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Medicare Reimbursement Appeals Legal Alert

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Recent Decisions Extend Equitable Tolling to Reimbursement Disputes & Allow for Bad Debt Reimbursement While Collection Efforts Continue

For providers who miss the timeframe to appeal a cost report reimbursement issue to the Provider Reimbursement Review Board ("PRRB"), or who later identify issues that were not known during the appeal window, a recent decision by the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") may provide a basis to bring a late appeal. The D.C. Circuit recently held that equitable tolling can be appropriate to extend the statute of limitations for disputing Medicare cost reimbursement determinations by intermediaries.[1] Under this ruling, if the PRRB determines that it lacks jurisdiction because an appeal is not timely filed, the U.S. District Court for the District of Columbia ("District Court") may apply equitable tolling principles to review the decision and the intermediary determination.

Separately, the PRRB issued a pair of decisions[2] concluding that uncollectible Medicare co-insurance and deductible amounts can be reimbursed as bad debts *even if* collection efforts continue by an outside collection agency. The PRRB also determined that the bad debt moratorium passed in the Omnibus Budget Reconciliation Act of 1987 barred the subsequent audit guidance from CMS instructing intermediaries to disallow bad debts where outside collection efforts are ongoing. Under these decisions, providers would not need to choose between continuing to pursue the collection of co-insurance and deductible amounts and claiming those amounts as Medicare bad debts. However, similar cases reviewed by the CMS Administrator have concluded otherwise.

Please feel free to reach us at the phone number or email address to the left if you have questions about how these decisions could help you challenge an adverse reimbursement determination.

Equitable Tolling of PRRB Appeal Deadlines

In *Auburn Regional Medical Center v. Sebelius*, the D.C. Circuit first reaffirmed its earlier holdings that when the PRRB dismisses an appeal for lack of jurisdiction it becomes a "final decision" for the District Court to review. More importantly, the D.C. Circuit held that the presumption of equitable tolling applies in Medicare cost report disputes. The doctrine of equitable tolling allows a court to hear an action that would otherwise be barred by the statute of limitations if the party bringing the action could not or did not discover the circumstances giving rise to the action despite the exercise of reasonable due diligence. By making this doctrine available in Medicare cost report disputes, the D.C. Circuit has opened the door for Medicare providers to appeal cost report reimbursement issues

to the PRRB long after the standard 180-day period to file an appeal passes.

The case arose out of an appeal that was filed with the PRRB in 2006, over a decade after the statute of limitations for challenging the relevant disproportionate share hospital ("DSH") payments had expired. Information that came to light in another case caused the providers to believe that CMS had miscalculated the DSH percentage used to determine payments to providers in fiscal years 1987 to 1994, underpaying providers as a result. The PRRB dismissed the claim, noting that it lacked authority to toll, or extend, the statute of limitations period. The providers filed a civil action in the U.S. District Court for the District of Columbia, but that court also dismissed the providers' action, finding that the PRRB's determination that it could not toll the statute of limitations was not a "final decision," and thus was not reviewable.

The D.C. Circuit reversed, holding that the PRRB's dismissal was clearly a final decision, and further that the District Court could consider whether to apply the doctrine of equitable tolling here. In reaching this decision, the D.C. Circuit differentiated the Medicare statute from other statutes where equitable tolling is unavailable, stating:

> It is true that as a general matter, the Medicare statute, like the Internal Revenue Code, is quite complex. But unlike the tax code, the Medicare statute does not create a detailed Jenga tower of deadlines and exceptions that equitable tolling might topple. Rather, its timing scheme is straightforward and readily amenable to tolling.

The case was remanded back to the District Court to determine if the facts supported an untimely appeal under this doctrine.

