PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON-THE-RECORD
2003-D26

PROVIDER –
LAC & USC Medical Center
Los Angeles, CA

Provider No. 05-0373

vs.

INTERMEDIARY – Blue Cross Blue Shield Association/ United Government Services, LLC - CA

DATE OF HEARING -
February 13, 2003

Cost Reporting Period Ended -
June 30, 1987

CASE NO. 94-3266

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ISSUE:

Did the Intermediary correctly reduce the number of full-time equivalent interns and residents in approved training programs for the purpose of calculating the Provider's graduate medical education adjustment? (Whether the Intermediary may change the bases for excluding residents from the count more than three years after the issuance of the revised Notice of Program Reimbursement.)

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

LAC & USC Medical Center ("Provider") is a general-short term teaching hospital located in Los Angeles, California. As a teaching facility, the Provider is reimbursed for the costs of its approved graduate medical education ("GME") training programs in accordance with 42 C.F.R. § 413.86. In general, this means that the Provider's GME reimbursement is determined based upon an average rate per resident that is multiplied times the number of full-time equivalent interns and residents ("FTEs") that worked at the Provider's facility during its Medicare cost reporting period.

Blue Cross of California ("Intermediary") audited the Provider's cost report for its fiscal year ended June 30, 1987, and disallowed approximately 200 residents from the Provider's FTE count. The Intermediary listed reasons for the disallowances, each of which relates to a lack of information the Provider is required to furnish regarding each resident. The reasons specifically listed by the Intermediary include the lack of social security number, lack of medical school or graduation information, and lack of foreign medical school graduate data.

On June 17, 1993, the Intermediary issued a Revised Notice of Program Reimbursement ("NPR") reflecting its adjustment to the Provider's FTE count. On December 2, 1993, the Provider appealed the adjustment to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and met the jurisdictional requirements of those regulations.

Subsequently on or about April 19, 1999, and again on May 11, 2000, the Provider furnished documentation to the Intermediary responding to each of the Intermediary's concerns with respect to the disallowed FTEs. The Provider did not provide, and did not believe it needed to provide, rotation schedules for these individuals. Nevertheless, around June 2000, the Intermediary acknowledged that the Provider had supplied all of the resident information originally identified as missing. However, the Intermediary also indicated that it would still not allow 37.425 of the disallowed FTEs unless the Provider furnished rotation schedules or other evidence demonstrating that the residents were actually present at the Provider's facility during the subject cost reporting period.

On August 25, 2000, the Provider and Intermediary submitted a joint Stipulation of Facts in which the parties agree that the Provider is unable to produce rotation schedules for the 37.425 residents included as Attachment A, therein. The parties also agree that they have resolved all sub-issues regarding the Provider's FTE count except for the Provider's now

present argument that it is improper for the Intermediary to change the bases for excluding residents from the GME count more than three years after issuance of the pertinent NPR.[1] The amount of program funds in controversy is approximately $1,700,000.[2]

The Provider was represented by Jeffrey R. Bates, Esq., of Foley & Lardner. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's request for the subject rotation schedules, the bases for its adjustment, constitutes a cost report reopening that is illegal.[3] The Provider explains that Medicare's Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2931 specifically defines a reopening as an affirmative action taken by an intermediary to reexamine or question the correctness of a determination or decision otherwise final. Pursuant to 42 C.F.R. § 405.1885, a reopening must take place within three years of the date of the pertinent NPR, except in a case of fraud or similar fault. With respect to the instant case, the Intermediary did not originally disallow any of the subject residents based upon a lack of rotation schedules or similar proof that they were at the hospital during the time periods claimed. The Intermediary admits that it first requested the additional documentation in June of 1999, as a result of re-auditing the Provider's documents for a sample of the residents addressed in the Provider's April 1999 appeal resolution package.[4]

The Provider contends that the Board has supported the argument that the addition of a new reason for a disallowance constitutes a reopening. The Provider cites Bradford County Hospital v. Blue Cross and Blue Shield of Florida PRRB Dec. No. 92-D72, September 30, 1992, Medicare & Medicaid Guide (CCH) ¶ 40,842, aff'd, HCFA Admin., November 24, 1992, Medicare and Medicaid Guide (CCH) ¶ 41,062 ("Bradford County"), where the provider contended that the intermediary improperly broadened the basis for its disallowance between the issuance of the NPR and the Board hearing. Two dissenting members of that Board stated, in part, that "[t]he new reason for the disallowance must be rejected as untimely and without support."

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1 Provider's Supplemental Position Paper at 2. Intermediary's Position Paper at 1. Intermediary's Supplemental Position Paper at 3. Parties' Stipulation of Facts.

2 The amount of program funds in controversy is an estimate based upon the 37.425 FTEs at issue, and an average rate per resident of $45,500. See Intermediary's Position paper at 2.

3 Provider's Supplemental Position paper at 5.

4 Exhibit P-14.

The Provider rejects any argument the Intermediary may make that the three-year limitation is tolled by a pending Board appeal. The Provider asserts there is no statute or regulation for this argument, nor is there case law which clearly holds that such tolling exists.

Notwithstanding, the Provider contends that the Intermediary's request for rotation schedules is invalid because it was made after the expiration of the documentation retention period. The Provider asserts that it could not reasonably have been expected to still have copies of the rotation schedules at the time the Intermediary actually requested them.[5] The Provider explains that Medicare's Hospital Manual ("HCFA Pub. 10") § 413, requires providers to maintain documentation for at least five years. Moreover, the manual allows providers to destroy material that they no longer need to retain.[6]

With respect to the instant case, the Provider asserts it had no reason to believe it had to retain rotation schedules for the residents at issue from its June 30, 1987 cost reporting period. The Provider notes that when the Intermediary issued its Revised NPR in 1993, it explained the specific basis for each of the disallowed residents in accordance with 42 C.F.R. § 405.1803(b). Although lack of documentation regarding resident presence at the Provider's facility was listed as a reason for the disallowance of several other residents, lack of documentation of physical presence was not listed as a basis for denying the residents at issue. The Provider notes that the Doctrine of Laches is applicable to this case: a party that does not exercise its rights may not later assert those rights where the delay has resulted in prejudice to the other party.

Finally, the Provider contends that the Board has considered such factors as bad faith on the part of an intermediary or prejudice to a provider in evaluating the reasonableness of an intermediary's delay in making revisions to a cost report. The Provider cites Rapides Regional Medical Center Alexandra, LA. v. Blue Cross and Blue Shield of Louisiana, PRRB Dec. No. 94-D5, December 30, 1993, Medicare & Medicaid Guide (CCH) ¶ 42,054, decl'd rev., HCFA Admin., Feb. 9, 1994. With respect to the instant case, the Intermediary's failure to timely notify the Provider that it would reopen its cost report within three years of a Revised NPR and request documentation many years after the Provider was permitted to destroy its documents is unreasonable and prejudicial.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it is not improper to require rotation schedules or other required documentation after the Provider had addressed other deficiencies specifically noted in audit work-papers or the audit adjustment report appended to the NPR. The Intermediary asserts the Provider misapplies two basic principles regarding this matter.

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5 Provider's Supplemental Position Paper at 9.

6 Exhibit P-22.

First, it is improper to presume in a complex issue such as GME that citing specific flaws in an audit adjustment report or audit work-papers represents a discrete or even implied finding that all other requirements are satisfied. The pertinent regulation regarding this matter, 42 C.F.R. § 405.1803(b), supports this position, as follows:

> (b) Requirement for intermediary notices. The Intermediary must include in each notice appropriate references to law, regulations, HCFA Rulings, or program instructions to explain why the Intermediary's determination of the amount of program reimbursement for the period differs from the amount the provider claimed. The notice must also inform the provider of its right to an intermediary or Board hearing (see §§405.1809, 405.1811, 405.1815, 405.1835, and 405.1843) and that the provider must request the hearing within 180 days after the date of the notice.

42 C.F.R. § 405.1803(b).

Second, it is improper to presume that an intermediary's request for required documentation; i.e., pertaining to reimbursement items not specifically addressed in audit work-papers or an audit adjustment report, is a "reopening." The relevant regulations and manuals relate a reopening to a change in the amount of money due the provider. A reopening is for dollars, not concepts, as follows:

> A. Reopening an Intermediary Determination.-- An intermediary's initial determination on the amount of program payment contained in a notice of amount of program reimbursement, which is otherwise final, may be reopened by the intermediary within 3 years of the date of such notice.

HCFA Pub. 15-1 § 2931.1

No reimbursement was lowered after the challenged NPR. Payments were increased but not to what the Provider wanted. Again, there is no legal requirement that a deficiency not addressed in the audit must be raised through a formal reopening within three years.

The Intermediary notes the Provider's reliance upon the dissenting opinion in Bradford County. The Intermediary cites to the majority in that case.

Finally, the Intermediary rejects the Provider's proposition that document retention is limited and there was a day certain in which it could dispose of all documents related to 1987. Given the history of the GME issue, the Provider was at peril for not retaining all records associated with its residents until the matter was ultimately resolved.

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 Intermediary audited the Provider's count of FTE interns and residents for the purpose of determining the Provider's reimbursement for GME expenses. Based upon this audit, the Intermediary issued an NPR in June 1993, reflecting a disallowance of approximately 200 FTEs of the approximate 750 FTEs claimed by the Provider. The reason specified by the Intermediary for the disallowances was a lack of required information with respect to each of the various residents. For example, in some instances the Provider failed to furnish a resident's social security number, medical school data, or foreign medical school graduate data. Importantly, the Intermediary did not list as a reason for disallowance, the lack of rotation schedules or other proof of a resident's presence at the Provider's facility.

In a letter dated April 19, 1999, the Provider furnished information identified by the Intermediary "as missing" with respect to approximately 121 of the disallowed FTEs. At this time, in June 1999, the Intermediary advised the Provider that no rotation schedules or proof of presence had been sought during the audit for any of the disallowed FTEs because of the other missing information. Moreover, the Intermediary requested that the Provider now furnish that information, i.e., rotation schedules.

The Provider furnished all of the information the Intermediary had requested except for rotation schedules applicable to 37.425 FTEs, which are at issue in this appeal. In August 2000, the Intermediary and Provider entered a Stipulation of Facts agreeing, in part, that the generic issue in this case is still whether or not the Intermediary properly reduced the Provider's FTE count. The Parties also agree that they have resolved all sub-issues regarding the correct FTE count except for the Provider's subsequently raised argument that the Intermediary's disallowance is improper because the basis of the disallowance was changed. That is, the Provider argues that the disallowance is improper because the Intermediary's June 1999 request for rotation schedules constitutes a cost report reopening that is improper because it was initiated more than three years after the pertinent NPR. Notwithstanding, the Provider argues that the Intermediary's disallowance is improper because the request for rotation schedules was made beyond the record retention period prescribed by the program.

The Board concludes that the Intermediary's disallowance of the subject 37.425 FTEs is proper. The Board finds that the factual issue in this case is the proper counting of FTE interns and residents in accordance with 42 C.F.R. § 413.86(f)(2). The Intermediary's audit adjustment report, which accompanied the pertinent NPR, specifically references 42 C.F.R. § 413.86(f)(2) as the basis for its adjustment, and it is that disallowance that was appealed by the Provider and put before the Board. The Provider must be able to fulfill all requirements of those regulations in order to have the subject FTEs included in its resident count, which it cannot do. According to the parties' Stipulation of Facts, the Provider is unable to furnish rotation schedules or other documentary evidence of the subject residents' presence or service dates at its facility.

The Board finds that the Intermediary's request for rotation schedules does not represent a cost report reopening. Once this issue had been appealed to the Board and jurisdiction granted, both the Provider and Intermediary are encouraged by the regulations, the

Board's procedural rules and intermediary guidelines to work together to resolve differences and develop their cases including the introduction of new arguments and evidence. Notably, it is this authority that allowed the Provider to submit additional documentation more than three years after the issuance of the subject NPR, and allowed the Intermediary to accept that documentation and yet request other information relevant to its case/disallowance. 42 C.F.R. § 405.1869, Scope of Board's decision making authority, 42 C.F.R. § 405.1855, Evidence at Board hearing.

The Board also finds the Provider's argument regarding Medicare's record retention period to be without merit. Since the Provider had an appeal pending at the Board regarding intern and resident information, it was responsible to maintain all records regarding this matter. Moreover, it is unclear from the record exactly what occurred between the Intermediary's initial disallowance of approximately 200 FTEs and the 37.425 FTEs at issue. It appears that the Provider did in fact present rotation schedules for approximately 155.6 FTEs, leaving open the question of why rotation schedules pertaining to the other residents were unavailable. The Board also notes that the Provider apparently did not furnish any of the missing information identified by the Intermediary until April 1999, or about six years after the pertinent NPR was issued. This period alone is beyond Medicare's record retention period.

In conclusion, the Board finds that the Provider is responsible to establish with a preponderance of evidence that it is entitled to be reimbursed program funds in accordance with applicable rules and regulations. The Board finds that the Provider did not establish that it met the criteria at 42 C.F.R. § 413.86 with respect to the subject disallowed interns and residents.

DECISION AND ORDER:

The Intermediary's adjustment disallowing 37.425 residents from the Provider's FTE count for GME reimbursement is proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Henry C. Wessman, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.

Date: May 2, 2003

FOR THE BOARD:

Suzanne Cochran, Esq.

Chairman