PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D57

PROVIDER -
Valley Hospital Medical Center
Las Vegas, Nevada

Provider No. 29-0021

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING-
April 22, 1998

Cost Reporting Period Ended -
December 31, 1986

CASE NO. 94-1800C

INDEX

ISSUE:

Was the revision to the hospital-specific portion of the Provider's payment under the Medicare prospective payment system made by the Provider's fiscal Intermediary pursuant to a revised Notice of Program Reimbursement dated August 30, 1993, valid?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Valley Hospital Medical Center ("Provider") is a short term, acute care facility located in Las Vegas, Nevada. The Provider entered Medicare's prospective payment system ("PPS") on January 1, 1984, and began receiving reimbursement for inpatient hospital services based upon a prospectively determined rate per discharge. In accordance with 42 U.S.C. § 1395ww(d) and implementing regulations at 42 C.F.R. § 412.70, the Provider's reimbursement rate during the initial four-year transition period of PPS was based upon a blend of a Federal rate and a hospital-specific portion ("HSP") determined from the Provider's 1982 base period operating costs.
On January 31, 1984, 30 days after the Provider entered PPS, Ætna Life Insurance Company ("Intermediary")[1] notified the Provider that its base period cost per discharge was $4,016.61 and that its target amount per discharge for purposes of establishing its HSP was $4,137.91.[2]

However, on February 17, 1984, the Intermediary issued a Notice of Program Reimbursement ("NPR") for the Provider's 1982 base period cost report reflecting the results of its audit of the Provider's cost and statistical records.[3] According to the Provider, the audit adjustments reflected in the NPR reduced its 1982 cost per discharge to $3,566.73. Subsequently, on March 26, 1984, the Intermediary notified the Provider that its adjusted target amount per discharge would be $3,678.21 for discharges occurring on or before February 2, 1984, and $3,674.45 for discharges occurring on or after February 3, 1984, in accordance with 49 Fed. Reg. 328-329 and 338-339 (1984). The Intermediary's calculation of the Provider's adjusted target amount was based upon the revised base period cost per discharge of $3,566.73.[4]

On September 21, 1984, the Intermediary notified the Provider that its revised PPS blended

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1 Ætna Life Insurance Company was the Medicare intermediary during the periods and events addressed in this appeal. Subsequent to the submission of arguments and evidence presented in this case the Provider was transferred to its current intermediary, Mutual of Omaha Insurance Company.

2 Provider's Position Paper at 2. Exhibit P-1.

3 Exhibit P-2.

4 Exhibit P-3.

rate applicable to discharges occurring on or after October 1, 1984, was $3,944.59.[5] This revised rate apparently incorporated the base year cost per discharge of $4,016.61, i.e., the amount determined prior to the issuance of the NPR for 1982, which reduced the cost per discharge to $3,566.73. Similarly, on December 26, 1984, the Intermediary notified the Provider that effective January 1, 1985, and continuing throughout calendar year 1985, its revised target amount for purposes of calculating the HSP would be $4,386.31. The 1985 revised target amount was calculated using a target amount for 1984 of $4,137.9l, which in turn was derived from a base year cost per discharge of $4,016.61.[6]

Subsequently, on April 30, 1986, the Intermediary notified the Provider that its revised PPS rate effective for discharges occurring on or after May 1, 1986 was $3,147. 78.[7] Then, on May 19, 1986, the Intermediary notified the Provider that that rate had been corrected to $3,767.42. On September 30, 1986, the Intermediary notified the Provider that for discharges occurring on or after October 1, 1986, the applicable PPS rate would be $3,723.65. All three notices identified the Provider's HSP as $4,137.91, consistent with the Provider's initial HSP pursuant to the January 31, 1984 notice, which was derived from the base year cost per discharge of $4016.61.[8]

On September 18, 1989, the Intermediary issued an NPR for the Provider's cost reporting period ended December 31, 1986. On January 23, 1990, the Provider timely appealed various issues contained in that NPR to the Provider Reimbursement Review Board ("Board" or "PRRB").[9] On January 23, 1992, while the Provider's appeal was still pending,[10] the Intermediary issued a notice of reopening for the 1986 cost report. This notice advised the Provider that the purpose of the reopening was to adjust Medicare payments "to include corrected base year cost (pending verification of jurisdiction under HCFAR 89- 1)."[11]

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5 Exhibit P-4.

6 See Exhibits P-1 and P-5.

7 The Provider explains that Congress froze PPS rates from October 1, 1985 through April 30, 1986. Thus, a rate notice was not issued for the Provider's 1986 fiscal year until April 30, 1986. The Provider's PPS rate in effect during 1985 remained in effect from January 1, 1986 through April 30, 1986.

8 Exhibits P-6 through P-8, respectively.

9 Exhibit P-10.

10 The case was decided on February 11, 1993. See PRRB Decision No. 93-Dl6, Exhibit P-11.

11 Exhibit P-12.

The Intermediary's notice of reopening was followed by a letter confirming a discussion the Intermediary had with a representative of the Provider. The letter explained that the Provider had been reimbursed an incorrect HSP throughout the PPS transition period. Specifically, the Provider had been reimbursed based upon a cost per discharge of $4,016.61, which stemmed from the Intermediary's original 1982 determination, rather than the adjusted rate of $3,566.73 per discharge determined in March 1984. The Intermediary added that the newer rate had never been installed in its claims processing system, and because of this error the Provider had been substantially overpaid. Moreover, the letter confirmed the Intermediary's intent to reopen each effected cost reporting period, and to actually perform the reopenings after resolution of other appeals pending for those periods.[12]

On August 30, 1993, the Intermediary issued a revised NPR for the Provider's cost reporting period ended December 31, 1986, adjusting the HSP of the Provider's PPS payments.[13] On February 18, 1994, the Provider appealed the Intermediary's adjustment to the Board pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The amount of Medicare reimbursement in controversy is $1,235,199.

The Provider was represented by Julia E. Schollenberger, Esquire, of Hooper, Lundy & Bookman, Inc. The Intermediary was represented by Paul R. Gulbrandson, Senior Appeals Officer, Ætna Life Insurance Company.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustment to its HSP for 1986 is improper because it is based upon a retroactive adjustment to its initial HSP, which is prohibited.

Medicare regulations at 42 C. F. R §§ 412.71 and 412.72 prohibit an intermediary from reducing a provider's HSP to reflect a change to the hospital's allowable base year costs after the provider has entered PPS, with certain exceptions. Since none of the exceptions apply in this case, the Provider contends that the Intermediary's March 26, 1984 revision to its original HSP, issued on January 31, 1984, is unauthorized.[14]

Regulation 42 C.F.R. § 412.71 states, in pertinent part:

> (a) *Base-year costs*. (1) For each hospital, the intermediary will estimate the hospital's Medicare Part A allowable inpatient operating costs, as described in Section 412.2(c), for the twelve month or longer cost reporting period ending

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12 Id.

13 Exhibit P-13.

14 Provider's Position Paper at 7.

> on or after September 30, 1982 and before September 30, 1983 . . .
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> (d) *Intermediary's determination*. The intermediary uses the best data available at the time in estimating each hospital's base-year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the cost reporting period beginning on or after October 1, 1983, except as provided in Section 412.72.

42 C.F.R. § 412.71(a) and (d) (Emphasis added).

Regulation 42 C.F.R. § 412.72 contains five exceptions to the finality rule contained in 42 C.F.R. § 412.71(d) that are not applicable to the instant case.

First, § 412.72(a)(1)(I) provides for adjustments to base period costs for hospitals that became subject to PPS before November 16, 1983. The Provider in the instant case became subject to PPS on January 1, 1984. Therefore, this provision is inapplicable.

Second, § 412.72(a)(1)(ii) permits an intermediary to initiate changes to the estimate of base year costs for any reason before the hospital becomes subject to PPS, or before November 16, 1983, to take into account various inadvertent omissions. The adjustment made by the Intermediary to the Provider's HSP occurred after November 16, 1983, and after the Provider became subject to PPS. Therefore, § 412.72(a)(1)(ii) does not apply.

Third, under § 412.72(a)(2), an intermediary may revise a hospital's HSP within ninety days of the intermediary's notification to the hospital of its HSP to correct "mathematical errors of calculations." The revision to the Provider's HSP described in the March 26, 1984 notice was not due to a mathematical error of calculation, but was due to a revision in the Provider's base year costs. Therefore, this provision does not apply.

Fourth, § 412.72(a)(3) allows an intermediary to adjust base period costs through the reopening process, and to prospectively adjust a provider's HSP, but only to take into account additional costs recognized as allowable costs for the hospital's base year. This section does not authorize the intermediary to adjust base period costs through the reopening process to reduce costs recognized as allowable costs for the hospital's base year.

The fifth and only provision of § 412.72(a) which allows an intermediary to modify and reduce a hospital's base year costs is subprovision (5), Unlawfully Claimed Costs, which permits an intermediary to modify base year costs to exclude costs that were unlawfully claimed as a result of a criminal conviction, imposition of a civil judgment under the False Claims Act, or a proceeding for the exclusion of the provider from the Medicare program. Clearly, the Intermediary's reduction to the Provider's HSP is not within the scope of subsection (a)(5).

The Provider asserts that the Health Care Financing Administration ("HCFA") clearly intended these regulations to be strictly construed in adopting the PPS regulations. The preamble to the initial PPS regulations stated:[15]

> [t]herefore, fiscal intermediaries will be estimating the hospital-specific portion amounts using the best data for the base period cost reporting period available prior to the hospital's entry into the prospective payment system. Once the amounts have been calculated, they will be applied throughout the entire three year transition period, except as indicated below.

48 Fed. Reg. 39772 (Sept. 1, 1983) (Emphasis added).[16]

The Provider asserts that HCFA reaffirmed its view that an HSP may not be revised after a hospital enters PPS, except in limited circumstances. As stated in the preamble to the final PPS regulations published on January 3, 1984:

> [t]he starting point for resolving these issues is the prospective nature of the system and Congressional recognition that, during the transition period, the establishment of the prospective rates would have to be done rapidly based on the data available. The conference committee stated, "since the hospital-specific portion of the rate must be determined in advance of the hospital's first fiscal year under the system, the managers expect that the Secretary will use the best data available at that time to determine operating costs for purposes of the phase-in (citations omitted). In short, the determination of a particular provider's hospital-specific portion was not to be subject to subsequent revision -- either up or down -- since such revision would defeat the prospective nature of the system and it would be inappropriate fine-tuning of an inherently crude transitional payment factor. Moreover, subsequent revisions of the hospital--specific portions could upset the budget neutrality adjustments upon which the levels of the rates were set . . .
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> In view of the prospective nature of the payment system and the conference committee's expectation that final determinations would be made on the basis of the best information available at a time prior to a hospital's entering the

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15 Provider's Position Paper at 10.

16 Exhibit P-16

> system, we believe that the proper scope of review of adjustments to base year costs is extremely narrow.

49 Fed. Reg. 259 (January 3, 1984) (Emphasis added).[17]

The Provider asserts that HCFA Ruling 89-1 ("HCFAR 89-1")[18] also does not authorize an intermediary to reduce its estimate of a provider's base year costs and HSP during the transition period. Rather, it only authorizes an increase to a provider's HSP.[19]

The Provider asserts that HCFAR 89-1 was issued to acquiesce in the D.C. Circuit Court of Appeals opinion in Georgetown University Hospital v. Bowen, 862 F.2d 323 (D.C. Cir. 1988) ("Georgetown II").[20] That decision holding that where a provider successfully appeals base year costs which were disallowed on the basis of specifically delineated erroneous legal assumptions, the provider's HSP may be retroactively increased to the beginning of PPS. Respectively, the Provider asserts that the issue in the instant case does not involve any of the matters identified in the HCFA ruling as permitting a revision to a hospital's HSP. Furthermore, the only revision allowed under the ruling is an increase in the HSP, not a decrease, such as that at issue in the instant case.

The Provider notes that in the preamble to HCFA Ruling 89-1, in a parenthetical, HCFA explains that intermediaries may make downward adjustments to a hospital's HSP to reflect reductions in base year costs. The Provider asserts, however, that this discussion is not part of the ruling but is only part of the preamble to the ruling, and thus does not have legal force and effect. The Provider further asserts that HCFA has not modified its PPS regulations to permit downward adjustments, and that HCFA may not depart from its own regulations.

Moreover, the Provider asserts that in Georgetown II the court clearly indicated that it was not authorizing the Secretary to make downward adjustments to a provider's base year cost per discharge and its HSP. The court also made it clear that it was not invalidating the Secretary's regulations which do not permit a downward adjustment after the hospital enters PPS, as follows:

> . . . more to the point, however, the fact that the Secretary has concluded that his estimates of certain figures under PPS are not subject to later revision does not determine the appropriate method of dealing with estimates based on

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17 Exhibit P-17.

18 Exhibit P-18.

19 Provider's Position Paper at 11.

20 Exhibit P-19.

> invalid regulations. And even if retrospective payments in this case do tend to favor the hospitals, we do not have the opportunity here to review the "panoramic equity" of the Medicare reimbursement scheme (citation omitted). Finally, we note that it is not at all inconsistent with Congress' purposes in phasing in PPS that the transition payments err on the side of cushioning the economic jolt involved in the implementation of the new system.

Georgetown II supra, at 329, footnote 13.

The Provider argues that it is clear from this footnote that the Georgetown II court did not decide that HCFA's regulations are invalid to the extent that they do not permit adjustments to an HSP to reflect reductions to base year costs occurring after a hospital enters PPS. In fact, the court indicates that a policy which allows retrospective increase in a hospital's HSP to reflect increases to base year costs resulting from appeals, while precluding adjustments to a hospital's HSP to reflect reductions to base year costs, would be consistent with Congress' intent in enacting PPS.

The Provider concludes that 42 C.F.R. §§ 412.71 and 412.72 remain the enabling regulations, and that HCFA is bound by such regulations so long as they remain operative. Romeiro De Silva v. Smith, 773 F.2d 1021 (9th Cir. 1985).[21] See also Dyer v. Secretary of Health and Human Services, 889 F.2d 682 (6th Cir. 1989), where the court stated:

> [s]tatements made by federal agencies may constitute substantive rules or merely be general policy statements. Agencies are bound by duly promulgated substantive rules, which have the force of law . . . while interpretive rules or policy statements do not have binding effect.

Dyer v. Secretary of Health and Human Services, 889 F.2d 682 (6th Cir. 1989).[22]

The Provider contends that the Intermediary's adjustment is also improper because it is based upon an invalid reopening.[23] The Intermediary's notice of reopening was not made within three years of the final determination as required by 42 C.F.R. § 405.1885(a), which states, in pertinent part:

> [a] determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or

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21 Exhibit P-20.

22 Exhibit P-22.

23 Provider's Position Paper at 16.

> decision, by such intermediary officer, or panel of hearing officers, Board, or Secretary . . . . Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or board hearing decision, or, where there has been no such decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination.

42 C.F.R. § 405.1885(a) (Emphasis added).

The Provider asserts there are two intermediary final determinations that must be adjusted to revise the Provider's HSP for 1986 and to recover any sums resulting from that revision. First, the Intermediary must reopen and revise its determination of the Provider's PPS rate for 1986. Second, to recover any sums resulting from this revision, the Intermediary must reopen and revise the Provider's NPR for 1986.

Respectively, the Provider asserts that the Intermediary issued its notice of intent to reopen the 1986 cost report on January 23, 1992. Since the pertinent NPR was dated September 26, 1989, the Intermediary's reopening was timely. However, the Intermediary's notice of intent to reopen is not timely with respect to the Intermediary's notices advising the Provider of its PPS rates.

The Intermediary issued a notice of PPS rate for the Provider's 1985 fiscal year on December 26, 1984. The rate contained in that notice remained effective through April 30, 1986, because Congress froze the PPS rates through April 30, 1986, at fiscal year 1985 levels. See Emergency Extension Act of 1985, Public Law 99-107 at § 5.[24] The Intermediary subsequently issued a PPS rate notice for the Provider on April 30, 1986, effective May 1, 1986, which the Intermediary subsequently corrected on May 19, 1986. On September 30, 1986, the Intermediary issued a notice revising the Provider's PPS rate beginning October 1, 1986.[25]

The Provider asserts that each of the foregoing PPS rate notices were issued more than three years before the Intermediary's January 23, 1992 notice of intent to reopen its 1986 cost report. Accordingly, the Intermediary did not reopen these determinations in a timely manner and may not now adjust the PPS rate for the Provider's 1986 cost reporting period as set forth in the aforementioned notices.

The Provider asserts that applicable Medicare regulations and previously heard court cases make it clear that a notice of a hospital's PPS rate is a final intermediary determination subject to Medicare's reopening rules. In 1986, the United States Court of Appeals for the District of Columbia Circuit clarified that an intermediary's final determination of a hospital's

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[24] Exhibit P-26.

[25] See Chronological Table at Provider's Position Paper at 5. Exhibits P-5 through - P-8.

prospective payment rate for a fiscal year during the PPS transition period constitutes a "final intermediary determination that is appealable, and thus, by implication, can be reopened." Washington Hospital Center v. Bowen, 795 F.2d 139 (D.C. Cir. 1986).[26] See also U.S. Court of Appeals for the Ninth Circuit, Sunshine Health Systems, Inc., v. Bowen, 809 F.2d 1390 (9th Cir. 1987) holding that the intermediary's letter to the provider stating that the provider is not entitled to any hospital-specific portion in its PPS rates was "notice of the Secretary's final determination."[27]

The Provider contends that the Intermediary's reopening for 1986, which is the basis for the revised NPR at issue, is also invalid pursuant to 42 C.F.R § 405.1855 because it was issued while an open appeal for that cost reporting period was already pending.[28]

On January 23, 1990, the Provider appealed adjustments contained in the original NPR issued for its 1986 cost reporting period.[29] The Board issued its decision pertinent to that case on February 11, 1993.[30] As mentioned above, the Intermediary's notice of intent to reopen the 1986 cost report to amend HSP payments was issued on January 23, 1992, while the initial appeal for that year was still pending. The Provider argues, however, that if an intermediary wishes to raise a new issue for a fiscal year while an appeal is pending before the Board for that year, the Intermediary's only alternative is to ask the Board to include the issue in the pending appeal. Therefore, the Provider asserts that the Intermediary's January 23, 1992 notice is invalid and may not form the basis for the issuance of a revised NPR for 1986.

In support of this argument the Provider explains that the Medicare Part A Intermediary Manual, Part I ("HCFA Pub.13-1") § 2631.1A[31] provides that an intermediary may reopen an initial determination of program reimbursement within three years of the date of the NPR "which is otherwise final." Id. The manual provides at § 2630.1A that an intermediary's initial determination becomes final upon the expiration of 180 calendar days after mailing of the NPR, unless before that time the provider requests a hearing. The Provider asserts that it is clear from the manual provisions that where a provider requests a Board hearing within 180 days of an NPR, the NPR is not final. As noted above, under HCFA Pub. 13-1 § 2631.1 an

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26 Exhibit P-24.

27 Exhibit P-25.

28 Provider's Position Paper at 21.

29 Exhibit P-10.

30 Exhibit P-11.

31 Exhibit P-27.

intermediary may only reopen a final determination. Accordingly, an intermediary may not reopen an NPR which has been timely appealed.

The Provider asserts that its foregoing analysis is supported by a February 23, 1981 letter from the Director of the Bureau of Program Policy, HCFA, to the Blue Cross Association, stating in pertinent part:

> [u]nder current regulations at 42 C.F.R. § 405.1885, jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision and that authority may reopen the determination or decision only with respect to findings on matters at issue in such determination or decision. The Bureau of Program Policy has consistently interpreted that provision of the regulations to mean that when a provider has requested an intermediary or PRRB hearing, the intermediary may not reopen the cost report even to consider matters that are not explicitly contained in the provider's request for a hearing. At this juncture, the intermediary must wait to determine whether it will retain the authority to reopen its determination. If the request for hearing is denied or otherwise subsequently dismissed by the hearing authority, the intermediary would retain its authority. However, if a hearing is granted and a decision is rendered, the intermediary can no longer reopen its determination. Thus, when a hearing is granted, it is essential that the intermediary raise any additional issues that should be considered by the PRRB during its hearing.

HCFA Letter dated February 23, 1981.[32]

The Provider asserts that the Board has also issued decisions holding that an intermediary has no authority to reopen a cost report which has been appealed. In its December 27, 1990 letter to an intermediary regarding Columbia Regional Hospital v. Blue Cross and Blue Shield Association, PRRB Case No. 88-1003, the Board stated:

> [t]he Board finds that under the reopening regulation, 42 C.F.R. § 405.1885, an intermediary loses its authority to reopen a cost report, even to consider matters not contained in a provider's hearing request, when the Board accepts an appeal from the provider . . . . Thus, the Board concludes that the intermediary is without authority to reopen any of the subject cost reports.

Board Letter dated December 27, 1990 (Emphasis added).[33]

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[32] Exhibit P-28.

[33] Exhibit P-29.

Similarly, on May 28, 1991, in a letter to an intermediary regarding Monticello Medical Center v. Blue Cross and Blue Shield Association, PRRB Case No. 89-0336, the Board stated that:

> [t]he Board finds that under the reopening regulation, 42 C.F.R. § 405.1885, an intermediary loses its authority to reopen a cost report, even to consider matters not contained in a provider's hearing request, when the Board accepts an appeal from a provider. This Decision is supported by the enclosed February 23, 1978 and 1981, interpretation of the regulations by HCFA. Thus, the Board concludes that the intermediary is without authority to reopen the subject cost report.

Board Letter dated May 28, 1991 (Emphasis added).[34]

Accordingly, the Provider maintains that since its initial 1986 appeal was pending before the PRRB on January 23, 1992, the Intermediary had no authority to reopen its 1986 cost report at that time. Therefore, the Provider maintains that the Intermediary's notice of intent to reopen for 1986 is invalid and can be given no effect. Moreover, the NPR which is based upon the invalid notice of intent to reopen is also invalid.

The Provider contends that the Intermediary's notice of reopening for 1986, which is the basis for the revised NPR at issue, is also invalid because it did not advise the Provider of its right to comment, object, or submit evidence in rebuttal, pursuant to 42 C.F.R. § 405.1887, HCFA Pub. 15-1 § 2932 and HCFA Pub. 13-1 § 2632.A.[35]

Regulations at 42 C.F.R. § 405.1887(a) state:

> [a]ll parties to any reopening described above shall be given written notice of the reopening. When such reopening results in any revision in the prior decision, notice of said revision or revisions will be mailed to the parties with a complete explanation of the basis for the revision or revisions.

At 42 C.F.R. § 405.1887(b), the regulations provide that the parties to the prior decision must be allowed a reasonable period of time in which to present any additional evidence or argument in support of their position.

Program instructions at HCFA Pub. 15-1 § 2932 state that providers "will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it was necessary to take

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[34] Exhibit P-30.

[35] Provider's Position Paper at 24. Exhibit P-12.

such action, and the opportunity to comment, object, or submit evidence in rebuttal." Id. Program instructions at HCFA Pub. 13-1 § 2632.A contain identical language.

Respectively, the Provider argues that since the Intermediary's January 23, 1992 notice of intent to reopen the 1986 cost report fails to satisfy these requirements, it is once again invalid. And, as a result, the adjustment made by the Intermediary to the HSP of its PPS payments for 1986 is also invalid.

The Provider cites Grimm-Smith Hospital and Clinic, Inc. v. Blue Cross and Blue Shield Association, PRRB Decision No. 93-D37, May 13, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,439,[36] vac'd and rem'd HCFA Admin. July 9, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,670, where the Board found that a notice of reopening must advise the provider, in writing, of its right to comment, object or submit evidence in rebuttal. As a result, the Board stated that the intermediary failed to comply with HCFA's requirements and that the notice of reopening was defective. The Board subsequently concluded that any adjustment made by the intermediary pursuant to the improper notice of reopening was also improper and must be reversed.

Finally, the Provider contends that the Intermediary is prohibited from revising its HSP before May 1, 1986, pursuant to the Emergency Extension Act of 1985, which required that hospitals under PPS be paid "on the same basis" for discharges occurring from October 1, 1985 through April 30, 1986, as they were paid on September 30, 1985.[37] With respect to the instant case, the Provider asserts that the HSP used for its payments on September 30, 1985 was $4,386.31.[38] Therefore, under the Emergency Extension Act of 1985, the Provider argues that it must be paid based on this HSP for all discharges occurring from January 1, 1986 through April 30, 1986.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the issue in this case is not a matter of whether or not there has been a proper cost report reopening or revised final settlement. Rather, the issue to be decided is whether or not the Intermediary has the ability under Medicare law, regulations and manual instructions to correct a patent error which resulted in an overpayment to the Provider. As explained to the Provider in a letter dated January 23, 1992,[39] the correct PPS rate that was

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36 Exhibit P-32.

37 Provider's Position Paper at 26.

38 Exhibit P-5.

39 Exhibit P-12.

determined in March 1994, had never been installed in the Intermediary's claims processing system. As a result, the Provider received a substantial amount of improper payments and the 1986 cost report had to be reopened to recover the incorrectly paid funds.[40] The Intermediary asserts that the Provider received proper notice of the correct PPS rate and that the Provider acknowledged that it received such notice on a timely basis. Furthermore, the Provider never raised any objection to that determination.

The Intermediary contends that the Provider knew it was being overpaid and, therefore, was legally obligated to advise the Intermediary of the improper payments; the Provider's acceptance of the improperly paid funds was unlawful. The Intermediary asserts that PPS providers routinely use computer programs to project the amount of Medicare reimbursement they should receive from each patient billing. The Intermediary believes with certainty that the Provider used such a program and knew that its PPS payments were in error. The Intermediary opines that had the Provider been underpaid it surely would have brought that matter to the Intermediary's attention.
The Intermediary asserts that it stands to reason that the Provider does not have title to the funds at issue in this case. For example, if someone were to enter a bank and deposit $100, and the bank, by error, were to credit that person with $100,000, no rational person would claim that that error gave title to the funds. Moreover, the person would be obliged to inform the bank of the error, and anyone who would attempt to convert the improperly credited $99,900 would be guilty of criminal activity.

The Intermediary cites Heckler v. Community Health Services of Crawford County, Inc., 467 U.S. 51, where the Supreme Court held that the provider cannot rely upon (nor profit by) the errors of the intermediary. The Court further stated that the provider must be held to a high level of knowledge and responsibility in dealing with public funds.[41]

The Intermediary rejects the Provider's argument that the revision to its 1986 settlement was improper because it was based upon an improper cost report reopening.[42] The Intermediary notes the Provider's reliance on prior Board decisions holding that an intermediary has no authority to reopen a cost report with a pending appeal before the Board. In opposition, the Intermediary refers to a portion of the transcript from Pacific Hospital of Long Beach v. Ætna Life Insurance Company, PRRB Case No. 91-2235M, held Dec. 1, 1995, at 157, line 11, where the Board stated:

> [w]hile previous Boards have articulated a policy about the Intermediary initiating reopenings, the Board does not believe it has legal authority to

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40 Intermediary's Position Paper at 2.

41 Intermediary's Supplemental Position Paper at 12.

42 Intermediary's Supplemental Position Paper at 9.

> prevent the Intermediary from reopening the cost reports nor to toll the three-year time period associated with the reopening.

Pacific Hospital of Long Beach v. Ætna Life Insurance Company, PRRB Case No. 91-2235M, Transcript at 157, line 11.[43]

The Intermediary also believes the Board should consider whether or not the Provider's actions were abusive. The Intermediary cites 42 C.F.R. § 405.1885(d) which states, in part:

> an intermediary determination or hearing decision . . . shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision.

42 C.F.R. 405.1885(d).

Finally, the Intermediary rejects any arguments raised by the Provider regarding the validity of the revised HSP contained in the March 26, 1984 notice to the Provider. Clearly the Provider was aware of this notice having included it in its Chronology Table[44] and as an exhibit in its Position Paper. (Exhibit P-3) And, although this rate should have been the basis of the Provider's PPS payments in its 1984, 1985, and 1986, cost reporting periods, the Provider never challenged its propriety. Therefore, the Intermediary asserts that under the best case scenario, in order for the provider to question the validity of that HSP, it would have had to file an appeal within 180 days of its 1984 cost year.[45]

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1.	Law - 42 U.S.C.:		
	§ 1395ww(d)	-	PPS Transition Period; DRG Classification System; Exceptions and Adjustments to PPS.
2.	Law - 31 U.S.C.:	-	False Claims Act
3.	Public Law 99-107 § 5:	-	Emergency Extension Act of 1985

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[43] Intermediary's Supplemental Position Paper at Exhibit I-1.

[44] Provider's Position Paper at 5.

[45] Intermediary's Supplemental Position Paper at 13.

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

§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1885	-	Reopening a Determination or Decision
§ 405.1887	-	Notice of Reopening
§ 412.70	-	Subpart E-Determination of Transition Period Payment Rates
§ 412.71	-	Determination of Base-Year Costs
§ 412.72	-	Modification of Base-Year Costs

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

§ 2932	-	Notices (Including Notices of Refusal) Related to Reopening and Correction

6. Program Instructions - Part A Intermediary Manual, Part I (HCFA Pub. 13-1):

§ 2630.1A	-	Intermediary's Initial Determination
§ 2631.1	-	Time Limits for Reopening
§ 2632A	-	Requirements of the Notice

7. Case Law:

Georgetown University Hospital v. Bowen, 862 F.2d 323 (D.C. Cir. 1988).

Romeiro De Silva v. Smith, 773 F.2d 1021 (9th Cir. 1985).

Dyer v. Secretary of Health and Human Services, 889 F.2d 682 (6th Cir. 1989).

Washington Hospital Center v. Bowen, 795 F.2d 139 (D.C. Cir. 1986).

Sunshine Health Systems, Inc., v. Bowen, 809 F.2d 1390 (9th Cir. 1987).

Heckler v. Community Health Services of Crawford County, Inc., 467 U.S. 51.

Grimm-Smith Hospital and Clinic, Inc. v. Blue Cross and Blue Shield Association, PRRB Dec. No. 93-D37, May 13, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,439, vac'd and rem'd HCFA Admin., July 9, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,670.

Pacific Hospital of Long Beach v. Ætna Life Insurance Company , PRRB Dec. No. 97-D73, June 25, 1997, Medicare & Medicaid Guide (CCH) ¶ 45,465, declined rev., HCFA Admin., August 4, 1997.

8. Other:

48 Fed. Reg. (Sept. 1, 1983) 39752 and 39772.

49 Fed. Reg. (Jan. 3, 1984) 328 and 338.

49 Fed. Reg. (Jan 3, 1984) 234 and 259.

HCFA Ruling 89-1.

HCFA Letter dated February 23, 1981.

PRRB Letter dated December 27, 1990 re. Columbia Regional Hospital.

PRRB Letter dated May 28, 1991 re. Monticello Medical Center.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes that the Intermediary's revision to the HSP of the Provider's PPS payments was improper. The Intermediary's revision was based upon a change to the Provider's base period costs that was made after the Provider entered PPS, inconsistent with 42 C.F.R. §§ 412.71 and 412.72.

In its analysis of this case, the Board first considered arguments raised by the Intermediary regarding improper behavior on the part of the Provider. In particular, the Board reviewed the Intermediary's contention that the Provider knew it was receiving incorrect payments and did not bring that matter to the Intermediary's attention. With respect to this concern, the Board finds that beginning in 1983, and continuing throughout the PPS transition, the Intermediary issued a number of rate notices to the Provider as well as revisions to those notices. However, the Board finds no obvious error that would have been understood by both parties during these periods to support the Intermediary's contention of an unlawful act. Clearly, the Board finds no evidence in the record indicating the Provider was aware of an error in such a manner as to be construed as fraud, abuse or similar fault.

