# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2003-D47

**PROVIDER** –
Phelps Memorial Hospital Center,
Sleepy Hollow, New York

Provider No. 33-0261

**vs.**

**INTERMEDIARY** –
Blue Cross and Blue Shield Association/
Empire Medicare Services

**DATE OF HEARING -**
November 22, 2002

Cost Reporting Period Ended
December 31, 1993; December 31, 1994
and December 31, 1995

**CASE NO.** 98-2105, 98-2106, 98-2107

**INDEX**

ISSUE:

Was the Intermediary's treatment of the Provider's increase in bed size of its exempt rehabilitation unit proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Governing Statutes and Regulations:

The Medicare program was established in 1965 under Title XVIII of the Social Security Act (the Act) to provide health insurance to the aged and disabled. 42 U.S.C. §§ 1395--1395cc. The Health Care Financing Administration (HCFA) (now Centers for Medicare and Medicaid Services (CMS)) is the operating component of the Department of Health and Human Services charged with administering the Medicare program.

In order to participate in the Medicare program, a hospital must file a provider agreement with the Secretary 42 U.S.C. § 1395cc. The Secretary's payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under the Medicare law and under interpretative guidelines published by CMS. Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and what proportion of these costs are to be allocated to Medicare. 42 C.F.R. § 413.20. The fiscal intermediary audits the cost reports and determines the total amount of Medicare reimbursement due the provider, which it publishes in a notice of program reimbursement (NPR) that sets forth the individual expenses allowed and disallowed by the intermediary. 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the NPR. 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

In 1983, the Congress of the United States created the Prospective Payment System (PPS) to pay for hospital services to Medicare patients. PPS replaced the cost reimbursement system that was part of the original Medicare Act. Under PPS, inpatient-operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs. Congress also provided for exclusions to the PPS rates for certain hospitals that met specific criteria with respect to their inpatient population pursuant to 42 C.F.R. § 412.25, entitled, "Excluded distinct part hospital units." This exclusion allows the hospital to continue to be paid reasonable cost for services furnished in the excluded unit. 42 C.F.R. § 412.22(b). The regulations also provides a procedure for expanding excluded units under 42 C.F.R. § 412.30.

Background of the Provider:

Phelps Memorial Hospital Center (Provider) is a 235-bed general hospital located in Sleepy Hollow, New York. In 1975, the Provider opened a four-bed physical and rehabilitation unit.[1] On January 1, 1986, Medicare classified the four-bed unit as a distinct-part rehabilitation unit entitled to reimbursement at the PPS-exempt rate.[2] At issue here is whether the Provider obtained proper approval to expand the excluded unit. The Provider has appealed fiscal years ending December 31, 1993, December 31, 1994 and December 31, 1995.

During its review of the Provider's December 31, 1995 cost report, the Intermediary determined that the rehabilitation unit exceeded its capacity by 229.32%. This prompted the Intermediary to re-examine the previous years' cost reports which also reflected occupancy rates in excess of 100%.[3]

As part of its audit findings, the Intermediary required the Provider to correct its billings to the Medicare program. The Provider refunded its TEFRA rate billings and then billed its cases under the DRG Prospective Payment System. This dispute arises out of the Intermediary's refusal to reimbursement the Provider under the TEFRA rate for more than four patients per day in its distinct-part rehabilitation unit for the fiscal years at issue.

The Provider was represented by Roy W. Breitenbach, Esquire, of Garfunkel, Wild & Travis, P.C. The Intermediary's representative was Eileen Bradley, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that under New York law, in order to expand the bed capacity of a pre-existing unit, the requirements are simple: just notify the state of New York Health Department.[4] Thus, the Provider asserts that under New York law, Health Department "approval" can be given without amendment of the operating certificate and still meet Medicare requirements.

One of the Provider's witnesses, a senior New York Health Department official, testified that during the relevant period, the rehabilitation unit was approved to treat at least fifteen patients per day.[5] He further stated that the State was fully aware of

---

[1] See Tr. at 73.

[2] See Intermediary's position paper Exhibit I-3. This payment is known as the TEFRA rate because it was authorized by the Tax Equity and Fiscal Responsibility Act. See also 42 C.F.R. § 412.22.

[3] See Intermediary's position paper at 4.

[4] See Provider's post-hearing brief at 13. The Provider asserts that the specific form of approval is up to the Health Department; the amendment of the operating certificate is only one such form of approval. See Murphy Deposition 13-22 and N.Y. Pub. Health Law § 2802.

[5] See Murphy Deposition 13-22.

and had approved the rehabilitation unit regularly treating approximately ten patients per day since late 1992.[6] At that time, the State Health Department was not only the agency responsible for "licensing" facilities, but also the agency responsible for certifying compliance with HCFA's PPS-exempt distinct-part rehabilitation unit requirements.[7]

The Provider states that the Health Department consistently found that the rehabilitation unit fully complied with all State and Medicare requirements.[8] Senior Health Department officials recommended that the Provider treat approximately ten patients per day for an extended period of time to demonstrate the community need for expanded unit capacity.[9]

The Provider contends that the full knowledge and consent given by the State Health Department officials regarding the rehabilitation unit's consistently elevated occupancy levels conclusively establishes that the Provider had the State's approval to expand under New York Public Health Law § 2802 by late 1992. Thus, the expansion of the Provider's rehabilitation unit became effective, for PPS-exempt reimbursement purposes, on January 1, 1993, the start of the Provider's first cost reporting period after the State Health Department's approval.[10]

Regarding the Intermediary's reliance on HCFA Pub. 15-1 § 3001, which requires a hospital to directly notify HCFA of any expansion before it can take effect, the Provider notes that this section was not promulgated until August 1994.[11] At that time HCFA changed the method of annual re-certification of distinct-part rehabilitation units for Medicare purposes. In the State of New York, re-certification for distinct-part units is routinely conducted in June. The Provider contends that the new self-attestation procedures-including the requirement that providers directly notify HCFA of unit expansions – did not become effective for the Provider until June 1995.[12] Therefore, the Provider was under no obligation to directly notify HCFA of its rehabilitation unit expansion until June, 1995, as it was the State Health Department's obligation prior to that time.

---

[6] See Tr. at 83-98 and Murphy Deposition at 13-22.
[7] See Provider's post-hearing brief at 6 and Murphy Deposition at 12-13.
[8] The Provider also argues that the fact that the State Health Department consistently found, after conducting survey inspections of the Unit, that the Unit fully complied with State and Medicare requirements precludes the Intermediary from taking the position – as it attempted to do during the hearing – that the Unit's bed configuration failed to meet Medicare requirements during the relevant period. The Provider argues that because the State Health Department was Medicare's agent to determine Program compliance during the relevant period, the Medicare Program is now estopped from presenting evidence to contradict the Health Department's findings. Moreover, the Intermediary's failure to raise this issue at any time before the hearing provides another reason why the Board should categorically reject this position. See Provider's post-hearing brief at 14.
[9] See Tr. at 83-85.
[10] See Provider's post-hearing brief at 15 and 42 C.F.R. § 412.30(a).
[11] See Tr. at 207.
[12] See Tr. at 208.

The Provider believes it would be manifestly unfair to deny it Medicare reimbursement for services that it unquestionably provided solely because the operating certificate was not technically changed until several years later – due to circumstances largely beyond the Provider's control.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider received a notification letter on November 7, 1986, indicating that it had been approved for a four-bed excluded rehabilitation unit under Medicare PPS. Any changes to the excluded unit were to be communicated to HCFA five full months prior to the start of the next cost reporting period.[13]

On October 7, 1994, HCFA notified the Provider that the standards for re-verification by the State survey agencies for excluded rehabilitation units had been changed.[14] The revised procedures provided for self-attestation on an annual basis that the units continued to meet PPS exclusion criteria. In addition, providers were required to report any changes in operations to HCFA within ten days after change.[15] The Intermediary asserts that the Provider did not comply with the notification provisions of HCFA Pub. 15-1 § 3001 until it filed the self-attestation form on June 21, 1995. It was via this form that the Intermediary first became aware of the Provider's intent to expand its four-bed excluded rehabilitation unit to fifteen beds by January, 1996.[16]

The Intermediary contends that New York State was well aware of the fact that the Provider had occupancy levels substantially exceeding four patients per day in its distinct-part rehabilitation unit. However, the Intermediary does not believe that the State's awareness of the situation can be accepted as proof that the Medicare program concurred with the expansion to fifteen beds beginning in 1993. From the Provider's own documentation, it was not until June 21, 1995, that the Provider informed Medicare that an expansion to the rehabilitation unit was planned.[17]

The Intermediary points out that on December 1, 1994[18] the state of New York via a Certificate of Need (CON), formally approved the Provider's expansion of the rehabilitation unit to fifteen beds. The Intermediary does not view the CON as an approval to revise a facility's operating certificate. The Provider's operating certificate was not revised until 1996 per the state of New York's notification dated January 25, 1996.[19] The State's determination stipulated that, based on a survey

[13] See Intermediary's position paper Exhibit I-4.
[14] See Intermediary's position paper Exhibit I-4.
[15] See Intermediary's position paper Exhibits I-4 and I-5.
[16] See Intermediary's position paper Exhibit I-6.
[17] See Intermediary's position paper Exhibit I-6.
[18] See Intermediary's position paper Exhibit I-8.
[19] See Intermediary's position paper Exhibit I-9.

conducted on December 21, 1995, the renovated area was found to be in substantial compliance, and a revised operating certificate was being requested.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law, Program instructions, parties' contentions and evidence presented, finds and concludes that the Provider did not receive appropriate approval for Medicare certification to increase its bed capacity to fifteen beds in the rehabilitation unit for the fiscal years in question in accordance with 42 C.F.R. § 412.30(b).

The Board notes that the Provider staffed four beds in the rehabilitation unit certified by HCFA for participation in the Medicare program effective January 1, 1986.[20] When HCFA notified the Provider of its Medicare certification in a letter dated November 7, 1986, the Provider was informed that any changes made to the excluded unit were to be communicated to HCFA at least five full months prior to the start of its next cost reporting period.[21] Under these circumstances, the Board finds that the Provider had full knowledge of its responsibility to inform HCFA of the expansion of the rehabilitation unit. Therefore, the Board rejects the Provider's argument that it was under no obligation to directly notify HCFA of its rehabilitation expansion until June, 1995.

On October 7, 1994, HCFA notified the Provider that a change had occurred in the standards for re-verification by the State survey agencies for excluded rehabilitation units.[22] The revised procedures provided for self-attestation on an annual basis that the rehabilitation unit continued to meet the PPS exclusion criteria. Providers were required to report any changes in operations to HCFA within ten days after the change occurs.[23]

In complying with HCFA's new procedures, the Provider submitted its self-attestation dated June 21, 1995 for its fiscal year ending December 31, 1996.[24] The Board observes that the Provider reported that the existing beds in the rehabilitation unit would be expanding to fifteen by January, 1996.[25] As part of the worksheet the Provider disclosed, as a separate note, that it had received approval to expand the rehabilitation unit from four beds to fifteen beds and that the renovation of the unit was currently in process. The relocation and opening of the new unit was scheduled for January, 1996. Given the fact that the construction to the rehabilitation unit was not completed until January, 1996, the Board finds it

---

[20] See Intermediary position paper Exhibit I-3.
[21] The Intermediary points out that HCFA's letter was consistent with HCFA Pub 15-1 § 3001 even though the Medicare instruction was not promulgated until August, 1994.
[22] See Intermediary's position paper Exhibit I-4.
[23] The Intermediary asserts that HCFA's letter was in accordance with HCFA Pub 15-1 § 3001.
[24] See Intermediary's position paper Exhibit I-6.
[25] See Intermediary's position paper Exhibit I-6, entitled "Rehabilitation Unit Criteria Worksheet."

difficult to fathom that HCFA could reimburse the Provider for something that did not exist.
The Board finds the Provider's own statements to be contradictory, as its own witness testified that it had consistently reported four rehabilitation beds on the cost reports in question, even though it claimed it had received verbal approval from the State of New York to expand to fifteen rehabilitation beds.[26] During the hearing, when asked why the Provider did not report fifteen rehabilitation beds on the cost report, the Provider's witness responded that it did not have the supporting documentation to submit to the Intermediary.[27] This is further evidence that the Provider did not seek approval from the appropriate authority in order to properly claim Medicare reimbursement for all fifteen rehabilitation beds under the PPS exempt rate.

Although the Provider was approved by the State, through a CON, to expand its rehabilitation unit to fifteen beds on December 1, 1994,[28] Medicare was not officially notified of this change until the Provider's self-attestation, well after the cost reporting years in question as evidenced by the fact that the Provider's operating certificate was not revised until 1996.[29] Therefore, the Board concludes that approval from the State was not sufficient for Medicare purposes and there can be no "deemed" certification under the provisions of 42 C.F.R. § 412.30(b).

DECISION AND ORDER:

The Provider did not meet the requirements of 42 C.F.R. § 412.30(b) for obtaining the appropriate approval to add beds to its distinct-part rehabilitation unit for Medicare certification purposes. The Intermediary's determination is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Henry C. Wessman, Esquire
Dr. Gary Blodgett
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, C.P.A.

DATE: August 22, 2003

FOR THE BOARD

Suzanne Cochran, Esquire
Chairman

[26] See Tr. at 158, line 20.
[27] See Tr. at 158, line 1.
[28] See Intermediary's position paper Exhibit I-8.
[29] See Intermediary's position paper Exhibit I-9.