PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D2

PROVIDER –
Penrose/St. Francis Health Services
Colorado Springs, Colorado

Provider No.: 06-0031

vs.

INTERMEDIARY -
Wisconsin Physicians Service, Inc.

DATE OF HEARING -
July 10, 2009

Cost Reporting Periods Ended -
June 30, 2003 and June 30, 2004

CASE NOs.: 06-1009 and 07-0237

INDEX

ISSUE:

Whether the Intermediary improperly recouped alleged overpayments resulting from an incorrect cost-to-charge ratio (CCR) calculated and applied by the Intermediary to determine outlier payments made to the Provider for inpatient rehabilitation services furnished during the cost reporting periods at issue.

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 to organizations 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. §1395h; 42 C.F.R. §§413.20 and 413.24.

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 portion 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.

In this case, Medicare paid for inpatient rehabilitation services under the inpatient rehabilitation facility ("IRF") prospective payment system ("PPS"), which applies both to rehabilitation hospitals and to rehabilitation units of acute care hospitals. 42 U.S.C. §§1395ww(j). Under the IRF PPS, the IRF receives a predetermined amount per discharge for inpatient services furnished to Medicare Part A fee-for-service beneficiaries. The PPS rate covers the inpatient operating costs and capital costs of furnishing covered rehabilitation services. *Id*. In establishing the IRF PPS, Congress also provided for additional payments, called "outlier" payments, for IRF discharges with extraordinarily high costs. 42 U.S.C. §1395ww(j)(4)(A)(i).

CMS implemented the IRF PPS for cost reporting periods beginning on or after January 1, 2002. 42 C.F.R. §412.600. In implementing the statute, the regulations provided for "outlier payments," defined as an additional payment beyond the standard Federal prospective payment for cases with unusually high costs. 42 C.F.R. §412.602. To qualify for an outlier payment, estimated costs for a particular patient must exceed a fixed dollar amount, which is adjusted for area wage levels and factors to account for treating low-income patients, for rural locations and for teaching programs. 42 C.F.R. §412.624(e)(5). Outlier payments are not made on an interim

basis. Instead, the payments are made based on the submission of a discharge bill and represent final payment. 42 C.F.R. §412.632(d).

In addition to the regulations, CMS issued instructions to the intermediaries describing the appropriate data sources to use in computing outlier payments based on Medicare facility-specific cost-to-charge ratios. (CCR).[1] CMS Program Memorandum Transmittal No. A-01-131, Medicare and Medicaid Guide ¶152, 323 (November 1, 2001). For freestanding IRFs or for IRFs that are distinct part units of acute care hospitals, CMS instructed the intermediaries to use the latest available settled cost report and associated data in determining a facility's overall Medicare CCR. Intermediaries were instructed to calculate updated ratios each time a subsequent cost report settlement is made. Further, retrospective adjustments to the data used in determining outlier payments would not be made. 66 Fed Reg. 41315, 41363 (Aug. 7, 2001).

Effective for discharges on or after October 1, 2003, CMS revised the methodology used in determining CCR for the IRF outlier payments. 68 Fed. Reg. 45674, 45694 (Aug. 1, 2003). The purpose for the revision was for consistency with the existing PPS outlier payment policy for acute care hospitals. Under the revised methodology, the intermediaries would use either the most recent settled IRF cost report or the most recent tentative settled IRF cost report (whichever is for the latest cost reporting period) to obtain the applicable IRF cost-to-charge ratio.

When the cost report is settled, outlier payments are adjusted only if two conditions are met. For discharges on or after October 1, 2003, IRF outlier payments are revised if (1) the CCR calculated for the cost reporting period at settlement deviates in either direction by ten percentage points or more from the CCR used for calculating the outlier payments during the cost reporting period, and (2) total outlier payments exceed $500,000 for the cost reporting period. And if the intermediary concludes that both these conditions are met and a reconciliation is necessary, it must follow specific procedures described in the Medicare Claims Processing Manual (MCPM). See MCPM, CMS Pub. 100-04, Ch. 3 §20.1.2.7. The required procedures include reprocessing of the "claims" by the Central Office of CMS and the issuance of an NPR reflecting the reconciled amount.

