appeal any similar denial by their intermediaries to the Board to preserve their appeal rights, but stay tuned for the higher court's ruling in this matter.

- The court of appeals' ruling that there is no Medicare bad debt reimbursement for costs paid under a fee schedule is final in the D.C. Circuit. One other case on this issue has been appealed to the United States District Court for the Central District of California, but there has not been a decision rendered in that case. *Vitality Rehab v. Leavitt*, C.D. Calif., Case No. 2:08-cv-04575-VBF-SH.

- The final decision on these issues from the United States Court of Appeals for the District of Columbia Circuit is potentially of significance to all providers, as it will influence the court in which providers chose to file their judicial appeals from adverse Board or CMS Administrator decisions. Specifically, providers have a choice to appeal any final administrative decision, i.e., decision of the Board or CMS Administrator, to either the United States District Court for the District of Columbia or to the United States District Court in the federal district where the provider is located. If the only issue in the provider's appeal is the bad debt issue of whether an asset test must be applied in the determination of patient indigence, then providers should consider the United States District Court for the District of Columbia, if the *Baptist* decision is not reversed by the court of appeals for that circuit. However, if the only issue in an appeal is the allowability of bad debts paid under a fee schedule, the forum choice now becomes easy: Judicial review should be sought in the "home court" (assuming the circuit court for that district has not yet decided this issue) rather than in the United States District Court for the District of Columbia.