PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D23

PROVIDER -Colorado Therapy Services
Pueblo, Colorado

Provider No. 06-6549

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of New Mexico

DATE OF HEARING-
September 9, 1997

Cost Reporting Period Ended -
December 31, 1993

CASE NO. 95-1661

INDEX

ISSUE:

Does the Provider Reimbursement Review Board have jurisdiction over Provider extension locations that were not surveyed for purposes of certification?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Colorado Therapy Services ("Provider") is a rehabilitation agency headquartered in Pueblo, Colorado, and providing physical therapy, speech pathology, and occupational therapy at several extension sites located throughout the state of Colorado.[1] In 1994, Blue Cross Blue Shield of New Mexico ("Intermediary") audited the Provider's records for the fiscal year ending December 31, 1993. (Effective December 1, 1995, Blue Cross and Blue Shield Association assumed responsibility for all of the Provider's pending claims and appeals.)[2] The Intermediary disallowed all of the Provider's costs related to the provision of therapy services to Medicare recipients both in the clinics and outside of clinics during the months that the Provider's extension locations were not surveyed. The Intermediary took the position that because the Provider's extension locations were not surveyed prior to billing for Medicare services, the Provider was not eligible for reimbursement of its costs.[3]

The Intermediary issued a Notice of Program Reimbursement (NPR) on November 18, 1994.

On March 23, l995 the Provider appealed seventeen (17) issues from the Intermediary's adjustments and disallowances to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-1841.[4] The pivotal question of Board jurisdiction over unsurveyed extension locations remains as the paramount issue.

The Provider is represented by Thomas William Baker, Esquire, of Kilpatrick Stockton, L.L.P. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that they followed all appropriate procedures for opening and providing therapy services at the primary clinic and extension locations. The Provider's primary office was surveyed and certified by the Colorado Department of Health prior to the

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1 Provider Position Paper at 2

2 Id. At 1

3 Id. At 1

4 Baker Letter, dated March 23, 1995

fiscal year ending December 31, 1993.[5] The Provider subsequently opened several extension location clinics prior to the fiscal year ending December 31, 1993, after giving all required notices to regulatory authorities[6] and operating as they perceived HCFA's procedure to be.[7]

The Provider suggests that neither the statutes, regulations, manual provisions governing the Medicare program, nor HCFA procedural interpretations require that an extension location must be surveyed before any costs related to Medicare services can be reimbursed.[8] The Provider argues that Section 1166 of the Regional Office Manual[9] (HCFA Pub. 23-4) requires only that:
"[w]here the OPT/OSP bills the Medicare program for the services it renders, it must assume the administrative and supervisory responsibility for those services. . . ." The Provider further argues that the State Operations Manual[10] (HCFA Pub. 7) only requires a rehabilitation agency to notify the surveying agency of the opening of extension locations on an annual basis, in order to file Medicare claims. Thus, the Provider contends that its extension locations are not "non-reimbursable cost centers" as the Intermediary claims, and the Provider should be allowed to bill, and be paid, for services it provided to Medicare beneficiaries.

The Provider notes that to provide therapy services to Medicare patients, a Medicare-certified rehabilitation agency must meet the definitions of therapy services set forth in the statutes governing Medicare.[11] The Provider further notes that the rehabilitation agency must meet the Medicare Conditions of Participation cited at 42 C.F.R. § 485.703. The Provider contends that there is no requirement that extension locations of Medicare-certified rehabilitation agencies
be surveyed before costs relating to services to Medicare patients are allowable.[12] Rather, the critical factors are that the agency meets the Conditions of Participation, that it provides

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5 Provider Position Paper at 2

6 Provider Position Paper at 2; Provider Exhibits Nos. 1, 2, 3, & 4

7 Provider Position Paper at 2

8 Provider Position Paper at 7

9 Provider Position Paper, Exhibit 7

10 Provider Position Paper, Exhibit 8

11 Provider Position Paper at 12

12 Provider Position Paper at 14

yearly notice to the surveying state agent that new extensions have been opened, and that it assumes administrative and supervisory responsibility for the services provided.[13]

The Provider contends that it is absurd to think that providers will open their doors without treating Medicare patients and leave those doors open in anticipation of a survey, which in this case took almost three years for some locations. The Provider maintains that the HCFA Survey and Certification Program is underfunded,[14] and that the yearly notice of extension location openings allows rehabilitation agencies to provide services to Medicare beneficiaries while awaiting state agency survey[15] without denying beneficiaries needed services.