The Medicare regulation at 42 C.F.R. §405.1885(a) provides that a determination of an intermediary may be reopened with respect to findings on matters at issue in a cost report. A request to reopen must be made within three years of the date of the notice of the intermediary's determination. All parties to any reopening shall be given written notification of the reopening. 42 C.F.R. §405.1887. Additional rules concerning reopening and correction of intermediary determinations are addressed in CMS Pub. 15-1 §§2930, 2931 and 2932. CMS Pub. 15-1 §2932(A) states the following with regard to notices of reopening and correction: "[t]he provider or other party will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it was necessary to take such action, and the opportunity to comment, object, or submit evidence in rebuttal."

The regulations also describe specific rules for the reopening of claims under the claims appeals process. The claims appeals process is separate from the cost report appeal process and outside the scope of the Board's decision making authority. Under the claims reopening rules, an

[1] Program Instructions are contained in Intermediary's Exhibit I-11.

intermediary may reopen an initial determination relating to a claim for Medicare benefits for any reason within one year from the date of the initial determination. 42 C.F.R. §405.980(b)(1). However, if good cause exists, an intermediary may re-open within four years of the date of the initial determination. 42 C.F.R § 405.980(b)(2). After four years and in the absence of fraud, the intermediary may not reopen an initial determination except to correct clerical errors that were unfavorable to the provider. 42 C.F.R. § 405.980(b) (3) – (4). The revision of an initial determination is binding on all parties unless a party files a written request for a redetermination of the revised determination. 42 C.F.R. § 405.984(a). The request for redetermination is made in accordance with the claims appeals process at 42 C.F.R. § 405.940 through § 405.958. The redetermination is binding on all parties unless a party elects to file a written request for reconsideration by a Qualified Independent Contractor (QIC). 42 C.F.R. § 405.960 through §405.978. A party dissatisfied with a reconsideration decision may file a request for hearing with an Administrative Law Judge (ALJ). 42 C.F.R. § 405.1000 – 405.1064. If a party is dissatisfied following the issuance the ALJ decision, the party may file a request for review by the Medicare Appeals Council (MAC). 42 C.F.R. § 405.1100 – 405.1128. If a party is dissatisfied with the MAC's decision, the party may file an appeal to the Federal district courts. 42 C.F.R. §405.1130.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Penrose/St. Francis Health Services ("Provider") located in Colorado Springs, Colorado is a Medicare certified acute care hospital, which also includes a rehabilitation unit. The Provider was reimbursed under the IRF PPS for services rendered at the rehabilitation unit. Wisconsin Physicians Service, Inc. (Intermediary) issued a Notice of Program Reimbursement dated September 15, 2005. On March 10, 2006, the Provider appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §418.311 (cross- reference 42 C.F.R. §§405.1835-1841). The recoupment of the outlier payment, which is the issue in this hearing, was added to the appeal on November 28, 2007.[2]

The Provider was represented by Stephanie A. Webster, Esq. of King & Spalding, L.L.P. The Intermediary was represented by Marshall Treat of Wisconsin Physicians Service.

PARTIES' STIPULATIONS:

The parties submitted a joint stipulation of facts,[3] which includes the following:

1. The remaining issue in these appeals is whether the Intermediary improperly recouped alleged overpayments resulting from an incorrect cost-to-charge ratio (CCR) calculated and applied by the Intermediary to determine outlier payments made to the Provider for rehabilitation services furnished during the cost reporting periods at issue.

[2] The Provider originally by appealed the recouped outlier payment issue through the claims review process. In that process, the Intermediary, CMS and other reviewing entities took the position that the Board is the proper forum to hear this issue. *See*, letter from Doug Lemieux, Jr. AVP Reimbursement Centura Health (November 28, 2007); Transcript at 18. Upon appealing the issue to the Board, the Provider requested an Expedited Judicial Review on October 24, 2008. The Board denied the Provider's request on November 19, 2008. *See*, Letter from Suzanne Cochran, Esq. Chairman of the Board, dated November 19, 2008.

[3] Stipulations dated June 10, 2009.

2. On June 6, 2007, the Intermediary issued a "request for payment letter" to the Provider for alleged "overstated outlier payments" for discharges between July 1, 2002 and September 30, 2002. In response to the Intermediary's June 6th letter, on June 19, 2007, the Provider remitted $188,974. A redacted list of the payments at issue in the June 6th letter is found in Provider Exhibit 3.

3. In August 2007, the Intermediary made further revisions, totaling $583,502, to outlier payments made for discharges between October 1, 2002 and September 30, 2003. For these revisions, the Intermediary did not issue an "overpayment" letter, but rather changed the CCR in the provider-specific file and then reprocessed the outlier payments on a claim-by-claim basis due to the change in the CCR. A redacted list of the outlier payments revised in this fashion is found in Provider Exhibit 4.

4. The total amount of the recouped outlier payments at issue for both fiscal years is $772,476, and the amounts at issue for fiscal years 2003 and 2004 are $647,620 and $124,856, respectively. Redacted lists of the outlier payments at issue for the 2003 and 2004 fiscal years are reflected in Provider Exhibits 5 and 6, respectively.

5. As with all Medicare payments for covered hospital services, the provider (sic) reported outlier payments on its cost reports for the periods at issue. In the Provider's original NPRs for these periods, the Intermediary reconciled the reported outlier payments with the Provider Statistical and Reimbursement Report, resulting in only a $554 adjustment for FYE 2003 and no adjustment for FYE 2004. In the Provider's original NPRs for these cost reporting periods, the Intermediary did not adjust the outlier payments to reflect the revisions to outlier payments at issue here. Nor has the Intermediary adjusted outlier payments to reflect these revisions in any revised NPRs for the FYE 2003 or FYE 2004 periods.

PARTIES' CONTENTIONS

The Provider contends the revisions to the outlier payment were claims determinations and not cost report revisions because the outlier payments are calculated on a case-by-case basis based on data on claim forms. [4] The Provider asserts that the Intermediary revised the outlier payments outside of the applicable claims reopening period as prescribed in regulation 42 C.F.R. §405.980(b).[5] Specifically, all the recoupments were made by the Intermediary well beyond the twelve-month window for a completely discretionary reopening, and well beyond the four-year reopening window if good cause for the reopening existed.

In addition to violating claims reopening rules, the Provider states that the Intermediary's actions also violate the statutory "without fault" provision at 42. U.S.C. §1395gg(c).[6] Under the statute, absent a specific factual showing of fault, the Provider cannot be held liable for overpayments discovered more than three years after the initial payment. The Provider notes that there has

[4] Tr. 20.
[5] Provider's Supplemental Position Paper on Rehabilitation Facility Outlier Claims Revision Issue ("Provider's Supplemental Position Paper) at 10 – 11;Tr. 21.
[6] Provider's Supplemental Position Paper at 11, Tr. at 21-22.

been no allegation of fault on the part of the Provider to support a later reopening.[7]

The Provider further argues that the Intermediary's recoupment of the outlier payments is in violation of CMS' policy, which did not permit retrospective recalculations of IRF outlier payments for patient discharges prior to October 1, 2003.[8]

The Intermediary contends that contrary to the Provider's assertions, the revision of outlier payments is not a claims issue. Instead, it is a cost reporting issue because the revisions were based on data from the settled cost report of June 30, 1999.[9] The Intermediary explained that without this cost report data no outlier payments could have been made, and thus it is a cost report issue and properly before the PRRB.[10]

The Intermediary points out that the alleged overpayment resulted from the Intermediary applying an incorrect CCR calculation from the June 1999 settled cost report to set the outlier payment rates for the 2003 and 2004 fiscal years.[11] The Intermediary advised it simply recalculated the interim payment using the correct CCR from the settled June 30, 1999 cost report and recouped the difference created by the oversight.[12] The Intermediary asserted that since it used the data from the June 30, 1999 cost report, and not from later settled cost reports, it did not retrospectively adjust the outlier payments.[13]

The Intermediary acknowledged that it never reopened the cost reports; nevertheless, the revised outlier payments were recouped within three years of the NPRs issued September 15, 2005 and May 15, 2006.[14] The Intermediary explained that the changes could have been imposed through the 2003 and 2004 cost reports, but since the claims system recalculated the payments using the 2003/2004 corrected CCR, it offset the collections to current claims payments.[15] As a result of the claims re-processing and collection, it was unnecessary to issue a revised cost report and NPR.[16]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and guidelines, the parties' contentions and evidence submitted, the Board finds and concludes that the Intermediary's revisions to the outlier payments were improper.

Although, the Board initially accepted the Intermediary's characterization of the issue as cost report matter and granted jurisdiction,[17] it is undisputed that the Intermediary did not make the revisions to the outlier payments through the cost report. Moreover, the Intermediary never

[7] Tr. at 21.
[8] Provider's Supplemental Position Paper at 13; Tr. at 22.
[9] Tr. at 31-32, and 37-40.
[10] Intermediary's Post-hearing brief at 8.
[11] Tr. at 40.
[12] Intermediary's Position Paper at 9.
[13] Tr. at 39-40.
[14] Tr. at 52, 54; Intermediary's Post-hearing brief at 9.
[15] Tr. at 80-82.
[16] Intermediary's Post-hearing brief at 9.
[17] *See*, *supra*, note 3.

provided a notice of reopening, did not reopen the cost reports under appeal, nor did it issue revised NPRs as required under 42 C.F.R. §405.1885 and §405.1887. In fact, the Intermediary conceded that issuing a revised NPR was unnecessary because it "[s]imply just used the claims Pricer program to determine the amount and then offset that against current payments."[18] The Board finds the Intermediary's actions to correct its error was simply an attempt to compensate for its failure to use the proper claims reopening process addressed in 42 C.F.R. §405.980. The Board acknowledges it would lack the authority to consider issues brought under the claims appeals process.

Next, the Board rejects the Intermediary's contentions that the revisions are permissible because it used data from the June 1999 cost report, which was the latest settled cost report when the outlier payments were initially made, and from which the CCR was derived. In the final rule implementing the IRF PPS, CMS explicitly states, "we will not make any retrospective adjustments for outlier payments." 66 Fed. Reg. 41315, 41363 (Aug. 7, 2001). CMS reiterated this mandate in its Program Memorandum Transmittal No. A-01-131, Medicare and Medicaid Guide ¶152, 323 (November 1, 2001). This rule prohibiting retroactive adjustments to outlier payments was in effect for discharges before October 1, 2003. It is undisputed that all the Intermediary's outlier payment revisions were for discharges prior to October 1, 2003;[19] therefore, the Board finds the recoupment of the outlier payments were improper.

Finally, the Board rejects the Intermediary's characterization of the recoupment of the outlier payments as a recalculation of "interim" payments. In support of its position, the Intermediary cites CMS Pub. 15-1 §2408: "A retroactive adjustment will be made after the end of the provider's reporting year to bring the interim payment made during the period into agreement with the reimbursable amount payable to the provider." The Board finds the Intermediary's reliance on that Manual section is misguided as the regulations clearly state that "additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment." 42 C.F.R. §412.632. Likewise, as reflected in the Office of the Inspector General's report, CMS' longstanding practice prior to 2003 was to "consider all outlier payments as final payments not subject to retroactive adjustments."[20] The Board finds that even if the Intermediary has now determined that it used the wrong data in the making the outlier payments well-established Medicare rules that bind the Intermediary in the circumstances here, prohibits the Intermediary from retroactively correcting those payments.

DECISION AND ORDER

The Intermediary improperly recouped alleged overpayments for outlier payments made to the Provider for inpatient rehabilitation services furnished during the cost reporting periods at issue. The Intermediary's determination is reversed.

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[18] Tr. at 82.
[19] Stipulations 2 and 3.
[20] *See also*, Department of Health and Human Services, Office of Inspector General, A-07-06-04059, *Impact of Not Retroactively Adjusting Outpatient Outlier Payments*, at 2 (June 2007) (available at http://www.oig.hhs.gov/oas/reports/region7/70604059.pdf).

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairperson

DATE: October 7, 2010