PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2004-D17

PROVIDER –
Hatch Valley Home Health Agency
Salem, New Mexico

Provider No. 32-7125

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
December 19, 2003

Cost Reporting Period Ended
April 30, 1997

CASE NO. 00-2285

INDEX

ISSUE:

Was the Intermediary's adjustment to the Provider's cost limits proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Hatch Valley Home Health Agency ("Provider") is a solely owned, proprietary facility located in Salem, New Mexico. The Provider was certified to participate in the Medicare program on May 12, 1994. On March 20, 1995, New Mexico Blue Cross Blue Shield, serving as the Provider's intermediary, advised the Provider of the cost limits that would be used in the determination of its Medicare reimbursement. Moreover, the Provider was advised that the limits would be in effect until its cost reporting period beginning on or after July 1, 1996.[1]

Palmetto Government Benefits Administrators ("Intermediary") replaced New Mexico Blue Cross Blue Shield as the Provider's intermediary and was responsible for final settlement of the Provider's cost report for its fiscal year ended April 30, 1997. During the audit of this cost report, the Intermediary determined that the Provider's cost limits had been incorrectly computed, i.e., by the prior intermediary. Specifically, the Intermediary determined that the limits were computed as if the Provider had been located in a non-urban area even though it was actually located in Dona Ana County, which is listed under Las Cruces, New Mexico, an urban area, in Medicare's Schedule of Limits on Home Health Agency Costs Per Visit.[2] See 58 F.R. 36748, July 8, 1993.

The Intermediary issued a Notice of Program Reimbursement which included an adjustment to the Provider's cost limits, i.e., an adjustment applying cost limits based upon the Provider's urban location. The Provider appealed the adjustment to the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-405.1841 and met the jurisdictional requirements of those regulations. The amount of Medicare funds in controversy is approximately $60,000.

The Provider was represented by Antoinette L. Turner, Administrator, Hatch Valley Home Health Agency. The Intermediary was represented by Bernard M. Talbert, Esq., Associate Counsel, Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it was not given proper notice of the cost limits applied by the Intermediary and this precluded the Provider from being able to exercise fiscal responsibility over its budget and expenditures. The Provider explains that Medicare's Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1") § 2541 stipulates that each home health agency ("HHA") is to be notified of its cost limits at least 30 days prior to the start of the applicable cost reporting period. Accordingly, the Provider asserts that it has been penalized through no fault of its own but through an error made by the previous intermediary.[3]

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[1] Provider Position Paper at 2. Exhibit P-10.
[2] Intermediary Position Paper at 3. Exhibit I-4 at 23.
[3] Provider Position Paper at 3.

The Provider also contends that the Intermediary's adjustment is contrary to section 13564(a)(2) of the Omnibus Budget Reconciliation Act of 1993 ("OBRA "), which provides that there shall be no changes in the HHA cost limits for cost reporting periods beginning on or after July 1, 1994 and before July 1, 1996. The Provider notes that the cost limits it used in the preparation of the subject cost report were assigned by its previous intermediary for its fiscal year ending April 30, 1995, and were still in effect or "frozen" pursuant to OBRA. The Provider notes that the Intermediary used the cost limits computed by the previous intermediary to settle its cost reports for its fiscal years ended April 30, 1995 and April 30, 1996, which were the first two cost reporting periods affected by the OBRA freeze.

The Provider contends that its position is supported by the Administrator's decision in Reavis Homecare, Inc. v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of New Mexico/Palmetto Blue Cross and Blue Shield, PRRB Dec. No. 98-D96, September 17, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,073, mod'd, CMS Administrator, November 17, 1998, Medicare & Medicaid Guide (CCH) ¶ 80,121 ("Reavis Homecare"). The Administrator stated:

> [t]he effect of this provision is that a HHA's latest per-discipline cost limit for a period beginning on or after July 1, 1993, and before July 1, 1994, as calculated under this notice, without regard to subsequent adjustments under section 1861(v)(i)(L)(ii) for exceptions, will remain in effect until its cost reporting period beginning on or after July 1, 1996. . . . Accordingly, there will be no changes, besides those due to the elimination of the A&G add-on, to a HHA's cost limit for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996, to account for inflation, changes in wage index or to MSA designations.

Reavis Homecare at 7.

Finally, the Provider contends that the overpayment created by the Intermediary's adjustment represents payments it received on behalf of Medicare-eligible beneficiaries. Since the Provider asserts that it was without fault, it believes the overpayment should be waived in accordance with 42 U.S.C. §1395gg(b)(1)(C). In part, the statute states: "there shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made . . . With respect to an individual who is without fault . . . ." Id.

INTERMEDIARY'S CONTENTIONS:

The Intermediary agrees that HCFA Pub. 15-1 § 2541 requires an HHA to be notified of its cost limits before the cost reporting period begins. However, the Intermediary argues that this requirement is not controlling if the notice is incorrect.[4]

The Intermediary cites Evangeline Home Health Agency v. Blue Cross Blue Shield Association/Blue Cross of Louisiana, PRRB Dec. No. 85-D40, April 29, 1985, Medicare & Medicaid Guide (CCH) ¶ 34,650, where the intermediary corrected a notice of cost limits after the end of the applicable cost reporting period. In that case, the Board found that the retroactive

[4] Intermediary Position Paper at 3.

correction met the requirements of 42 U.S.C. § 1395x(V)(1)(A) and 42 C.F.R. § 413.64 (previously 42 C.F.R. § 405.454) which provide for retroactive adjustments where reimbursement is either inadequate or excessive. See also Serv-U Home Health Agency v. Blue Cross Blue Shield Association/Blue Cross and Blue Shield of Mississippi, PRRB Dec. No. 93-D27, March 2, 1993, Medicare & Medicaid Guide (CCH) ¶ 35,336, aff'd, CMS Administrator, March 24, 1993, Medicare & Medicaid Guide (CCH) ¶ 35,494, where the Board affirmed an intermediary decision to retroactively rescind an incorrect exemption to the HHA cost limits.

The Intermediary acknowledges that the subject cost reporting period is within the 3-year freeze imposed by OBRA. However, the Intermediary contends that the limits themselves were not changed; rather, an error in the initial notice to the Provider advising it of its limits was corrected.

Finally, the Intermediary disagrees with the Provider's reliance upon the overpayment waiver presented in 42 U.S.C. § 1395gg. The Intermediary believes the waiver applies to individuals and that the Provider is not an individual as intended by the statute.

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 Provider began its participation in the Medicare program on May 12, 1994. Shortly thereafter, on September 20, 1994 and March 20, 1995, respectively, the Provider received written notice from its then intermediary of the cost limits that would be used to determine its final year-end reimbursable costs. It is undisputed in this case, however, that the limits conveyed to the Provider in these notices were incorrect. Specifically, the limits were higher than they should have been because the previous intermediary calculated them using an adjustment factor reserved for HHAs located in rural areas rather than an adjustment factor reserved for facilities located in an urban or Standard Metropolitan Statistical Area ("SMSA").[5]

The issue in this case stems from the fact that the current Intermediary discovered the error in the cost limits during its audit of the Provider's 1997 cost report and perfected an adjustment based upon revised or corrected limits. The result of this adjustment was a disallowance of part of the Provider's otherwise reimbursable costs.[6]

The Provider believes the Intermediary's adjustment is improper because it was not notified of its actual limits 30 days prior to the start of the subject cost reporting period as required by

[5] The Board notes that each of these notices also contained incorrect reference to regulations at 42 C.F.R. § 405.460 which had been re-designated to 42 C.F.R. § 413.30.

[6] The Provider asserts that it received the same erroneous information directly from the Centers for Medicare & Medicaid Services ("CMS") that it received in the September 20, 1994 and March 20, 1995 notices from its initial intermediary. The Provider explains that in response to a telephone inquiry made to CMS regarding its geographical designation, CMS furnished a copy of HCFA Pub. 15-1 § 2510.3 Exhibit II, issued in July 1975, which shows only two counties in New Mexico as being SMSA. The Provider is not located within either of those counties. See Provider's Index to its Exhibits at P-11.

program instructions at HCFA Pub. 15-1 § 2541. The Provider adds that it is essential for health care providers to be advised of their cost limits prior to the start of each applicable cost reporting period in order to maintain fiscal responsibility over their operations. Moreover, failure to receive prior notification and be subjected to an unforeseen retroactive adjustment such as that made by the Intermediary may cause an overpayment situation through no fault of a provider. Notwithstanding, the Provider contends that the Intermediary's adjustment is also improper because the cost limits imposed by the initial intermediary were frozen by OBRA during the subject cost reporting period.

The Board agrees that the circumstances in this case clearly defeat the purpose of HCFA Pub. 15-1 § 2541 that requires advance notice of cost limits applicable to provider cost reporting periods. However, the Board also finds that manual instructions cannot grant rights to a provider that are inconsistent with program regulations. Here, 42 C.F.R. § 413.30, along with two different notices published in the Federal Register, prescribe limits that are to be applied to HHA costs for reporting periods beginning on or after July 1, 1993. Moreover, the Federal Register notices prescribe revised SMSA designations clearly placing the Provider in an urban area. Similarly, the Board finds that the OBRA legislation clearly freezes HHA cost limits in effect for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. However, this freeze cannot be used to legitimize program payments that are otherwise inconsistent with program rules, i.e., improper payments.

The Board disagrees with the Provider's reliance upon the Administrator's decision in Reavis Homecare. That case was a matter of determining which properly-calculated cost limits should be applied to the provider's costs; that is, limits applicable to the provider's previous geographical location or the limits established for the geographical location where the provider had moved during the cost reporting period. That circumstance is not the same as the instant case where an obvious error led to the calculation of incorrect cost limits, which the Provider wishes to preserve.

The Board also disagrees with the Provider's argument that because it is without fault regarding the overpayment that resulted from the Intermediary's adjustment, the Intermediary should not be allowed to recover the overpayment pursuant to 42 U.S.C. § 1395gg. Here the Board finds that the statute, which does bar the recovery of incorrect payments under certain circumstances, pertains only to individuals and not to providers of service. In VNA of Southwestern Indiana, Inc. v. Shalala, U.S. Court of Appeals for the Seventh Circuit, No.99-3494, May 17, 2000 the court found that the rights created by 42 U.S.C. § 1395gg(a) must be an individual's rights whether or not payments are made directly to the individual or to a provider.

The Provider in this case was unjustly prejudiced and has likely suffered financial harm as a result of errors by its initial intermediary. While the Board would like to remedy this situation, it has not been granted authority to provide equitable relief. The Board is compelled to find for the Intermediary.

DECISION AND ORDER:

The Intermediary's adjustment revising the Provider's cost limits is proper. The Intermediary's adjustment is affirmed.

Board Members Participating:

Suzanne Cochran, Esq.
Dr. Gary B. Blodgett
Martin W. Hoover, Jr., Esq.
Elaine Crews Powell, C.P.A.
Anjali Mulchandani

DATE: April 29, 2004

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman