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Medicare Bad Debts: Recent District Court Decision Undermines CMS's Must-Bill Policy

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The United States District Court for the District of Columbia recently issued a decision that could prove favorable to Medicare providers struggling with CMS's asserted "must bill" policy on dual eligible bad debts. *Summer Hill Nursing Home, LLC v. Johnson*, civil action no. 08-268 (RMC) (March 25, 2009).

The Intermediary's Disallowance

The case stems from a nursing home's appeal to the Provider Reimbursement Review Board (Board) regarding its fiscal intermediary's disallowance of claimed bad debts relating to uncollectible deductible and co-insurance amounts for "dual eligible" patients. The Intermediary disallowed the bad debts on the basis that the nursing home wrote off the bad debts prior to billing the state Medicaid program for the uncollected amounts. Stated another way, the nursing home did not comply with CMS's "must bill" policy. After receiving the disallowance, the nursing home billed the Medicaid program and received remittance advices stating that the Medicaid program would not provide payment towards the uncollected amounts. After it obtained this documentation, the nursing home filed its appeal with the Board.

The Board and CMS Administrator's Decisions

The Board reversed the intermediary's disallowance, concluding that the "must bill" policy has no foundation in the law and that it is beyond the requirements of the Medicare regulations and Provider Reimbursement Manual (PRM). The Administrator reversed the Board's decision, but concluded it did need to address the Board's conclusion regarding the legality of the must-bill policy. Rather, the Administrator found that a reversal was warranted based on its finding that the bad debts were not worthless when written-off. Because the provider did not bill the Medicaid program and receive a remittance advice, it did not perform reasonable collection efforts necessary to demonstrate the bad debts were uncollectible.

The Court's Opinion

On appeal before the Court, the Secretary asserted that providers must bill the

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state Medicaid program and receive a remittance advice before claiming a bad debt as worthless and uncollectible. To the Court's dismay, the Secretary did not provide any explanation why the nursing home's subsequent receipt of a remittance advice was insufficient to establish that the bad debts were actually uncollectible when claimed. For this reason, the Court found that the Secretary's decision lacked any basis upon which the Court could conclude his decision was based on reasoned decision making.

The Court was not swayed by the citation to CMS' Joint Signature Memorandum (JSM) – 370, cited by the Secretary's counsel. JSM-370 states that "the provider must make certain that no source other than the patient would be legally responsible for the patient's medical bill… prior to claiming the bad debt from Medicare." The Court pointed out that this reasoning was not included in the Administrator's decision, that the Secretary's counsel cannot assert a *post hoc* rationalization in place of the agency's explanation, and that the agency had not articulated such a satisfactory explanation.

This finding, by itself, would suggest that, had the Administrator supported its reversal of the Board with a citation to JSM-370, the Court would have upheld the Secretary's decision. That is not all the Court said, however. In the last sentence of its analysis, the Court challenged the substance and relevance of JSM 370. The Court stated that JSM-370 does not provide a rationale for why remittance advices received after a claim is filed but prior to the Secretary's decision must be disregarded, considering the remittance advice establishes that the debts were actually uncollectible when claimed.

Ober|Kaler's Comments: While the Court did not address the legal basis of CMS's "must bill" policy, as the Board did, it certainly challenged its application. CMS and its intermediaries have consistently touted JSM-370 as clear authority requiring providers to bill state Medicaid programs and receive remittance advices **before** claiming dual eligible bad debts, pursuant to the must-bill policy. In contrast, this Court stated that JSM-370 does not provide any rationale why a provider must obtain a remittance advice before claiming the bad debts. The Court seems to conclude that, to the extent a remittance advice demonstrates a bad debt's uncollectibility, such documentation should be taken into consideration even if the provider receives the remittance advice after the provider submits its claim for the related bad debt, but before the Administrator's decision.

We would expect the Secretary to appeal the district court's decision, and the true impact of the case won't be known until then. In the meantime, providers that have claimed dual eligible bad debts prior to billing Medicaid may want to consider billing Medicaid now, if they are awaiting audit or have received disallowances and are in the administrative appeals process.