Bad Debt Collection Efforts

The PRRB issued two decisions in cases where providers sought reimbursement for uncollectible co-insurance and deductible amounts (*i.e.*, cost sharing) after 120 days of collection efforts but where outside collection agencies continued to pursue payment from beneficiaries. In both cases, the Medicare intermediary refused to reimburse the claimed amounts as Medicare bad debts. The PRRB reversed these determinations, deciding that continuing outside collection efforts do not bar a provider from claiming cost sharing amounts as bad debts.

The providers had an established policy to try to collect outstanding balances due from patients internally before referring unpaid accounts to collection agencies. Upon sending the accounts to collection agencies, the providers simultaneously wrote the accounts off as uncollectible bad debts.

Medicare will reimburse providers for bad debts resulting from unpaid Medicare co-insurance and deductibles if four criteria in the regulation at 42 C.F.R. § 413.89(e) are met:

(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.

The Provider Reimbursement Manual, Part 1, CMS Pub. 15-1 ("PRM") provides further guidance on these criteria. The PRM, § 310, interprets "reasonable collection efforts" as those that are comparable to efforts to collect similar amounts from non-Medicare patients, including issuing bills and collection letters, as well as making phone calls. PRM § 310A also permits a provider to use a collection agency "in addition to or in lieu of" these efforts. Finally, PRM § 310.2 creates a "Presumption of Noncollectibility" if, 120 days from the date the first bill is mailed out to the patient, the debt remains unpaid. Bad debts are reimbursable in the cost reporting year in which they are claimed, but, under 42 C.F.R. § 413.89(f), any previously claimed bad debts that are subsequently collected must be credited against future bad debt reimbursement claims for the year in which the collection was made.

In these cases, the providers exhausted their internal collection procedures for the requisite 120 days before deeming the balances uncollectible and referring them to outside collection agencies. The intermediaries, though, refused to reimburse such bad debts as long as the collection agencies were still trying to actively collect the debts. The providers argued that the 120-day presumption establishes that the balances were "actually uncollectible" within the meaning of the regulation. The intermediaries countered that CMS had instructed them that a debt could not be "actually uncollectible" while collection efforts were still ongoing.

The PRRB sided with the providers, defining "uncollectible," as the term is used in 42 C.F.R. 413.89(e)(3), to mean "that no payments have been received or are expected to be made on an account based upon the provider's experience and sound business judgment," and that "[t]he mere 'active' status of an account with an outside collection agency does not automatically constitute proof of value or collectibility."

Bad Debt Moratorium

In deciding these two cases, the PRRB also held that the bad debt moratorium passed as part of the Omnibus Budget Reconciliation Act of 1987 barred CMS from issuing audit guidance to intermediaries in 1989 that directed them to treat a debt as collectible if a collection agency was still attempting to recoup the unpaid amount. The PRRB held that the guidance, promulgated two years after the moratorium took effect, contradicted the preexisting bad debt policy in the PRM, discussed above.

The moratorium states:

> In making payments to hospitals under [Medicare], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under [Medicare] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under [Medicare].[3]

Despite the moratorium, CMS published audit guidance in 1989 instructing intermediaries to disallow bad debts for cost sharing amounts that outside collection agencies were still working to collect. This guidance appears at section 4198 of the Medicare Intermediary Manual, CMS Pub. 13 ("MIM"):

> If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort.

The PRRB relied on a recent decision by the U.S. District Court for the District of Columbia in *Foothill Hospital – Morris L. Johnson Memorial v. Leavitt* ("*Foothill Hospital*"),[4] which found that this MIM instruction created new bad debt policy in the form of a presumption of collectibility in violation of the bad debt moratorium. Agreeing with the District Court, the PRRB found that MIM § 4198 violates the bad debt moratorium and is contrary to the Presumption of Noncollectibility found in PRM § 310.2.

The CMS Administrator has taken the position that unpaid Medicare co-insurance and deductibles cannot be written off and reimbursed if the account remains with an outside collection agency.[5] It is likely, therefore, that these two PRRB decisions will be reversed by the Administrator and require review by the federal courts. However, the *Foothill Hospital* decision stands as strong support for a legal challenge in the D.C. Circuit. When other courts have not directly addressed the moratorium, they have often ruled against the provider on this issue.[6]

More broadly, these cases exemplify the current struggle between CMS and Medicare providers on bad debt reimbursement. CMS has consistently sought to limit bad debt reimbursement to providers, which is paid as a percentage of cost, while providers have consistently challenged such limitations through the appeal process in an effort to chip away at the agency's proscriptive policies. The bad debt moratorium has the potential to help providers accomplish this task.

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[1] *Auburn Reg'l Med. Ctr. v. Sebelius*, ___ F.3d ___, No. 10-5115 (D.C. Cir. June 24, 2011).

[2] *George Washington Univ. Hosp. v. BlueCross Blue Shield Ass'n/CareFirst of Md., Inc. and Highmark Medicare Servs.*, PRRB Decision 2011-D31 (May 27, 2011); *Universal Health Servs., Inc., v. BlueCross Blue Shield Ass'n/Highmark Medicare Servs./Wisconsin Physician Servs.*, PRRB Decision 2011-D30 (May 27, 2011).

[3] Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, § 4008(c), 101 Stat. 1330, 1355 (1987). Later amendments clarified that "reasonable collection effort" included "determining whether to refer a claim to an external collection agency," and that the Secretary may not require a provider to change its policy if the policy was accepted by an intermediary prior to August 1, 1987. Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8402, 102 Stat. 3798 (1988); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6023, 103 Stat. 2106, 2167 (1989).

[4] 558 F. Supp. 2d 1 (D.D.C. 2008).

[5] See MIM § 4198; *CMS Administrator Decision in the Case of Various Genesis Health Care Corporation Providers v. BlueCross Blue Shield Ass'n/Highmark Medicare Servs.*, PRRB Dec. No. 2011-D12 (Feb. 1, 2011); *CMS Administrator Decision in the Case of El Centro Reg'l Med. Ctr. v. BlueCross Blue Shield Ass'n/United Gov't Servs., LLC*, Medicare and Medicaid Administrative Decisions (CCH) ¶ 81,273, PRRB Dec. No. 2007-D21 (Feb. 23, 2007).

[6] Federal courts that have considered the issue are split, with some in accordance with the logic in *Foothill Hospital*, including *Dameron Hosp. Ass'n v. Leavitt*, Medicare and Medicaid Cases (CCH) ¶ 302,169 (E.D.Cal. Aug. 8, 2007) (holding that bad debt moratorium precluded change in handling accounts that remain in outside collection), and some reaching the opposite conclusion, such as *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401 (6th Cir. 2007) (upholding CMS' interpretation that an account in outside collection cannot be deemed uncollectable, although not addressing the bad debt moratorium) and *Mesquite Cmty. Hosp. v. Leavitt*, Medicare and Medicaid Cases (CCH) ¶ 302,619 (N.D.Tex. Sept. 5, 2008) (agreeing with *Battle Creek* but taking notice of *Foothill Hospital*, which it did not consider because the plaintiff did not raise the bad debt moratorium in its argument). The

United States District Court for the Northern District of Illinois took a middle ground approach, which other courts have explicitly declined to follow, in *Mt. Sinai Hosp. & Med. Ctr. v. Shalala*, Medicare and Medicaid Cases (CCH) ¶ 300,164 (N.D.Ill. Mar. 30, 1998), applying a 5.7 percent offset to the bad debt reimbursement amount to account for what the hospital likely would have recovered had the accounts been sent to outside collection.

About Us

The Law Offices of Jason M. Healy PLLC is a health care law firm that focuses exclusively on legal issues affecting health care providers. We help health care providers and their trade associations understand Medicare and Medicaid laws and regulations. We also represent health care providers in reimbursement audits, appeals, and litigation. Located in Washington, DC, we are well positioned to provide legal support for advocacy efforts. Our principal, Jason M. Healy, is a health care lawyer with over 14 years of experience with the array of legal issues facing health care providers.