Having concluded there are no improprieties to address, the Board finds that the substantive issue in this case stems from a revision to the Provider's base period costs. In effect, the Intermediary revised the Provider's base period costs and calculated a new HSP. The new HSP, which was less than the Provider's original payment rate, was then applied to the Provider's 1986 cost report through a cost report reopening.

The Board finds that the determination and modification of base period costs are controlled by 42 C.F.R. §§ 412.71 and 412.72. Essentially, these regulations explain that a provider's base period costs may not be revised after the provider has entered the prospective system except in limited circumstances. In part, 42 C.F.R. § 412.71(d) states that "[t]he intermediary's estimate of base-year costs . . . is final and may not be changed after the first day of the [provider's] first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72."

The chronology of events in this case shows that the Provider entered PPS on January 1, 1984. At that time, the Provider's HSP was calculated from a base period cost per discharge of $4,016.61. See Exhibits P-33 and P-1. The revision in dispute, which resulted in an HSP based upon base period costs of $3,566.73, was made on March 26, 1984. See Exhibit P-3. Accordingly, the Board finds that the "new" HSP that was applied to the Provider's 1986 cost report is invalid unless it were derived from a modification to the Provider's base period costs consistent with 42 C.F.R. § 412.72.

Pursuant to 42 C.F.R. § 412.72, base period costs may be modified in five categorical situations. They may be modified to: (1) account for inadvertent omissions identified before the provider becomes subject to PPS or by November 16, 1983; (2) correct mathematical errors identified within 90 days of the date of an intermediary's notice of HSP; (3) recognize additional costs resulting from a reopening or through the appeals process which will be applied prospectively; (4) recognize the results of a successful appeal of the base period made under 42 C.F.R. § 412.71(b) which will be applied retroactively; and (5) to exclude costs that were unlawfully claimed as determined from a criminal or civil action.

With respect to the instant case, the Board finds that the Intermediary's modification to the Provider's base period costs does not comply with any of the causes for modification allowed by 42 C.F.R. § 412.72. As noted above, the modification was made on March 26, 1984, which is after November 16, 1983 and the Provider's entrance into PPS. Also, the modification was not made to correct mathematical errors or to recognize additional costs, or to recognize the results of an appeal or unlawful activity. As explained in a letter to the Provider dated January 23, 1992 (Exhibit P-12), the Intermediary's modification to the Provider's base period costs was made, in fact, to recognize less costs resulting from a cost report reopening as opposed to additional costs authorized by the regulation, stated as follows:

> . . . Valley Hospital has been paid the incorrect Hospital Specific portion of the DRG throughout the PPS transition period. The Base Year (1982) Cost Per

> Discharge used for payment was $4,016.61 based on the original NPR. A subsequent Reopening was issued in March 1984 and the TAC 1007 was re-run. The Revised Base Year Cost Per Discharge was $3,566.73 . . . . Since the new rate was never installed in our claims system, the provider has been substantially overpaid throughout the transition period.

Intermediary letter dated January 23, 1992 (Emphasis added).

In summary, the Board finds that the Intermediary's revision to the Provider's HSP issued on March 26, 1984, is invalid and may not be used to determine program payments. In accordance with 42 C.F.R. § 412.71, a provider's base period costs may not be revised after the provider enters the prospective system except for reasons provided by 42 C.F.R. § 412.72, which are not part of this case. The Board finds support for its position in the preamble to the initial PPS regulations issued on September 1, 1983, where HCFA states:

> [t]herefore, fiscal intermediaries will be estimating the hospital-specific portion amounts using the best data for the base period cost reporting period available prior to the hospital's entry into the prospective payment system. Once the amounts have been calculated, they will be applied throughout the entire three year transition period, except as indicated below.

48 Fed. Reg. 39772 (Sept. 1, 1983).

and, in the preamble to the final PPS regulations published on January 3, 1984, as follows:

> [i]n view of the prospective nature of the payment system and the conference committee's expectation that final determinations would be made on the basis of the best information available at a time prior to a hospital's entering the system, we believe that the proper scope of review of adjustments to base year costs is extremely narrow.

49 Fed. Reg. 259 (January 3, 1984).

DECISION AND ORDER:

The revision made to the HSP of the Provider's payments made under PPS pursuant to a revised final settlement dated August 30, 1993, is invalid. The revision was made using a HSP that was improperly determined after the Provider had entered the prospective system. The Intermediary's adjustment effectuating the revision is reversed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: May 22, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman