PROVIDER REIMBURSEMENT REVIEW BOARD HEARING DECISION

98-D95

PROVIDER -North Ridge Medical Center
Ft. Lauderdale, Florida

Provider No. 10-0237

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Florida

DATE OF HEARING-
March 31, 1998

Cost Reporting Period Ended -
September 30, 1991

CASE NO. 97-2589

INDEX

ISSUE:

Did the Intermediary improperly reopen the Provider's fiscal year ended ("FYE") September 30, 1991 cost report?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

North Ridge Medical Center ("Provider") is a 318 bed hospital located in Ft. Lauderdale, Florida.

The parties have entered into a stipulation concerning the facts of the case.[1] The Provider filed its cost report for the period October 1, 1990 to September 30, 1991 with Blue Cross and Blue Shield of Florida ("Intermediary") on January 31, 1992. The Intermediary conducted a limited scope audit of the cost report and issued a Notice of Program Reimbursement ("NPR") on September 27, 1993. On January 24, 1994, the Provider appealed certain specific determinations of the Intermediary's limited scope audit review. The Provider Reimbursement Review Board ("Board") acknowledged the Provider's appeal on March 28, 1994, and requested a joint list of issues. The joint list of issues was filed with the Board on July 26, 1994.[2] On August 11, 1994, the Board issued a letter regarding scheduling the appeal.

On October 26, 1995, the Intermediary sent a Notice of Reopening of Cost Report for the diabetes counseling cost issue to the Provider. On August 15, 1996, a revised NPR was issued to reclassify the diabetes counseling costs from ancillary to the routine cost center. This issue was not identified as a matter over which the Board had accepted jurisdiction in the filed appeal. On February 10, 1997, the Provider appealed to the Board pursuant to 42 C.F.R. §§ 405.1835-.1841 and 405.1889, and has met the jurisdictional requirements of those regulations. The Provider contests the Intermediary's right to reopen an appealed cost report and has not specifically appealed the adjustment made on the reopened cost report. The amount of Medicare reimbursement exceeds $10,000.

The Provider was represented by John R. Hellow, Esquire, and Jon P. Neustadler, Esquire, of Hooper, Lundy and Bookman, Inc. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that once a provider has appealed an NPR to the Board, the intermediary loses its authority to reopen that NPR. The Provider contends that the NPR is

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1 See Provider Exhibit 4 and Tr. at 24.

2 Board Case No. 94-1474.

the intermediary's initial determination, and this determination only becomes final if the provider does not appeal or does not have a valid appeal to the Board. The Provider contends that the pertinent regulations and manual provisions provide that an intermediary may only reopen its initial determination when that determination is final. Finally, the Provider contends that once a provider has a jurisdictionally sound appeal before the Board, the Board has exclusive jurisdiction over the cost report.

The Provider asserts that the Intermediary cannot reopen its initial determination made in the NPR unless that determination is final. See HCFA Pub. 15-1 §§ 2930.1, 2931, and 2931.1. The Provider claims that the initial determination or NPR is not final if a provider files a timely appeal within 180 days to the Board. See 42 C.F.R. § 405.1807(c). The manual at HCFA Pub. 15-1 § 2930.1 states that "[a]n intermediary's initial determination (Notice of Amount of Program Reimbursement) becomes final and binding upon the expiration of the 180 calendar days after the date of mailing of the notice, unless before that time the provider (entity) requests a hearing . . . If a hearing is granted, the provisions with respect to finality of a hearing decision become applicable." Id.

The Provider filed a timely appeal and the parties executed a Joint List of Issues agreeing that there was not an impediment to Board jurisdiction.[3] More than a year later, the Intermediary sent a Notice of Intent to Reopen. The Provider asserts that the Intermediary has no authority to reopen because the NPR was not final as a result of a proper appeal to the Board pursuant to 42 C.F.R. § 405.1807 and HCFA Pub. 15-1 § 2930.1.

The Provider claims that the NPR, not individual audit adjustment is at issue. The pertinent regulation, 42 C.F.R. § 405.1801(a), defines the intermediary determination as "a determination of the total amount of payment due the hospital . . . ." (emphasis added). The manual at HCFA Pub. 15-1 § 2930.1.A clearly equates "intermediary's initial determination" with "Notice of Amount of Program Reimbursement." The Provider maintains that jurisdiction over the entire "cost report" transfers to the Board under 42 U.S.C. § 1395oo(d), not just jurisdiction over the specific adjustments appealed. The Provider points out that in 1990, the Board ruled that 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 for the provider."[4] The Provider also indicates that this is completely consistent with the HCFA Administration's Program Policy Position, set forth in a letter dated July 31, 1981.[5]

The Provider notes that the policy was proposed to be changed by regulation. See Proposed Rule 45 Fed. Reg. 9953 (February 14, 1980). This proposed rule was never finalized so it is

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[3] See Provider Exhibit 4.

[4] See Provider Appendix C.

[5] See Provider Appendix B.

not current law. The proposed change supports the Provider's argument that HCFA recognized that a change was needed.

The Provider disagrees with the Intermediary argument that there is a clock for appeal to the Board and a clock for the Intermediary to reopen. The Provider again indicates that concurrent jurisdiction does not exist because the reopening clock only begins after the NPR date and only if the Provider has not appealed to the Board. The Intermediary cannot reopen its initial determination because when appealed to the board it does not become final.

The Provider interprets the regulation at 42 C.F.R. § 405.1885(a) as providing no opportunity to reopen when the provider appeals to the Board. It establishes a 3-year reopening rule for determinations or decisions of the Board or Secretary. Then it states "[a]ny 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 the 3 years of the date of the intermediary determination." Id. Although the Intermediary points to the distinction between decision and determination, the Provider interprets this to mean that the intermediary only gets a 3-year right to reopen if there is not going to be a Board decision, that is, where the provider has not appealed to the Board or where its appeal is jurisdictionally or procedurally unsound.

The Provider indicates that concurrent jurisdiction is not practical, because a provider has the right to add an issue right up to the date of the hearing. See 42 C.F.R. § 405.1841(a). Thus, the intermediary would not know if its reopening would conflict with a Board decision on the same issue. This would be unworkable and was not even proposed in the proposed regulation in 1980.

The Provider also disagrees that a provider would be insulating itself for intermediary reopening by simply appealing to the Board. The Provider asserts that if a provider seeks to have a correction made to its cost report, for example for unclaimed costs, it must make a reopening request to the intermediary. The Provider asserts that if a provider has an appeal before the Board, it may not do so.

The Provider maintains that the Intermediary concern regarding the need for the Board to become involved in Intermediary reopenings is unfounded. The Provider asserts that the Intermediary has no right to reopen after the provider has appealed to the Board, that is, it loses that right when jurisdiction is transferred to the Board. Thus, the Board need not concern itself with reopening by the Intermediary because the Intermediary has no right to do so.

INTERMEDIARY'S CONTENTIONS:

The Intermediary notes that the Provider believes that once an appeal have been made to the Board, the intermediary loses its authority to reopen the cost report and the Board has sole

jurisdiction over the cost report. The Intermediary contends that the Medicare Act provides for retroactive corrective cost adjustments when reimbursement is either inadequate or excessive. The regulations permit retroactive correction by the last agency to make a determination, 42 C.F.R. § 405.1885(c), in this case the Intermediary. The Board addresses a specific question in an appeal and gives a decision that does not extend past the issue it considered, leaving intact the intermediary determination on items or issues not considered by the Board.

Regulations at 42 CFR § 405.1885 state:

> (a) 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 decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

Id.

Further, the regulations state:

> (c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

Id.

The key point in this regulation is item (c). The intermediary is the last administrative authority to make a "determination" in this case, on the issue of diabetes counseling; therefore, it is authorized to reopen the cost report. The regulations consistently preserves the distinction between "a determination of an intermediary" and "a decision by a hearing officer or panel of hearing officers, a decision by the Board or a decision of the Secretary." The difference between a determination and decision is important in analyzing the issues concerning reopenings.