The Provider contends that not only did the Colorado Department of Health, as HCFA's surveying and certifying agent know about each extension clinic opening, but the requirement that the site be operational prior to survey placed an inordinate financial burden on the Provider, considering that in some circumstances the extension locations were not surveyed for almost three (3) years from the date of notification.[16]

INTERMEDIARY'S CONTENTIONS:

The Intermediary notes that the Board's jurisdiction is governed by Section 1878(a)(1), 42 U.S.C. Section 1395oo which permits Board review only where a provider:

> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report . . .[17]

Thus, the Board only has jurisdiction over disputes regarding the amount of payment owed a provider for services that are covered by the Medicare program. The Intermediary contends that the Board has no discretion to hear the Colorado Therapy appeal, since the Provider is

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13 Id. At 14

14 Provider Position Paper at 26 (See: Footnote 8)

15 Id. At 27

16 Id. At 23

17 Intermediary's Position Paper at 6

basically appealing the lack of Medicare coverage at its extension locations, not a determination relating to the amount of Medicare reimbursement.[18]

The Intermediary notes that Section 1166 of HCFA Pub. 23-4 states the requirements for extension units of outpatient physical therapy/speech pathology services (OPT/OSP). This section, in part, states the following:

> A. Conditions and Standards to be Surveyed. - Except for those noted . . ., all subpart Q conditions and standards are to be applied to the premises of EACH extension location . . .[19]

Id. (emphasis added).

Also, Section 2302 of the State Operations Manual (HCFA-Pub.7) instructs surveying and certifying agents to survey each condition and standard in the OPT/OSP Conditions of Participation at each multiple and extension unit.[20]

Colorado Therapy Services' first facility was properly surveyed and met the conditions of participation. However, the Intermediary notes that the Provider opened several extension sites in the state of Colorado, and billed Medicare for services provided at these branches prior to the branches having been surveyed and certified for Medicare participation.[21] The Intermediary maintains that a survey is required for each extension site in order for that unit to be certified, and that an agency cannot bill for Medicare services, and be paid, prior to the site being surveyed and certified.[22]

The Intermediary explains that they notified the Provider that the costs at the extension locations were disallowed as non-reimbursable cost centers since they had not been surveyed and certified as meeting the Medicare conditions of participation. The Provider was told that various regulations (42 C.F.R. § 405.1701, 42 C.F.R. §§ 488.10-488.18, and HCFA Pub. 7 §§ 2000, 2002, 2004, 2298B, 2298C and 2302, and HCFA Pub. 23-4 § 1166), required providers to be surveyed and certified as meeting the conditions of participation before they can bill for Medicare services. Since some of the Provider's facilities were not surveyed for all of FYE

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18 Id. At 7

19 Intermediary Position Paper at 5

20 Id.

21 Id. At 6

22 Id.

12/31/93, the costs for these extension clinic sites prior to certification are non-reimbursable costs.[23]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws:

42 U.S.C. § 1395cc	-	Agreements with Providers of Services
42 U.S.C. § 1395oo(a)(1)(A)(i)	-	Provider Reimbursement Board

2. Regulations - 42 C.F.R.:

42 C.F.R. § 400.202	-	Definitions Specific to Medicare
42 C.F.R. § 405.1835-.1841	-	Right to Board Hearing
42 C.F.R. § 485.703	-	Conditions of Participation for Clinics etc.: Definitions
42 C.F.R. § 488.10-.18	-	State Survey Agency Review: Statutory Provisions
42 C.F.R. § 489.10	-	Basic Requirements

3. Manuals:

a. State Operations Manual (HCFA Pub. 7)

§ 2000	-	Certification Surveys - Citations
§ 2002	-	Meaning of Providers and Suppliers
§ 2004	-	Identification of Potential Providers and Suppliers
§ 2298	-	Site of Service Provision

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[23] Intermediary Position Paper at 8

§ 2302C - Survey of OPT/OSP Controlled and Extension Units of Providers Offering OPT Only

b. Regional Office Manual (HCFA Pub. 23-4)

§ 1166 - Extension Units of Outpatient Physical Therapy/Speech Pathology Services

c. Outpatient Physical Therapy and Comprehensive Outpatient Rehabilitation Manual (HCFA Pub. 9)

§ 130 - Definition of Provider

FINDINGS OF FACT. CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the controlling law, regulations, manual guidelines, case law, as well as the facts, parties' contentions and the evidence presented in the record finds and concludes as follows:

The Board's jurisdiction over an appeal is governed by Title XVIII of the Social Security Act, as amended, 42 U.S.C. § 1395oo. Section 1395oo(a)(1)(A)(i) permits Board review where a provider is dissatisfied with a final determination . . .as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report. . . Id. (emphasis added.)

In addition, the regulations reiterate this position by stating that a "provider (but no other individual, entity or other provider) has a right to a hearing before the Board". 42 C.F.R. § 405.1835. A provider is defined in 42 C.F.R. § 400.202 as

> a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has a similar agreement but only to furnish outpatient physical therapy or speech pathology services.

Id.

The Outpatient Physical Therapy and Comprehensive Rehabilitation Facility Manual (HCFA Pub. 9) § 130A further defines a provider as a rehabilitation agency that meets the eligibility

requirements of Title XVIII and the regulations thereunder (i.e. conditions of participation). To be a participating provider, qualified to receive payment under Medicare, the physical therapy agency must enter into an agreement with the Secretary. 42 U.S.C. § 1395cc. A provider which has executed an agreement becomes qualified to participate after the agreement is accepted for filing. Outpatient Physical Therapy and Comprehensive Oupatient Rehabilitation Manual (HCFA Pub. 9) § 130B.

The Secretary has published regulations which establish a process by which HCFA determines whether an applicant for participation in the Medicare program complies with the conditions of participation. An entity must apply to HCFA to be certified to participate in Medicare. 42 C.F.R. § 489.10. In order to be certified, an applicant for participation must first be surveyed to determine whether the applicant meets all of the Medicare participation requirements. 42 C.F.R. §§ 488.10 and 489.10(d). HCFA has delegated to State survey agencies the authority to conduct surveys on its behalf. Id.

Contrary to the Provider's assertion, the Board finds that the State Operations Manual (HCFA Pub. 7) §§ 2298B and 2302 require a survey for each OPT extension location prior to certification as a provider of services. See also Regional Office Manual, Part 4 (HCFA Pub. 23-4) § 1166. The State, when certifying compliance, is to make findings at all locations, but the findings are to be considered as a whole (if the OPT provider has deficiencies in some locations and they warrant termination, all locations are terminated). Id.

The Board finds that the extension locations did not meet the conditions of participation since they had not been surveyed and certified. Since the extension locations had not met the conditions of participation they could not be incorporated into the provider agreement filed on behalf of the primary location of Colorado Physical Therapy. Since they were not incorporated into the participation agreement, they were not providers of services as defined in 42 C.F.R.
§ 400.202 and, thus, not entitled to a hearing before the Board.

DECISION AND ORDER:

The Board finds that it lacks jurisdiction over the extension locations because they had not been certified to participate in the Medicare program and, thus were not providers of services as defined by the statute and regulations. Since this is the only issue remaining under appeal, the Board hereby dismisses the case.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Teresa B. Devine
Henry C. Wessman, Esquire (Concurring)

Date of Decision: January 23, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman

CONCURRING OPINION

I concur with the majority of the Board, but wish to emphasize my concern about the nuances of this case. Clearly, in my opinion, equity is on the side of the Provider. Unfortunately, the reality of administrative law at the level of the Provider Reimbursement Review Board is not. This case begs for a forum where equitable issues rise to an adjudicable level.

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Henry C. Wessman, Esquire