PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D8

PROVIDER -
Marion General Hospital
Columbia, Mississippi

Provider No.: 25-0085

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
TriSpan Health Services

DATE OF HEARING -
May 9, 2006

Cost Reporting Period Ended -
September 30, 1999

CASE NO.: 05-0448

INDEX

ISSUES:

1. Whether the Provider Reimbursement Review Board may grant jurisdiction for the adjustment included in the Provider's initial Notice of Program Reimbursement.

2. Whether the Intermediary's adjustment to remove unliquidated liabilities in the year incurred was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the proper amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' 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 Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395(h), 42 C.F.R. §§413.20(b) and 413.24(b).

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 the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 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 issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Medicare requires that providers accumulate and report their costs on the accrual basis of accounting.[1] Under accrual accounting, revenue is reported in the period in which it is earned, regardless of when it is collected, and an expense is reported in the period in which it is incurred, regardless of when it is paid.[2] Although Medicare recognizes the accrual of costs for which a provider has not actually expended funds in the year of the accrual, it does not recognize the accrual of costs for purposes of payment, unless the related liabilities are liquidated timely.[3] For short-term liabilities, the regulations generally require that the liability be liquidated within one year after the end of the cost

[1] 42 CFR §413.24(a).
[2] 42 CFR §413.24(b)(2).
[3] 42 CFR §413.100(c)(1); PRM-1 §2305.

reporting period in which the liability is incurred.[4] However, the program permits the provider to submit written justification for non-payment of the liability to the intermediary within the one-year time limit.[5] The intermediary may, in turn, grant an extension for good cause that may not exceed three years beyond the end of the cost reporting period in which the liability was incurred.[6] If liabilities are not liquidated within the required time frame established in the regulations, the cost is disallowed for Medicare payment purposes, generally in the year of accrual.[7] At issue in this case is in which cost reporting period should the costs associated with liability that remains unpaid (or unliquidated) after the expiration of the extension period (3 years after the end of the cost reporting period in which the liability was incurred) be disallowed.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Marion General Hospital (Provider) is an acute care county hospital that is located in Columbia, Mississippi. The Provider accrued $425,773 for short-term liabilities on its cost report for FYE 9/30/99. The accrual included $362,369 in billings owed to Wesley Health Systems (Wesley). PRM-1 §2305 requires that a short-term liability must be liquidated within one year after the end of the cost reporting period in which the liability is incurred, subject to the exceptions specified in §§2305.1 and 2305.2. The Provider was unable to liquidate the liabilities within the one-year limitation period and petitioned TriSpan Health Services (Intermediary) for an extension of the liquidation period pursuant to the provisions of PRM-1 § 2305.1. This manual section extends the period of liquidation from one to three years from the close of the cost reporting period in which the costs were accrued. The Provider filed its petition on September 22, 2000, and the Intermediary approved the request on July 24, 2002. In the interim period between the date of the Provider's request and its approval, the Intermediary found that the Provider had negotiated a settlement of liabilities in dispute with Wesley that reduced the amount owed by $297,359. The Intermediary issued an original NPR dated August 12, 2003 that adjusted the cost report to reflect the $297,259 settlement. The Provider never appealed this adjustment from the original NPR. On April 2, 2004, the Intermediary reopened the NPR to adjust for "nonallowable expenses due to untimely liquidation of liabilities" and disallowed an additional $128, 414 in a revised NPR dated July 1, 2004. The Provider timely appealed the revised NPR and identified the combined $425,773 disallowance ($297,259 Initial NPR + $128,414 Revised NPR) as the amount in controversy. Both parties agree that the unliquidated liabilities are non-allowable costs, and there is no dispute that the regulations at 42 C.F.R. §413.100 and the instructions at PRM-1 §2305 are controlling. At issue is whether the Board may properly accept jurisdiction for the entire amount of the adjustment made for unliquidated liabilities owed to Wesley, in spite of the fact that a portion was disallowed in the original NPR and the remainder in the revised NPR and whether the Provider's cost associated with unliquidated liabilities should be disallowed in the year the costs were accrued or in the year the extension period expired.

[4] 42 CFR §413.100(c)(2)(i)(A).
[5] 42 CFR §413.100(c)(2)(i)(B); PRM-1 §2305.1.
[6] Id.
[7] 42 CFR §413.100(c)(2); PRM-1 §2305.2.

PARTIES' CONTENTIONS:

Issue 1: Jurisdiction

The Provider contends that the combined adjustment is subject to the Board's jurisdiction. The Provider argues that the Intermediary reopened the cost report for a particular issue and made an adjustment to that same specific issue. The adjustments in both (the original and revised) NPRs relate to the same subject matter and, consequently, both adjustments are subject to the jurisdiction of the Board. The Provider argues that CMS precedent supports jurisdiction where the same issue is the subject of the reopening.[8] Further, the Provider argues that the Intermediary held the original cost report open for the entire three-year extension period to determine which liabilities were paid. The Provider contends that the Intermediary reconsidered the previous Wesley disallowance in its reopening when it made additional Wesley disallowances in the revised NPRand effectively admitted that it knew its initial disallowance was incomplete.

The Provider also contends that both parties identified the audit adjustment (Number R1-002) in its entirety as the subject of the appeal, and the Intermediary made no challenge to its full inclusion. Further, both parties addressed the entire amount in their submissions to the Board.

The Intermediary contends that the Board's jurisdiction is limited to the amount adjusted in the revised NPR. The Intermediary argues that 42 C.F.R. §405.1841 requires that an appeal must be filed within 180 days, but the Provider never appealed the initial NPR within the established time frame.

The Intermediary argues further that 42 C.F.R. §405.1889 makes clear that an NPR revision "shall be considered a separate and distinct determination or decision…" As such, it generates its own appeal rights before the Board and limits an appeal of a revised NPR to matters adjusted in the revised NPR. It does not include adjustments from an earlier NPR. Further, CMS precedent holds that a revised NPR does not reopen the entire cost report to appeal, nor does it extend the 180-day appeal period of an earlier NPR.[9]

Issue 2: Period for Disallowance

The Provider contends that unliquidated liabilities are properly disallowed at the end of the three-year extension period, and that the disallowance in this case should be made on the FYE 9/30/02 cost report. The Provider argues that the Administrator's Decision in *Jewish Memorial Hospital vs. Blue Cross and Blue Shield Association/Empire Blue Cross and Blue Shield* [10] (Jewish Memorial) holds that an adjustment for unliquidated accrued

[8] HCFA Administrator Decision; *Jewish Memorial Hospital V. Blue Cross and Blue Shield Association/Empire Blue Cross and Blue Shield;* PRRB Decision 89-D75; November 27, 1989.
[9] CMS Administrator Decision; *Care Unit Hospital of Dallas vs. Mutual of Omaha;* PRRB Decision 95-D26; May 5, 1995.
[10] HCFA Administrator Decision; *Jewish Memorial hospital vs. Blue Cross and Blue Shield*

costs is properly made in a subsequent period if the allowability of the cost depends on actions taken (or not taken) by the provider in that subsequent period. When such costs are not liquidated within the three-year extension period, they are properly recoverable in the third cost reporting period of the extension, and not in the period the costs were incurred and accrued.

The Intermediary argues that 42 C.F.R. §413.100 (c)(2)(i) generally requires that the liquidation of a short-term liability take place within one-year of the accrual; consequently, the disallowance should be made on the FYE 9/30/99 cost report. The Intermediary argues that program instructions at PRM-1 §2305 state that where a liability is not liquidated within one-year (or not excepted under §§2305.1 and 2305.2), the cost incurred is not allowable in the cost reporting period when the liability incurred was and accrued but is allowable in the cost reporting period when liquidation occurs. The Intermediary contends that nothing in §2305.1 suggests any other instruction relative to the timing for the removal of accrued costs that remain, and that any unliquidated such a provision would be contrary to the requirements of 42 C.F.R.§413.100.

The Intermediary also challenges the Provider's application of the Administrator's Decision in Jewish Memorial to this case. In Jewish Memorial, the three-year reopening period for cost reports had closed before the extension of time to liquidate liabilities had run. The intermediary in that case was obligated to recover the costs of the unliquidated obligations but was statutorily blocked from reopening the cost report for the year of the accrual. The Administrator concluded that in those circumstances, recovery in the final year of the exemption was proper. The decision did not mean that recovery was not proper in the year of accrual; it meant that recovery in the year of accrual was not proper in that particular case.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of Medicare law and guidelines, the parties' contentions and arguments, and the evidence presented at the hearing, finds and concludes as follows:

Issue 1: Jurisdiction

The central issue for the Board's consideration is whether the Board may accept jurisdiction for the amount of the adjustment made in the original NPR when no appeal was filed by the Provider. The regulations at 42 C.F.R. §405.1841 require that a request for a Board hearing must be filed in writing within 180 days of the date the notice of the intermediary's determination was mailed to the provider. Further, the regulations at 42 C.F.R. §405.1889 state that where an NPR is reopened and revised, such revision shall be considered a separate and distinct determination. The facts and circumstances of this case indicate that the Intermediary was fully aware that the issue of unliquidated liabilities was not resolved at the time that it issued the original NPR, and that it would revisit unliquidated liabilities, in general, and the specific adjustment related to the

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Association/Empire Blue Cross and Blue Shield; PRRB Decision 89-D75; November 27, 1989.

Provider's liabilities to Wesley at some point beyond the issuance of the original NPR. The Board majority believes, therefore, that the original adjustment made in the NPR was a partial determination and that it operated as an interim settlement. The Intermediary's revised NPR reopened the cost report for the same issue (i.e., unliquidated liabilities). The reopening included a reassessment of the initial adjustment to the Wesley debt and increased the amount of the disallowance. The Board majority, therefore, concludes that the revised NPR dealt with both the same issue and the same adjustment as the original NPR. The Board notes that the Provider's appeal included the combined $425,773 disallowance ($297,259 Initial NPR + $128,414 Revised NPR) and went unchallenged by the Intermediary until the Board itself raised jurisdiction at the hearing. The Board majority believes that both the Provider and the Intermediary believed a single issue was under appeal and fully intended that the Board examine the combined adjustment. Accordingly, the majority concludes that the Board may properly accept jurisdiction for the adjustment made in the original NPR.

Issue 2: Period for Disallowance

The single substantive issue for the Board's consideration is whether the Provider's accrued costs that remain unliquidated at the end of the three year extension period should be disallowed either in the year they were incurred and accrued or in the cost reporting year at the end of the extension period. It is undisputed that unliquidated liabilities are non-allowable costs, and that the regulations at 42 C.F.R. §413.100 and the manual instructions at PRM-1, §2305 are controlling.

The regulations set forth in 42 C.F.R. §413.100 address the treatment of certain accrued costs and permits recognition of the costs in the year of accrual if the related liabilities are liquidated timely. Liquidation of short term liabilities is considered timely if such liquidation is made within one-year after the end of the cost reporting year of accrual (42 C.F.R. §413.100(c)(2)(i)(A)) or within three years of the year of accrual where an extension has been granted (42 C.F.R. §413.100(c)(2)(i)(A)). Where liquidation does not meet these requirements, the cost is disallowed, generally in the year of accrual. (42 C.F.R. §413.100(c)(2)). The regulation establishes no separate timetable for the disallowance where an extension has been granted. The program instructions at PRM-1 §2305 state that the costs incurred for related goods and services are not allowable in the cost reporting period when the liability is incurred if the liability is not liquidated within the one-year time limit or does not qualify under the exceptions specified in PRM-1, §2305.1 and 2305.2. The instructions in §2305.1 allow for the Intermediary to grant the three-year extension for the liquidation of liabilities, but like the regulation they implement, establish no separate rule for the timing of the disallowance when the extension granted is not met. In the absence of a discrete rule regarding the treatment of extended liabilities, the Board concludes that the language of 42 C.F.R. §413.100(c)(2) is controlling. That language calls for unliquidated liabilities to be disallowed in the cost reporting period in which they were accrued; accordingly, the Board finds that the Provider's unliquidated liabilities were properly disallowed in the cost reporting period ended September 30, 1999.

The Board notes that the Provider relied upon the decision of the HCFA Administrator in Jewish Memorial to support its position. However, the Board's review of that case indicated that the Administrator vacated his decision on September 12, 1990, pursuant to the stipulation and order of the United States District Court for the Southern District of New York.[11] The Administrator's action to vacate the decision precludes the Board from relying on the decision as being official or established HCFA/CMS policy. Accordingly, the Board did not rely on the findings of the Administrator in Jewish Memorial but performed an independent analysis of the regulations and program instructions.

DECISION AND ORDER:

Issue 1: Jurisdiction

The Board majority concludes that jurisdiction is proper over the original NPR dated August 12, 2003.

Issue 2: Period for Disallowance

The Provider's unliquidated liabilities were properly disallowed in the cost reporting period ended September 30, 1999. The Intermediary's adjustment is affirmed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Gary B. Blodgett, D.D.S.
Elaine Crews Powell, C.P.A. (Dissenting Opinion)
Anjali Mulchandani-West
Yvette C. Hayes

FOR THE BOARD:

DATE: December 8, 2006

Suzanne Cochran, Esquire
Chairperson

[11] *Jewish Memorial Hospital v. Secretary HHS*, United States District Court for the Southern District of New York; Civil Action 90-0631; August 14, 1990.

Dissenting Opinion of Elaine Crews Powell

The Board majority granted jurisdiction over an adjustment made in the original Notice of Program Reimbursement (NPR) for the FYE 09/30/99 despite the fact that the Provider never appealed that adjustment. I respectfully dissent.

The Provider filed a request for an extension of time to pay certain of its accrued liabilities. During the Intermediary's review of the extension request, it became aware that $297,359 of the accrued liabilities would never be paid because they had been forgiven by the creditor. Accordingly, these costs were disallowed when the FYE 09/30/99 cost report was settled and the original NPR was issued. The Provider never appealed that NPR.

The Intermediary granted an extension for the liquidation of the remainder of the accrued liabilities that related to debts incurred during the FYE 09/30/99. The extension period was for three years as provided for in 42 C.F.R. §413.100(c)(2)(*i*)(B). However, when the Provider failed to liquidate the liabilities within that three-year period, the 1999 cost report was reopened, the unliquidated liabilities were disallowed, and a revised NPR (RNPR) was issued. When the Provider appealed the RNPR, it included the $297,359 in costs that had been disallowed in the original NPR in its appeal request, albeit not separately identified. The Provider maintains that since the costs were all included in the original extension request, the Board has jurisdiction over both NPRs since they addressed the same issue, and the Board majority agreed. In accepting jurisdiction over the original NPR, the majority concluded that the adjustment made in the original NPR was one part of a two-part adjustment, and that the Provider knew that the Intermediary would be revisiting the issue of unliquidated liabilities when the three-year extension period expired.

The RNPR did not address nor did it adjust the forgiven costs eliminated in the original NPR. Furthermore, the Notice of Reopening did not list the forgiven costs among the items to be addressed in the reopening. Since the Intermediary's decision regarding the disallowance of the forgiven cost was not appealed within the time frame provided for in 42 C.F.R. §405.1841, the Provider missed its opportunity to object to the treatment of those costs. 42 C.F.R. §405.1835 entitled **Right to Board Hearing** addresses the circumstances under which a provider has a right to Board hearing, stating in relevant part:

> (a) *Criteria.* [t]he provider . . . 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. . . .

Since the Intermediary made no determination regarding the forgiven costs in the RNPR, we do not have jurisdiction.

By accepting jurisdiction over an adjustment that was never appealed, the majority

ignores the requirements of 42 C.F.R. §405.1885(c) entitled **Reopening a determination or decision** and §405.1889 entitled **Effects of a revision**, which state in relevant part:

> 405.1885 (c)
>
> Jurisdiction for reopening a determination or decision rests exclusively with that administrative body that rendered the last determination or decision.
>
> 405.1889
>
> 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 to which the provisions of §§405.1811, 405.135 and 405-1877 are applicable.

I find that by granting jurisdiction here, the majority has, at bottom, granted a de facto reopening of the Intermediary's determination contained in the original NPR. In my opinion, this action violates the regulations quoted above.

My position on this issue is buttressed by the circuit court's decision in HCA Health Services of Oklahoma v. Shalala, 27 F3d 614 (D.C. Cir. 1994), where the court agreed with the Administrator's holding in General Hospital of Everett v. Blue Cross and Blue Assn., Medicare and Medicaid Guide (CCH) ¶35,926, that:

> [t]he separate and distinct determination gives a right to a hearing on matters corrected by such determination. Thus, a revised NPR does not reopen the entire cost report to appeals. It merely reopens matters adjusted by the revised NPR.

The District Court's decision stated:

> [g]iven that no specific statutory provision governs reopenings, and that the Secretary's interpretation of the reopening regulations is a permissible reading of the regulatory language and implements the statutory time restriction on appeals from an intermediary's determination of the amount of total program reimbursement, we uphold the Board's determination that it lacked jurisdiction to review cost items that were not the subject of the reopening.

Regarding the merits of the case, I am in agreement with my colleagues.

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Elaine Crews Powell, C.P.A.