An intermediary determination is defined in 42 C.F.R. § 405.1801 as follows: "[a] determination as to the amount of total Program reimbursement due to provider for items and services furnished to individuals for which payment may be made under Title XVIII of the Social Security Act for the period covered by such report." Id.

The word "decision" is not so specifically defined. However, the word is used in its most common context. Under 42 C.F.R. § 405.1871, the Board evaluates the record of the appeal

and renders a written decision. The decision takes the form of a statement as to whether an intermediary's adjustment is sustained, reversed, or modified. The Board does not review issues or items in the cost report beyond those identified. The intermediary then incorporates the Board's decision into the cost finding process to determine a provider's reimbursement as a result of the decision on the matter. Therefore, even when a provider takes a disputed adjustment through the appeal process, it is the intermediary who makes the final determination of Medicare reimbursement.

The regulation at 42 C.F.R. § 405.1871(b) states that the decision of the Board shall be final and binding on all parties to the hearing unless it is reversed by the Secretary. The phrase "decision of the Board" when considered in this context cannot be construed as an affirmative finding by the Board that every cost claimed by the provider and reimbursed by the intermediary was correct.

The Board, when it agrees to hear an appeal, has jurisdiction over those specific items that have been appealed. The act of agreeing to hear an appeal is not considered rendering a 'decision' as referred to in regulation at 42 C.F.R. § 405.1885(c).

In its initial position paper, the Provider cited a letter dated July 31, 1981, from the Director, Bureau of Program Policy, as the final authority on this issue.[6] The letter states that the current interpretation of the provision of this regulation is to mean that when a provider has requested an intermediary or PRRB hearing, the intermediary may not reopen its determination, even to consider matters that are not explicitly contained in the provider's request for a hearing. The last paragraph of the letter says, "[w]e have proposed changes to the regulations which would permit intermediaries to reopen cost settlement determinations that have been appealed to consider any aspects of the determination that were not at issue in the appeal."[7] Shortly after this letter was written, the Intermediary requested a determination of the regulations from the Office of General Counsel ("OGC") of the Department of Health and Human Services Based on OGC instructions, Blue Cross and Blue Shield Association, Administrative Bulletin #1590,[8] was issued on September 14, 1982, concerning reopening appealed Medicare provider cost reports. The Administrative Bulletin states:

> In a memorandum to the Attorney Advisor HCFA dated March 16, 1982, OGC stated that current regulations and general instructions permit the reopening of a cost report by an intermediary for purposes of revising a determination within three years of the date of the Notice of Program Reimbursement regardless of

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6 See Intermediary Exhibit 1.

7 Id.

8 See Intermediary Exhibit 2.

> the existence of a decision by a reviewing authority (intermediary Hearing Officer, HCFA Hearing Officer, PRRB, or Administrator HCFA) involving that cost report. The specific issues within the cost report which were ruled upon by the reviewing authority may not, of course, be reopened by the intermediary, but those aspects of the reimbursement determination which were not "issues" 'decided upon by the reviewing authority may be reopened.'

Administrative Bulletin No. 1590, at 2 (emphasis in original).

Also, the bulletin affirms an intermediary's right to revise an aspect of a determination while some other aspect of that determination is before a hearing authority. Id. at 3, Question 2.

OGC based its findings in part on the following:

> 1. Is there a distinction between the terms 'Determination' and 'Decision' . . . .
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> . . . . 'Determination' refers to an action taken by an intermediary to establish, confirm, or approve the final liability of the Medicare program on any or all aspects of a cost report for a particular fiscal period as submitted by a provider. A 'decision' refers to an action taken by an authorized individual or body to affirm , reverse, or modify any or all aspects of an Intermediary's determination as a result of an administrative appeal filed by the provider.

Id. at 2 (emphasis in original).

Thus, intermediaries never make 'decisions' in the strict sense. Hearing authorities, intermediary hearing officers, the Board, and the HCFA Administrator, do not issue 'determinations.'

An intermediary may make a determination encompassing any reimbursement questions presented by a cost report except for those which have been considered by the Board. That is why the Intermediary's determination can be modified by the Intermediary even though an appeal is pending or has been conducted. It is the Intermediary's position that an intermediary has jurisdiction to reopen a provider's cost report for the purpose of raising a new issue. This position is consistent with the Medicare statute, regulations, general instructions and sound policy considerations. It is fair to contributors of the Medicare trust fund since it provides for the recovery of costs paid in excess of necessary and proper costs and it is fair to providers since all rights to appeal the new issue are preserved. Providers do not and should not have a legitimate expectation that the filing of a PRRB appeal will cut off the possibility of the intermediary reopening its cost report before three years have elapsed from the issue date of the NPR.

If 42 C.F.R. § 405.1885 means that an intermediary has three years from the date of its final determination of Medicare program reimbursement to review and correct any errors in determining the Providers reimbursement cost, then the Providers interpretation of policy produces a curious double standard. For a provider that does not take an appeal, its cost report is subject to reopening for a full three years. However, if another provider has taken an appeal to the Board, its cost report cannot be reopened and it has effectively stopped an intermediary from doing its job. No matter how serious the error in the cost report, the second provider's cost report is beyond correction merely because an appeal has been filed. Such an interpretation of 42 C.F.R. § 405.1885 would also unfairly restrict providers' access to the administrative process afforded by this section. The Intermediary does not believe that such a result was ever intended by Congress or by the Secretary.

The regulation at 42 C.F.R. § 405.1871(b) states that the decision of the Board provided for in paragraph (a) shall be final and binding upon all parties to the hearing unless it is reversed by the Secretary or revised in accordance with 42 C.F.R. § 405.1885. The focus is on the specific decision of the Board on the issue before it. The phrase, “Decision of the Board”, then considered in this context cannot be construed as an affirmative finding by the Board that every cost claimed by the Provider and reimbursed by the Intermediary was correct. Therefore, the Providers appeal of selected issues and the Board's decision on those issues cannot be extended to an unreviewable determination of every single cost claimed by a Provider. That is not contemplated by either statute or regulation.

Under 42 C.F.R. § 405.1803, the intermediary makes a ‘determination’ as that term is defined in the regulations. Accordingly, the last determination within the meaning of the regulation on new issues is made by the Intermediary. Therefore, under 42 C.F.R. § 405.1885, the Intermediary has jurisdiction to reopen that determination notwithstanding any intervening appeal to the Board for all issues other than those to be decided by the Board.

The general instructions as currently published cannot be interpreted to cut off the Intermediary's ability to reopen a cost report to raise a new issue just because the Provider has filed or completed an appeal. The Board should uphold the Intermediary's right to reopen the cost report for a new issue.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395oo et seq.	-	Provider Reimbursement Review Board

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

§ 1801(a)	-	Introduction; Definitions
§ 1803	-	Intermediary Determination and Notice of Program Reimbursement
§ 405.1807	-	Effect of Intermediary Determination
§ 405.1835	-	Right to a Board Hearing
§ 405.1841	-	Time, Place, Form, and Content of Request for Board Hearing
§ 405.1871	-	Board Hearing Decision an Notice
§ 405.1885	-	Reopening a Determination or Decision
§ 405.1889	-	Effect of a Revision

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

§ 2930.1 et seq.	-	When Determinations and Decisions Become Final
§ 2931	-	Reopening and Corrections
§ 2931.1	-	Time Limits for Reopening

4. Other:

Blue Cross and Blue Shield Association, Administrative Bulletin No. 1590, September 14, 1982 - Reopening Appealed Medicare Provider Cost Reports

Proposed Changes in PRRB Procedural Regulations, 45 Fed. Reg. 9953 (February 14, 1980)

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and evidence presented, finds and concludes as follows:

The Board finds that the this case involves reopening provisions of the regulation. The Board finds that the reopening of a cost report is a separate authority given to intermediaries, Intermediary hearing officers, the Board and the Secretary to change its determination or decision within a 3-year period. The Board disagrees with the Provider argument that a provider's proper appeal to the Board under 42 C.F.R. § 405.1841 cuts off the Intermediary's right to reopen under 42 C.F.R. § 405.1885.

The Board notes that it has jurisdiction over the entire cost report once a provider has filed a proper appeal pursuant to 42 C.F.R. § 405.1841. In order to have a right to a hearing, there must have been an intermediary determination, a written request to the Board within 180 days and the amount in controversy must be greater than $10,000. Separately in the regulation, after completion of the sections dealing with the Board, and HCFA Administrator and judicial review of Board and HCFA Administrator decisions, there is a provision for reopening of a determination or decision. 42 C.F.R. § 405.1885. The regulation provides in pertinent part that:

> 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 decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

42 C.F.R. § 405.1885(a).

It also provides at 42 C.F.R. § 405.1885(c) that jurisdiction for reopening a determination or decision rest exclusively with that administrative body that rendered the last determination or decision. It states:

> Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.

42 C.F.R. § 405.1885(c).

The Board believes that the correct interpretation of these regulatory provisions is that an administrative body that makes the last determination or decision has the right to reopen its determination or decision for a 3-year period. The Board notes that the intermediary makes its determination in the NPRs issued with regard to the cost report. Under the regulations, the intermediary has a 3-year period in which to reopen the cost report and revise its determination.

Although the Board may have jurisdiction over specific issues and the cost report in general due to a proper appeal by provider, the intermediary is still the last administrative body under the regulation at 42 C.F.R. § 405.1885(c) to which the 3-year reopening provision applies. The Board notes that an intermediary cannot reopen any issues that have been appealed to the Board and for which the Board has issued a decision. In such a case, the Board is the last administrative body, under 42 C.F.R. § 405.1885(c), to have rendered a decision on those issues precluding further action by the intermediary.

The Board notes that it generally concurs with the interpretation of the reopening regulation contained in the Blue Cross and Blue Shield Association, Administrative Bulletin 1590, September 14, 1982.[9] In the bulletin, the issue in the instant case is specifically addressed in the following question and answer:

> 2. May an intermediary reopen a cost report for any reason if that cost report was the subject of an administrative appeal?
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> . . . . While the issues that were decided upon by the hearing authority may not be reopened and revised by anyone except the hearing authority (see 42 C.F.R. § 405.1885), all other aspects of the intermediary's determination may be reopened by the intermediary at its discretion within three years of the date of the Notice of Program Reimbursement (NPR).

Id. at 3 (emphasis in original).

The Board disagrees with the Providers' interpretation of the HCFA Pub. 15-1 §§ 2930.1, 2931 and 2931.1, that would have an intermediary determination never be "final" where an appeal is made to the Board. The Board views the use of the word final as indicating that if the provider does not appeal within 180 days there is no further appeal for the provider, other than a reopening, whereas, if the provider does appeal, the determinations of the intermediary are now subject to Board review.

The Board does not believe that the ability of an intermediary to reopen a cost report for a 3-year period, including those appealed to the Board, results in lack of finality with respect to provider cost reports. The Board notes that an intermediary must reopen within the 3-year period after the initial NPR. If the intermediary does reopen the cost report, it is only opened for specific issues and not the whole cost report. The intermediary would then have a 3-year period to reconsider any revised NPR, but only with regard to the issues in the revised NPR. The Board notes that any revised NPR resulting from a reopening determination can be appealed to the Board. In addition, the Board again notes that issues already decided upon by the Board could not be reopened.

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[9] See Intermediary Exhibit 2.

The Board finds that the Intermediary properly reopened the Providers' cost report within the 3-year period pursuant to 42 C.F.R. § 405.1885. The Intermediary adjustments pursuant to that reopening, which were not challenged on their merits by the Providers, are affirmed.

DECISION AND ORDER:

The Board finds that the Intermediary's reopening of the Providers' FYE 1991 cost report was proper. The Intermediary adjustments are affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: September 15, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman