PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

99-D29

PROVIDER -
Charlotte Memorial Hospital and
Medical Center
Charlotte, North Carolina

Provider No. 34-0113

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of North
Carolina

DATE OF HEARING-
February 25, 1998

Cost Reporting Period Ended -
September 30, 1982

CASE NO. 92-0668

INDEX

ISSUE:

Did the Intermediary properly reopen the Provider's cost report and recoup an overpayment made to the Provider?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Charlotte Memorial Hospital and Medical Center ("Provider") is a 778-bed hospital facility located Charlotte, North Carolina. The issue in this case concerns the recoupment of an overpayment made by Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of North Carolina ("Intermediary") for the fiscal year ended September 30, 1982 ("FYE 1982"). The pertinent dates and events are as follows:

- December 31, 1982 - Provider filed its FYE 1982 cost report.
- August 24, 1983 - Intermediary issued first Notice of Program Reimbursement ("NPR")[1]
- June 10, 1984 - Provider requested reopening of cost report for deferred compensation costs, and asked that the cost year remain open until appeals on this matter are resolved for earlier cost reporting periods.[2]
- August 23, 1985 - Intermediary issued Notice of Reopening regarding self insurance, interns and residents grants and interest expense.[3]
- September 30, 1985 - Intermediary issued Revised NPR for self insurance, interns and residents grants and interest expense. This resulted in an additional payment to the Provider in the amount of $298,914.[4]

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[1] See Provider Exhibit P-1

[2] See Intermediary Exhibit I-1.

[3] See Provider Exhibit P-2.

[4] See Provider Exhibit P-3.

- December 2, 1985 - Intermediary issued Notice of Reopening regarding non-primary care grants.[5]

- December 10, 1985 - Intermediary issued Revised NPR for non-primary care grants. However, when the amount due was calculated, the Intermediary erroneously omitted $298,914 from Medicare payments made to date (Worksheet E-1) causing a $298,914 overpayment to Provider.[6]

- July 27,1990 - Provider sent letter to Intermediary requesting TEFRA adjustment.[7]

- August 30, 1990 - Intermediary sent letter to Provider denying TEFRA adjustment request.[8]

- October 22, 1990 - Intermediary issued Notice of Reopening regarding deferred compensation costs.[9]

- August 20, 1991 - Intermediary issued Revised NPR amending allowable deferred compensation costs for an additional payment of $56,589. At that time, the Intermediary corrected the Worksheet E-1 error of $298,914 made in the December 10,1985 NPR, which resulted in a net recoupment from the Provider of $242,325.[10]

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[5] See Provider Exhibit P-4.

[6] See Provider Exhibit P-5.

[7] See Provider Exhibit P-6.

[8] See Provider Exhibit P-7.

[9] See Provider Exhibit P-8.

[10] See Provider Exhibit P-9.

There is no dispute between the parties that an overpayment of $298,914 was made to the Provider with the Revised NPR issued December 10, 1985, and that the recoupment of the overpayment occurred nearly five years and eight months later with another Revised NPR issued August 20, 1991. The record shows that the Provider's Director of Reimbursement noted the overpayment error shortly after receiving the December 10, 1985 Revised NPR, and informed the Intermediary that a mistake had been made on Worksheet E-1 of the final cost report.[11] While the Intermediary informed the Provider that action would be taken to correct the error, no further action was taken on this matter until the deferred compensation issue was resolved in 1991.[12]

The Provider appealed the Intermediary's right to reopen and revise its FYE 1982 cost report to the Provider Reimbursement Review Board ("Board") on January 31, 1992, based on the reopening provisions of 42 C.F.R. § 405.1885. On June 12, 1992, the Intermediary challenged the Board's jurisdiction over the reopening issue based on its position that the overpayment recovery was not a cost determination subject to the three-year limitation on reopenings. At the request of the Board, both parties subsequently submitted jurisdiction briefs and supporting documentation to assist the Board in making a jurisdictional determination. On October 2, 1996, the Board found that it had jurisdiction over the reopening issue challenged by the Intermediary pursuant to 42 U.S.C. § 1395oo(a)(1), and that the Provider was entitled to a hearing before the Board.

The Provider was represented by Leslie Demaree Goldsmith, Esquire, of Ober Kaler, Grimes & Shriver. The Intermediary's representative was Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary is barred from recouping the overpayment at issue based on the applicable statute, regulations, and manual provisions which prohibit recovery more than three years after an overpayment. The Provider cites the statutory provisions of 42 U.S.C.
§ 1395gg(b)(1)(B) as the authority that prohibits recovery of an overpayment against a provider more than three years after the overpayment is made. When this statutory provision was adopted, the accompanying Senate report stated the following:

> The [finance] committee is particularly concerned about overpayments discovered long after the payment was made. It has, therefore, included an amendment providing that, after 3

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[11] See Provider Exhibit P-11.

[12] Tr. at 25.

> years have expired, there will be a presumption, in the absence of evidence to the contrary, that the provider or other person shall be deemed to be without fault with respect to an overpayment and that under such circumstances no collection should be made.

S. Rep. No 1230, 92d Cong., 2nd Sess., pt. 3, at 314 (1972), Pub. L. No. 92-603 (emphasis added).[13]

When the Secretary Health and Human Services ("Secretary") promulgated the regulations at 42 C.F.R. § 405.350 implementing Congress' prohibition, the regulations required the following:

> a provider of services...shall, in the absence of evidence to the contrary, be deemed to be without fault if the determination of...the intermediary,... that more than the correct amount was paid was made subsequent to the third year following the year in which the notice was sent to such individual that such amount had been paid.

42 C.F.R. § 405.350(c)[14]

In addition, the Provider notes that further rules regarding the recoupment of overpayments to providers are set forth in the Medicare Part A Intermediary Manual ("HCFA Pub. 13-3"), which addresses the issue in a detailed manner. The manual restates the application of the statutory provisions as follows:

> Overpaid Provider Not Liable Because It Was Without Fault (Section 1870(b) of the Act [42 U.S.C.A § 1395gg].)--If a provider was without fault with respect to an overpayment it received (or is deemed without fault, in the absence of evidence to the contrary, because the overpayment was discovered subsequent to the third calendar year after year of payment) it is not liable for the overpayment; therefore, it is not responsible for refunding the amount involved.

HCFA Pub. 13-3 § 3707.A.[15]

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[13] See Provider Exhibits P-15 and P-16.

[14] See Provider Exhibit P-19.

[15] See Provider Exhibit P-20.

The manual provides further instructions to intermediaries as follows:

> Time Limits on Recovery of Overpayments --...Do not recover an overpayment discovered later than 3 full calendar years after the year of payment unless there is evidence that the provider or beneficiary was at fault with respect to the overpayment.
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> * * *
>
> Liability for Overpayments Discovered Subsequent to Third Calendar Year After the Year the Payment Was Approved -- The Law prescribes special rules which apply when an overpayment is discovered (i.e., it is determined that a "payment was incorrect") subsequent to the third calendar year after the year in which the claim was approved. Under these rules, deem an overpaid provider without fault without further development, in the absence of evidence to the contrary, i.e., if there is no indication that the provider was at fault.

HCFA Pub. 13-3 § 3707.1 (emphasis added).[16]

The Provider argues that the Intermediary and the Secretary are bound by the provisions set forth in the statue, regulations, and manual instructions which specifically address the overpayment issue. In support of its argument that an administrative agency is bound by its own regulations, the Provider cites various court decisions including the following rationale cited by the Fourth Circuit:

> An agency of the government must scrupulously observe rules, regulations or procedures which it has established. When it fails to do so, its action cannot stand and courts will strike it down.... United States ex rel. Accardi v. Shaughnessy, 347 U.S. 260, 74 S. Ct. 499, 98 L. Ed. 681 (1954)....
>
> It is of no significance that the procedures or instructions which the IRS has established are more generous than the Constitution requires.... While it is of course true that . . . the Secretary was not obligated to impose upon himself these more rigorous substantive and procedural standards, . . . having done so he could not, so long as the Regulations remained unchanged, proceed without regard to them. 354 U.S. at 388.

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[16] Id.

* * *

> These cases are consistent with the doctrine's purpose to prevent the arbitrariness which is inherently characteristic of an agency's violation of its own procedures. As the Second Circuit said in Hammond v. Lenfest, 398 F. 2d at 715, cited with approval in United Stated exrel. Brooks v. Clifford, 409 F. 2d at 706, departures from an agency's procedures "cannot be reconciled with the fundamental principle that ours is a government of laws, not men."

United States v. Heffner, 420 F. 2d 809, 811-812 (4th Cir. 1970) (citations omitted).

The Provider asserts that the overpayment at issue on this case occurred with the Revised NPR issued December 10, 1985, and that the first action by the Intermediary to recoup the overpayment occurred more than five years later in August of 1991. Under the above cited Medicare statute, regulations and manual instructions, the Intermediary is prohibited from recouping the overpayment.

Independent of the three year limitation, the Provider contends that the Intermediary is also barred from recovery of the overpayment by the regulatory requirements that: (1) overpayments must be part of an intermediary determination; and (2) intermediary determinations cannot generally be reopened beyond three years. The Provider cites the following series of regulations in support of this contention:[17]

> Use of notice as basis for recovery of overpayments. The intermediary's determination as contained in its notice constitutes the basis for making any retroactive adjustment . . . to any program payments made to the provider during the period to which the determination applies, including . . . any overpayment identified in the determination . . . .

42 C.F.R. § 405.1803(c).

* * *

> (a) A determination of an intermediary...may be reopened with respect to findings on matters at issue in such determination....Any such request to reopen...must be made within 3 years of date of notice of the intermediary determination. No such determination...may be reopened after

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[17] See Provider Exhibits P-23 and P-24.

> such 3-year period except as provided in paragraphs (d) and (e) of this season.

42 C.F.R. § 405.1885 (a).

* * *

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision....

42 C.F.R. § 405.1889.

In addition to the regulatory provisions, § 2932 of the Provider Reimbursement Manual ("HCFA Pub. 15-1") requires that the intermediary provide written notice of the reopening and the purpose of the reopening.[18] Based on the above-cited regulatory and manual provisions, the Provider argues that no revision may be made to its cost report or NPR without a proper reopening. The October 1990 notice of reopening which the Intermediary issued in connection with its August 1991 revision to Worksheet E-1 and resulting overpayment stated that the reopening was for the purpose of allowing certain deferred compensation costs.[19] The Provider's request for reopening was similarly restricted to the issue of deferred compensation.[20] These deferred compensation costs were in no way related to the Worksheet E-1 revision. Further, none of the reopenings or revisions to the Provider's cost report within three years prior to the August 20, 1991 Revised NPR and cost report addressed the issue of the error on the December 10, 1985 Worksheet E-1. Pursuant to the reopening rules and issue specificity requirement of reopening, the Intermediary was required to send a notice of its intent to reopen the Provider's cost report to correct the Worksheet E-1 error within three years of the error. Since the Intermediary never issued such a notice of reopening, it is barred from revising the Worksheet E-1 error and recouping the overpayment. Further, the Intermediary is barred from reopening the Provider's cost report by the three year limitation set forth in 42 C.F.R. § 405.1885(a) and HCFA Pub. 15-1 § 2931.1.

Lastly, the Provider argues that the Intermediary's revision to Worksheet E-1 and recoupment of overpayment are barred as against equity and good conscience. The 1996 addition to the

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[18] See Provider Exhibit P-26.

[19] See Provider Exhibit P-8.

[20] See Intermediary Exhibit I-1.

regulations at 42 C.F.R. § 405.358 stated the following in addressing overpayments.

> Section 1870(c) of the Act provides that there shall be no recovery in any case where an incorrect payment under Title XVIII (hospital and supplementary medical insurance benefits) has been made (including a payment under section 1814 (e) of the Act with respect to an individual :
>
> (a) Who is without fault; and
> (b) Adjustment or recovery would either
> (1) Defeat the purposes of Title II or Title XVIII of the Act, or
> (2) Be against equity and good conscience.

42 C.F.R. § 405.358.[21]

Given the numerous statutory, regulatory and manual provisions quoted above, the Provider asserts that it would be clearly against equity and good conscience to allow the Intermediary to reopen its cost report to amend Worksheet E-1 and recover the overpayment three years after the error and overpayment were made. Furthermore, the Intermediary denied the Provider's request to reopen cost reports and payments related to an admitted error on the Intermediary's part in using FYE 1982's as-filed rather than audited costs to calculate allowable TEFRA reimbursement.[22] The Intermediary acknowledged it used the wrong numbers to calculate the allowable TEFRA costs, but asserted it could not correct the amounts because it was beyond the three-year reopening period. The Provider believes it is beyond any semblance of equity or good conscience for the Intermediary to apply the three-year restriction only when it suits its interest. The law which prohibits the reopening and recoupment of overpayments should be equally and fairly applied to the overpayment at issue in this case, because it is beyond the three year restriction.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the issue in dispute resulted from an unfortunate error of a clerical nature that emanated from a unique set of facts. Because of this unfortunate clerical error, the Provider received $298,914 more in payments than it incurred in allowable costs that were reimbursable under the Medicare program. The Intermediary argues that the overpayment at issue raises three interconnected questions which must be addressed:

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[21] See Provider Exhibit P-32.

[22] See Provider Exhibits P-6 and P-7.

1. Was the overpayment recoverable at the point of the Intermediary's recoupment;

2. Was the Intermediary's method of recovering the overpayment proper; and

3. If there are legal questions in regard to the recovered overpayment, is the Board the proper forum to adjudicate the disagreements?

The Intermediary notes that it previously challenged the Board's jurisdiction in this matter, and that its jurisdictional arguments are not materially different from its substantive arguments presented for this case. It is the Intermediary's position that this case presents a novel problem, and that the relevant statutes, regulations, and manual provisions were not formulated to deal with the correction of clerical type errors as compared to analytical or interpretative errors.

In response to the Provider's arguments that, neither the reopening of the cost report nor the recoupment of the overpayment complied with the statutory and regulatory time limits for such actions, the Intermediary contends that the Provider's categorization of the problem does not apply to the type of erroneous overpayment recovery at issue in this appeal. The Intermediary insists that this is not a reopening problem as described under 42 C.F.R. § 405.1885. The key question in applying the provisions of 42 C.F.R. § 405.1885 is to define what is meant by an intermediary determination. The Intermediary believes this can only be achieved by a proper examination and application of the various provisions of the regulations which deal with provider reimbursement determinations and appeals. In defining an intermediary determination, the regulations at 42 C.F.R. § 405.1801 state the following:

> Intermediary determination means the following:
>
> (1) With respect to a provider of services that has filed a cost report under §§ 413.20 and 413.24(f) of this chapter, the term means a <u>determination of the amount of total reimbursement</u> due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, <u>for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report</u>.

42 C.F.R. § 405.1801 (emphasis added).

The concept that the intermediary's determination refers to the total cost allowable for the care of Medicare beneficiaries carries forward to 42 C.F.R. § 405.1803 as follows:

> Intermediary determination and notice of amount of program reimbursement.
>
> (a) General requirement. Upon receipt of a provider's cost report, or amended cost report where permitted or required, the intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider and other parties as appropriate (see § 405.1805) a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider. The intermediary must include the following information in the notice, as appropriate:
>
> (1) Reasonable cost. The notice must-
>
> (i) Explain the Intermediary's determination of total program reimbursement due the provider on the basis of reasonable cost for the reporting period covered by the cost report or amended cost reports; and
>
> (ii) Relate this determination to the provider's claimed total program reimbursement due the provider for this period.

42 C.F.R. § 405.1803(a)(1) (emphasis added).

In establishing a provider's right to a Board hearing, the regulations at 42 C.F.R. § 405.1835 carry forward the doctrine of an intermediary determination by stating the following:

> (a) Criteria. The Provider (but no other individual, entity, or party) has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if:
>
> (1) An intermediary determination has been made with respect to the provider; and
>
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in § 405.1841 (a) (1); and
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> (3) The amount in controversy (as determined in § 405.1839(a)) is $10,000 or more.

42 C.F.R. § 405. 1835(a).

If there is any lingering doubt as to the meaning of an intermediary determination, the Intermediary believes this question is answered by the following regulations which define how the $10,000 jurisdictional threshold is established:

> Amount in controversy.
>
> (a) Single appeals. The $1,000 amount in controversy required under § 405.1809 for an intermediary hearing and the $10,000 amount in controversy required in § 405.1835 for a Board hearing is, as applicable to the matters for which the provider has requested a hearing, the combined total of the amounts computed as follows:
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> * * *
>
> (2) Providers not under prospective payment. For providers that are not paid under the prospective payment system, by deducting the adjusted total reimbursable program costs due the provider on a reasonable cost basis from the total reimbursable costs claimed by the provider.

42 C.F.R. § 405.1839 (a) and (a)(2) (emphasis added).

The Intermediary points out that the Provider agrees that the amount of program reimbursement finally determined after the last revision to its 1982 cost report is correct. Since there is no complaint with the Intermediary's determination, two conclusions are inevitable:

1. The Intermediary's action did not violate the provisions of 42 C.F.R § 405.1885; and
2. There is no issue before the Board for which it has jurisdiction to decide.

In addition to determining the amount of program reimbursement, the NPR also serves a second purpose. It is also used to effect a reconciliation between the amount determined to be due and the amount due as set forth under 42 C.F.R. § 405.1803(c). Since a provider participating in the Medicare program receives a series of interim or periodic payments during a fiscal period, a second step beyond the determination of allowable cost is required to fully close out the year. The amount determined due for a fiscal year almost never equals the amount paid for the period. Pursuant to 42 C.F.R. § 405 1803 (c), the NPR identifies the balance due one participant or the other (i.e., the provider or the government), and any

revision to the amount due must always be reconciled with the amount paid to arrive at a new bottom line. The Intermediary stresses that the dispute in this case only concerns the correct amount of payments to be used to compare to the amount of allowable costs determined for the Provider.

The Intermediary argues that its use of the 1991 NPR to recover the 1985 overpayment to the Provider is justified by statute, regulations and logic. The regulation at 42 C.F.R. § 405.1803(c) instructs the intermediary to use the NPR to calculate any retroactive adjustment resulting from the application of 42 C.F.R. § 413.64(f). This regulation states:

> (c)Use of notice as basis for recovery of overpayments. The intermediary's determination as contained in its notice constitutes the basis for making the retroactive adjustment (required by
> § 413.64(f) of this chapter) to any program payments made to the provider during the period to which the determination applies, including the suspending of further payments to the provider in order to recover, or to aid in the recovery of, any overpayment identified in the determination to have been made to the provider, notwithstanding any request for hearing on the determination the provider may make under § 405.1811 or § 405.1835.

42 C.F.R. § 405.1803 (c).

In outlining the general settlement process, the regulations at 42 C.F.R. § 413.64 state the following:

> Payments to providers: Specific rules.
>
> (a) Reimbursement on a reasonable cost basis. Providers of services paid on the basis of the reasonable cost of services furnished to beneficiaries will receive interim payments approximating the actual costs of the provider. These payments will be made on the most expeditious schedule administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of a reporting period.
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> * * *
>
> (3) To determine the retroactive adjustment, the amount of the provider's total allowable cost apportioned to the program for

> the reporting year is computed. This is the total amount of reimbursement the provider is due to receive from the program and the beneficiaries for covered services furnished during the reporting period. The total of the interim payments made by the program in the reporting year and the deductibles and coinsurance amounts receivable from beneficiaries is computed. The difference between the reimbursement due and the payments made is the amount of the retroactive adjustment.

42 C.F.R. § 413.64 (a) and (f)(3).

In calculating the adjustment after the amount of allowable cost is initially determined, the reconciling item (i.e, retroactive adjustment) is the difference between cost determined to be allowable and the interim payments made for covered services rendered during the cost reporting period. When an NPR is revised and additional allowable costs are recognized, all program payments made to date (i.e., all interim payments and previous reconciling retroactive adjustments) have to be compared to the "revised determination" to calculate the amount due because of the favorable change. In this context, all of the prior payments are interim payments within the structure of the regulation at 42 C.F.R. § 413.64.

One of the arguments put forth by the Provider cites the statutory provisions of 42 U.S.C. §1395gg(b)(1)(B) and the implementing regulation at 42 C.F.R. § 405.350 (c). While these authorities impose a general three year limit on recovering overpayments, the Intermediary insists that these rules relate to a different and inapplicable situation which involves claim payments. Since the issue before the Board is not an erroneous claim payment problem, the Provider's argument is misplaced. The Intermediary espouses that a complete reading of the cited regulation clearly supports the fact that its context is claim payments:

> <u>Individual's liability for payments made to providers and other persons for items and services furnished the individual</u>.
>
> Any payment made under Title XVIII of the Act to any provider of services or other person with respect to any item or services furnished an individual shall be regarded as a payment to the individual, and adjustment shall be made pursuant to §§ 405.352 through 405.356, where:
>
> > (a) More than the correct amount is paid to a provider of services or other person and the Secretary determines that:

> (1) Within a reasonable period of time, the excess over the correct amount cannot be recouped from the provider of services or other person, or
>
> (2) The provider of services or other person was without fault with respect to the payment of such excess over the correct amounts, or
>
> (b) A payment has been made under the provisions described in section 1814(e) of the Act, to a provider of services for items and services furnished the individual.
>
> (c) For purposes of paragraph (a)(2) of this section, a provider of services or other person shall, in the absence of evidence to the contrary, be deemed to be without fault if the determination of the carrier, the intermediary, or the Health Care Financing Administration that more than the correct amount was paid was made subsequent to the third year following the year in which notice was sent to such individual that such amount had been paid.

42 C.F.R. § 405.350

The Intermediary points out that the overpayment issue in this appeal had nothing to do with an individual's claim payment or an adjudication of what is or isn't a covered item or service furnished an individual. Accordingly, the three-year limit and the 'fault" concept have no relevancy to the pending dispute. In the instant case, the Intermediary made a clerical error when it used an understated amount of program payments in the December 10, 1985, NPR. The considerations in correcting that math error are much different from revisiting allowable costs or a paid claim to determine if controlling rules were misapplied and an outcome changed. Had the error been in the other direction (a provider repayment of a retroactive adjustment was omitted in a subsequently revised NPR), the Intermediary advises that a routine correction would have been made. The Provider would not have been held to a three-year time limit under such reverse circumstances.

While conceding its jurisdiction argument, the Intermediary contends that, if the Board needs a time limit to consider in this dispute, there is a six-year limit that is applicable. In making this argument, the Intermediary relies on the statutory provisions of 42 U.S.C. § 1395(g) and the "Judiciary and Judicial Procedure" statue under Title 28. Payments to Medicare providers are based on 42 U.S.C. § 1395(g) which includes the following:

> (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayment; except that no such payment shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

42 U.S.C. § 1395 (g)(a).

The actions to recover overpayments are subject to the statutory provisions of 28 U.S.C. § 2415 (a) which state:

> Subject to the provisions of section 2416 of this title, and except as otherwise provided by Congress, every action for money damages brought by the United States or an officer or agency thereof which is founded upon any contract expressed or implied in law or fact, shall be barred unless the complaint is filed within six years after the right of action accrues or within one year after final decisions have been rendered in applicable administrative proceedings required by contract or by law, whichever is later....

28 U.S.C. § 2415 (a).

The Intermediary advises that the applicability of 28 U.S.C. § 2415(a) to the recovery of Medicare overpayments is a well settled point, and cites the court's decision in United States v. Withrow, 593 F.2d 802 (7th Cir. 1979).

As to the equity argument raised by the Provider, the Intermediary again notes that the overpayment at issue resulted from a clerical error as opposed to a reversal of a judgement call on what is an allowable cost or a covered claim. While the Provider's good faith is not in question, it was aware of the overpayment from the beginning. Since the essence of the Provider's appeal is that it knowingly wants to keep more Medicare funds than it is entitled to for reimbursable services performed in its FYE 1982, the Intermediary questions the equity of that position. The Intermediary believes that the Provider's real complaint was with the

Intermediary's refusal to accept a reopening request related to the 1983 cost report because of an error in calculating the target rate which was based on the 1982 cost report.[23] In response to the Provider's request, the Intermediary pointed out that the 1983 year was beyond the three year reopening period set forth in 42 C.F.R. § 405.1885. However, reopening corrections were made for cost years 1984 through 1987 because the Provider's request was timely for those periods.[24] By contrast, in the instant case the 1982 cost report was held open at the Provider's request to apply the outcome of a prior year dispute concerning deferred compensation. While the Provider obtained a favorable adjustment in FYE 1982 for deferred compensation, a clerical error was also corrected in the process. The Intermediary asserts that the problem with the 1983 TEFRA calculation has no legal or moral relevance to whether the recovery of the overpayment at issue in this case was correct and equitable.

It is the Intermediary's position that the Board should decline to rule on the overpayment issue in dispute because it is outside the parameters of its jurisdiction. However, should the Board retain jurisdiction, the Intermediary requests that its action be affirmed.

CITATION OF LAW, REGULATIONS AND PROGRAM JURISDICTIONS:

1. Law - United States Code ("U.S.C."):

28 U.S.C. Judiciary and Judicial Procedure:

§ 2415(a)	-	Particular Proceedings

42 U.S.C. Public Health and Welfare:

§ 1395g et seq.	-	Payment to Providers of Services
§ 1395gg	-	Overpayments on Behalf of Individuals and Settlement of Claims for Benefits on Behalf of Deceased Individuals
§ 1395gg(b)(1)(B)	-	Incorrect Payments on Behalf of Individuals: Payment Adjustment
§ 1395oo et seq.	-	Provider Reimbursement Review Board

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[23] See Provider Exhibit P-6.

[24] See Provider Exhibit P-7.

Other Statutes:

Pub. L No. 92-603, S. Rep. No. 1230, 92d Cong., 2nd Sess., pt.3, at 314 (1972).

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

§ 401.625	-	Effect of HCFA Claims Collection Decisions on Appeals
§ 405.350 et seq.	-	Individual's Liability for Payments Made to Providers and Other Persons for Items and Services Furnished the Individual
§405.358 (1996)	-	When Waiver of Adjustment or Recovery May be Applied
§ 405.374(j)	-	Effect of Compromise or Suspension, or Termination of Collection Action
§ 405.1801 et seq.	-	Provider Reimbursement Determinations and Appeals - Introduction
§ 405.1803	-	Intermediary Determination and Notice of Amount of Program Reimbursement
§ 405.1803 (a)(1)	-	General Requirement-Reasonable Cost
§ 405.1803(c)	-	Use of Notice as Basis for Recovery of Overpayments
§ 405.1835 et seq.	-	Right to Board Hearing
§ 405.1839(a)	-	Amount in Controversy - Single Appeals
§ 405.1839(a)(2)	-	Providers Not Under Prospective Payment

§ 405.1875	-	Administrator's Review
§ 405.1877	-	Judicial Review
§ 405.1885 et seq.	-	Reopening a Determination or Decision
§ 405.1889	-	Effect of a Revision
§ 413 .64 et seq.	-	Payments to Providers: Specific Rules

3. Program Instructions:

Medicare Part A Intermediary Manual (HCFA Pub. 13-3):

§ 3707.A	-	Overpayments for Provider Services - Overpaid Provider Not Liable Because it was Without Fault
§ 3707.1	-	Time Limits on Recovery of Overpayments

Provider Reimbursement Manual Part I (HCFA Pub. 15-1):

§ 2931.1	-	Provider Payments, Determinations and Appeals Procedures - Time Limits for Reopening
§ 2932	-	Notices (Including Notices of Refusal) Related to Reopening and Correction
Appendix A-Chapter 29	-	Provider Reimbursement Review Board Jurisdiction

4. Cases:

United States v. Heffner, 420 F. 2d 809 (4th Cir. 1970).

United States v. Withrow, 593 F.2d 802 (7th Cir. 1979).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after a comprehensive analysis of the controlling law, regulations, and manual guidelines, full consideration of the facts, parties contentions, documentary evidence, statements presented at the hearing, and post-hearing submissions, finds and concludes that it does not have jurisdiction over the overpayment recovery at issue in this appeal.

Upon review of all the facts and evidence, the Board finds that the issue in this appeal does not pertain to the reopening of the Provider's cost report, but concerns a payment issue which emanated from the Intermediary's recoupment of an erroneous overpayment that was caused by a clerical error during the payment reconciliation process. While the Intermediary used the issuance of an NPR as the vehicle to collect the erroneous overpayment, the Board notes that the resolution of the overpayment matter could have been resolved through other collection procedures. The fact that the Intermediary used an NPR as a functionally acceptable alternative for recouping the overpayment does not transform such action to an appealable reimbursement determination under the statutory provisions of 42 U.S.C § 1395oo and the controlling regulations at 42 C.F.R. § 405.1801ff.

It is the Board's conclusion that the regulatory provisions of 42 C.F.R. § 405.1801(a)(4), § 405.374(j) and § 401.625 preclude a Subpart R appeal for the overpayment recoupment action effected by the Intermediary in this case. Further, the Board's manual instructions set forth in HCFA Pub 15-1, Chapter 29, Appendix A, specifically states that the Board lacks jurisdiction over the intermediary's authority for recovering provider overpayments. Accordingly, the Board finds that it lacks jurisdiction over this appeal and hereby dismisses the case. Review of this decision may be subject to the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

DECISION AND ORDER:

The Board lacks jurisdiction to determine whether the Intermediary properly reopened the Provider's cost report to recoup an overpayment made to the Provider.

BOARD MEMBERS PARTICIPATING:

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

Date of Decision: March 18, 1999

FOR THE BOARD

Irvin W. Kues
Chairman