PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D2

PROVIDER –
L.O. Crosby Memorial Hospital
Picayune, MS

Provider No.: 25-0117

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Pinnacle Business Solutions, Inc.

DATE OF HEARING -
January 29, 2010

Cost Reporting Periods Ended -
December 31, 1997 and October 31, 1998

CASE Nos.: 08-2202 and 08-2203

INDEX

ISSUES:[1]

1) Whether CMS is precluded from recovering the alleged overpayments from the Provider's fiscal year end 12/31/97 and 10/31/98 cost reports due to the Intermediary's issuance of the Notice of Program Reimbursement over ten years after the cost report year ends.

2) Whether the Intermediary improperly disallowed bad debts claimed and costs related to the hospital's unduplicated census for fiscal year ends 12/31/97 and 10/31/98.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

Background:

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

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. § 1395 *et seq*. The Centers for Medicare & 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 (FIs) and Medicare administrative contractors (MACs).[2] FIs and MACs determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. The cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. *See* 42 C.F.R. § 413.20. The 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). *See* 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. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Timeliness of Intermediary Determination and Notice of Amount of Program Reimbursement

Upon receipt of a provider's cost report, "the Intermediary must within a reasonable period of time (see § 405.1835(b)), furnish the provider . . . a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider." 42 C.F.R. § 405.1803(a)

[1] *See* Transcript (Tr.) at 6. The Board notes that there were two additional issues in the parties' position papers. These two issues were whether Southern Regional Corporation (SRC) is liable for the debts of the hospital based on the Fifth Circuit's ruling in *U.S. v. Vernon Home Health, Inc.* [21 Fed.3d 693 (5th Cir. 1994)] and whether the amounts allegedly due were discharged in NAHC's bankruptcy in 2000. While these issues were outside the authority of the Board to decide, they are discussed briefly in the Board's decision so the relevance of these issues to the case is understood.

[2] FIs and MACs are hereinafter referred to as intermediaries.

(1997). With respect to a late intermediary determination, "the provider also has a right to a hearing before the Board if an intermediary determination concerning the amount of reasonable cost reimbursement due a provider is not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report . . . provided such delay was not occasioned by the fault of the provider." 42 C.F.R. §405.1835(c) (1997). The Program instruction also indicates that "[t]he intermediary is to make every attempt to issue an NPR within 12 months of receipt of a cost report." Provider Reimbursement Manual, Part 1 (CMS Pub. 15-1) § 2905.1.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

L.O. Crosby Memorial Hospital (Provider or L.O. Crosby) is an acute care hospital in Picayune, Mississippi. The Provider timely filed its cost report for fiscal year ended (FYE) 12/31/97 (FYE 1997) on May 15, 1998 and its terminating cost report for FYE 10/31/98 (FYE 1998) on June 1, 1999.[3] On November 1, 1998, L.O. Crosby sold certain of its assets used to operate the hospital and entered into a long-term lease agreement to operate the hospital with New American Healthcare Corporation (NAHC).[4] NAHC had many subsidiaries, including NAHC-Mississippi which operated the Provider.[5] Under NAHC's operation, the Provider continued as a participating provider in the Medicare program,[6] accepted assignment of the Provider's Medicare participation agreement and retained its provider number. CMS recognized the change of ownership (CHOW) to NAHC on November 1, 1998.[7]

On March 15, 2000, the Intermediary[8] issued a proposed adjustment report for FYE 1997 to Horne CPA Group (the Provider's consultant). On April 12, 2000, the Horne CPA Group submitted a "completed bad debt list for L.O. Crosby FY 97."[9]

On April 19, 2000, NAHC (including NAHC-Miss.), filed a voluntary petition for bankruptcy.[10] On June 20, 2000, the Secretary filed a limited objection to the sale of assets which stated that if the Medicare provider agreement was assumed, the "Secretary would note that there appear to be no currently-determined Medicare overpayments – requiring a cure prior to assumption by Crosby."[11]

On July 31, 2000 pursuant to the bankruptcy court's order, the hospital and the provider number were sold to Picayune Clinic, LLC and it assumed the lease for operation of the hospital.[12] CMS recognized the CHOW for this provider number took place on August 1, 2000.[13]

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[3] *See* Stipulation (Stip.) 1 for FYE 1997 and Stip. 3 for FYE 1998.
[4] *See* Stip. 2 for FYE 1997 and Stip. 1 for FYE 1998 and Tr. at 33.
[5] Provider Exhibit (PE) 3 and 4, Asset and Lease Agreement.
[6] Tr. at 36 and PE 37.
[7] Stip. 3 for FYE 1997 and Stip. 2 for FYE 1998.
[8] The Intermediary at the time of the Notice of Program Reimbursement was TriSpan Health Services, Inc. Pinnacle has since assumed the operations and responsibilities of TriSpan.
[9] Stip. 5 for FYE 1997.
[10] PE 5 and Tr. at 37.
[11] Stip. 8 for FYE 1997 and Stip. 6 for FYE 1998.
[12] Stip. 9 for FYE 1997 and Stip. 7 for FYE 1998.
[13] Stip 10 for FYE 1997 and Stip. 8 for FYE 1998.

The Intermediary conducted a desk review for the FYE 1998 cost report and issued a proposed adjustment report to the Provider on June 21, 2001.[14]

On December 31, 2004, the bankruptcy court issue a final decree and order of closing of the NAHC bankruptcy case.[15]

In April 2006, the lease for the operation of the hospital and Provider agreement and number were assigned to Forrest General Hospital (Forrest General), which currently operates the hospital under the name, Highland Community Hospital.[16] On May 1, 2006, CMS recognized the CHOW to Forrest General.[17]

On June 17, 2008, the NPR for FYE 1997 was issued by the Intermediary,[18] and on January 7, 2008, the NPR for FYE 1998 was issued by the Intermediary.[19]

Both NPRs were timely appealed by Southern Regional Corporation (SRC)[20] on behalf of the Provider and met the jurisdictional requirements of 42 U.S.C. § 1395oo(a).[21]

The Provider was represented by Thomas L. Kirkland, Jr., Esquire and Allison C. Simpson, Esquire, of Copeland, Cook, Taylor & Bush, P.A. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

Issue 1 – Delay in Issuing the NPRs

The Provider contends that the Intermediary's failure to timely issue the NPRs for both cost reporting years was in violation of 42 C.F.R. § 405.1803(a) which requires an intermediary to

[14] Stip. 10 for FYE 1998.
[15] Stip. 11 for FYE 1997 and Stip. 12 for FYE 1998.
[16] Stip. 12 for FYE 1997 and Stip. 13 for FYE 1998 and Provider Position Paper (PPP) at 7, n. 3.
[17] Stip. 13 for FYE 1997 and Stip. 14 for FYE 1998.
[18] Stip. 15 for FYE 1997.
[19] Stip. 16 for FYE 1998.
[20] The Board notes that until October 29, 1998, L.O. Crosby was a non-profit hospital entity under the laws of the State of Mississippi. In 1998, L.O Crosby leased the land and hospital building to NAHC – Miss. which continued to operate the hospital under the name of L.O. Crosby. However, the original non-profit corporation continued to exist and eventually changed its name to SRC. SRC now operates as a Mississippi not for profit corporation. *See* PE-8. In the lease agreement between L.O. Crosby and NAHC- Miss., L.O. Crosby agreed to indemnify lessee for costs related to any use, operation . . . by the lessor prior to the commencement of the date of the lease." *See* IE-25 at pp. 19-20. The lease agreement was assigned several times (*see* PPP at 7-8) and as a result, L.O. Crosby, now SRC, may be liable to the current operator of the hospital for any overpayment resulting from the operation of the hospital prior to November 1, 1998.
[21] The Board notes that the Intermediary raised a jurisdictional challenge concerning FYE 1998 indicating that the amount in controversy did not exceed $10,000 as required by 42 C.F.R. § 405.1835. *See* Intermediary Jurisdictional Challenge, January 15, 2010. In the NPR for FYE 1998, the Intermediary determined that the Provider owed Medicare $97,724. *See* Intermediary Jurisdictional Challenge, January 15, 2010, Exhibit 1. If the Provider were to prevail on this issue, the amount in controversy would exceed the $10,000 threshold, therefore, the Board finds it has jurisdiction over the FYE 1998 appeal.

issue an NPR "within a reasonable period of time (as described in § 405.1805(a)(3)(ii)), furnish the provider … a written notice reflecting the intermediary's determination of the total amount of reimbursement due the provider." 42 C.F.R. § 405.1803(a) (2008).[22] The Provider indicates that § 405.1835(a)(3)(ii) suggests a "reasonable period of time" is assumed to be no later than 180 days after the expiration of a 12 month period from the filing of the cost report. 42 C.F.R. § 405.1835(a)(3)(ii) (2008).[23] The Provider further contends that the Secretary has estimated that a reasonable time to issue an NPR is within one (1) year from the time the cost report is received.[24]

Though 42 C.F.R. § 405.1803(c) provides a right to seek a hearing if a NPR has not been issued, the court in *Woodruff* ruled that failure to demand a hearing is not deemed a waiver as to any delay in the issuance of the NPR.[25] In addition, the court in *Woodruff* held that the Administrative Procedures Act (APA) requires an agency to "within a reasonable time . . . conclude a matter presented before it." The Provider also has indicated that in order to have a NPR set aside on the grounds of an unreasonable delay, there must be a showing of prejudice suffered by the party.[26]

The Provider asserts that the facts in *Woodruff* are similar to the instant case as *Woodruff* involved issuance of NPRs approximately 9 years after the same were timely submitted. In that case, with regard to certain adjustments, the provider was able to argue that due to the unreasonable length of delay, the provider was without sufficient documentation to contest certain adjustments. The intermediary in *Woodruff* attempted to justify the delay based on criminal proceedings initiated against the owner; however, the court found these criminal actions were actually dismissed well before the NPR was issued.[27] The court also held that while civil and criminal actions might provide some justification for this delay, "in no event do they justify the entire delay."[28] Similarly, the Provider has demonstrated that the delay in the issuance of each of these NPRs was comparable to the delay in *Woodruff* and that it has been prejudiced because it simply has no documentation to contest the adjustments due to the unreasonable delay.[29] The Provider also noted that while the Intermediary has attempted to justify its delay because of the bankruptcy proceeding, the Provider emerged from bankruptcy nearly four (4)

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[22] The Board notes that the Provider cited the 2008 regulations, but that the 1997 and 1998 regulations, as cited in the Medicare Statutory and Regulatory background Section above, apply to these cases. The principle difference between the 1997 and 1998 regulation and the 2008 regulation is that in order to have a hearing for a late intermediary determination under the new regulation, the provider must request a hearing, "no later than 180 days after the expiration of the 12 months period for issuance of the intermediary determination." 42 C.F.R. § 405.1835(a)(3)(ii).

[23] The Board notes that the Provider again cited the 2008 regulations instead of the 1997 and 1998 version.

[24] The Provider cites Medicare Program Integrity Manual, Part I (PIM) § 2905.1 (PE 21), however, the Board notes that PE 21 is actually the PRM, Part 1 (CMS Pub.15-1) § 2905.1; *see also Woodruff Community Hospital v. Sullivan*, U.S. District Court, Central District of California, No. CV 91-2927 AWT, Feb. 27, 1992, [2002-2 Transfer Binder] Medicare and Medicaid Guide (CCH), ¶40,108 (Feb. 27, 1992)(*Woodruff*); *Great Rivers Home Care, Inc. v. Thompson*, 170 F.Supp. 2d 900 (E.D. Mo. 2001).

[25] *Woodruff* at CCH ¶ 40,108 at 30,110.

[26] 5 U.S.C. § 555(b); *Woodruff* at 30,109-10.

[27] *Woodruff* at 30,111.

[28] *Id*.

[29] Tr. at 47.

years before the NPR was issued.[30] In addition, the record indicates that the Intermediary was working on at least one of the cost reports after the bankruptcy petition was filed.[31]
The Provider contends that it has overwhelmingly demonstrated the prejudice it suffered as a result of the delay, and based upon the relevant statutes, the Secretary's interpretation of the statutes, and the court's ruling in *Woodruff*, the Board should set aside the adjustments and instruct the Intermediary to refund the amounts paid pursuant to those adjustments.

The Intermediary points out that in the original Board decision in the *Woodruff* case,[32] the Board found that it did not have the authority to review the timeliness issue presented in the case. The Board concluded that "it is without authority to rule on the timeliness arguments raised by the Provider. The Board considered the statute of limitation argument and related equitable doctrine of laches arguments and finds [sic] that neither apply to this case."[33] While the Board acknowledged that the provisions, later relied upon by the court in *Woodruff*, indicated a time period for settlement of a cost report and issuance of the NPR, it found that those provisions did not establish a statute of limitations and there was nothing in the controlling regulations which granted the Board authority to determine that the intermediary was precluded from issuing NPRs for those cost years.

The Intermediary also points out that the court ruling in *Woodruff* found that a provider must show both unreasonable delay and serious prejudice.[34] The Intermediary indicates that although there was a similarly long delay in issuing the NPR, the Provider cannot demonstrate that it was seriously prejudiced by the delay. Unlike *Woodruff*, where the some of the costs (laboratory fees paid to related parties) were not raised until the years after the cost reports were submitted, the Provider was put on notice as early as 2000 that its bad debt claim was not accepted. In the proposed adjustment to the 1997 cost report, mailed to the hospital on March 15, 2000, the Intermediary proposed to eliminate the hospital's bad debt claim because there was insufficient documentation with which to audit the bad debt list.[35] The Provider responded by submitting a new bad debt list in 2000.[36] The Intermediary accepted the revised bad debt list and paid the Provider everything it claimed. Thus, the Provider was not prejudiced by the delay in issuance of the NPR. The Provider had a copy of all the proposed adjustments in 2000, and if it believed there was a problem with the PS&R and home health visits, it could have raised its concerns at that time, or maintained the documentation to support its position. The Provider cannot now claim that it was unreasonably prejudiced because the NPR implementing the adjustment was delayed.

With respect to the 1998 cost report, the Intermediary supplied the proposed adjustments to the Provider in June 2001, and on July 11, 2001, the Provider indicated in writing that it agreed with

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[30] *See* Stips. 6, 11, 15 for FYE 1997 and Stips. 4, 12 and 16 for FYE 1998.
[31] Stips. 9 and 10 for FYE 1998.
[32] *Woodruff Community Hospital v. The Travelers Insurance Company*, PRRB Hearing Dec. No. 91-D40, April 18, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,208, CMS Adm. Declined Review, June 6, 1991 (*Woodruff-BD*)
[33] *Id*.
[34] Tr. 21-24.
[35] Intermediary Exhibit (IE) 8 for FYE 1997 at 7.
[36] IE 10 for FYE 1997.

those adjustments.[37] The Intermediary contends that the Provider cannot now claim it was prejudiced by the delay in issuing adjustments that it agreed were proper in the first place.

Issue 2 – Bad Debt Claim and Unduplicated Census

The Provide asserts that the Intermediary's excessive delay has severely hindered its ability to raise a defense to these adjustments. The Provider indicates that Medicare regulations require that documents be retained for only five years from the filing of the cost report. Because of the delay, it is now impossible to find documentation to contest the Intermediary's adjustments.

The Provider also indicated that since the fiscal years in question there have been three ownership changes and that in 2005 the hospital suffered extensive damage to its roof as a result of Hurricane Katrina. As a result, the Provider does not have any records to refute the Intermediary's adjustments. Because the Provider does not have any records, it must rely on the records it was able to obtain from the Intermediary.[38] While the Intermediary claims that the reports used to generate the unduplicated HHA census adjustments were accurate,[39] the Provider believes it might have been in a better position to challenge the Intermediary's position had the NPR not been so excessively delayed.

With respect to FYE 1997, the Intermediary indicates that in 1999, it initially denied the Provider's bad debt claims and requested information from the Provider. The Intermediary notes that the Provider submitted a revised list in 2000, and it allowed all claims on the revised list. The Intermediary does not believe that the delay in issuing the NPR has hindered the Provider's ability to locate the documentation. The Intermediary also indicates that the home health agency unduplicated census count and program visits were adjusted to the balances as accumulated on the PS&R using the proper run and paid dates. The Intermediary claims that the Provider has not indicated any disagreement with the results.

For FYE 1998, the Intermediary notes that the only adjustment to bad debts was for $1,680. The Intermediary's determination was based on the bad debts having been written off in another cost reporting period. The Intermediary states that it provided this adjustment to the Provider on June 21, 2001,[40] and that the Provider agreed with the adjustment on July 11, 2001.[41] The Intermediary indicates that other than the $1,680 adjustment there is no other bad debt adjustment and it is unclear how the delay in issuing the NPR has prejudiced the Provider. The Intermediary indicates that the home health agency unduplicated census count and program visits were adjusted to the balances as accumulated on the PS&R using the proper run and paid dates. The Intermediary claims that the Provider has not indicated any dissatisfaction with the specific results.

[37] IE 5 for FYE 1998.
[38] PE 35 for FYE 1997.
[39] Intermediary Position Paper (IPP) at 17 for FYE 1997 and 1998.
[40] IE 8 for FYE 1998.
[41] IE 5 for FYE 1998.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

The Board notes that when there is a change in ownership and the new owner accepts assignment of the Medicare Participation Agreement and provider number, it also assumes any associated outstanding liabilities. In this case, the Provider Participation Agreement and provider number were assigned to each successive operator of L.O. Crosby. As a result, the Intermediary recouped the contested overpayment from the current operator of the hospital, Forrest General. Under the lease agreements, however, Southern Regional Corporation (or SRC) appears to be liable to indemnify Forrest General for the overpayment.[42] SRC indicates that the underlying obligation for the overpayments transferred to each successive owner of the Provider Participation Agreement and provider number, and that while NAHC retained the Provider agreement and number it filed for bankruptcy. SRC asserts that the bankruptcy court permitted the sale of the hospital assets and assumption of the lease of L.O. Crosby building to Picayune Clinic, on June 22, 2000,[43] and claims that the sale discharged the obligations for the overpayment for FYE 1997 and 1998.[44]

SRC initially included the issue of whether the SRC is liable for the debts of the hospital based on the 5th Circuit ruling in *U.S. v. Vernon Home Health, Inc.* 21 Fed.3d 693 (5th Cir. 1994) (*Vernon*). The Board notes that the liability of SRC under its indemnity contract to subsequent holders of the Provider agreement is not a matter to be determined by the Board. The Board notes, however, the holding in *Vernon* is that a provider that continues to operate a health care facility under an assigned and assumed provider number after purchase of a seller's assets, does so with the acceptance of the liabilities associated with that provider number regardless of any attempts by the parties to restrict the transfer of such liabilities.[45] Based on a review of the parties' position on this issue, both appear to agree that subsequent holders of the provider agreement and number assumed the liabilities associated with it.[46]

Another issue initially raised by SRC was whether the amounts allegedly due (the overpayment for FYE 1997 and 1998) were discharged in NAHC's bankruptcy in 2000. While the Board did not consider that issue, it again notes that any provider that assumes a provider agreement and number assumes any outstanding liabilities associated with it. Moreover, the Board notes that the decision in *United States v. Consumer Health Services of America, Inc.* 108 F.3d 390 (D.C. Cir. 1997) holds that any withholding against any overpayment, made under the same Provider agreement, constitutes recoupment and is not affected by the filing of bankruptcy. The facts in this case indicate that Picayune Clinic, LLC assumed the provider agreement and number during the bankruptcy proceeding, assumed the liability associated with it and that the liability for the overpayment was not affected by the bankruptcy.

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[42] *See* Intermediary Supplemental Position Paper (ISPP), IE 25 and Tr. at 62. *See also n. 20, supra.*
[43] PE 7 for FYE 1997.
[44] Provider Position Paper (PPP) at 19-22 for FYEs 1997 and 1998.
[45] *Vernon* at 696.
[46] *See* Provider Position Paper (PPP) at 8-13 and Intermediary Supplemental Position Paper (ISPP) at 3.

The Board notes that overpayments were collected from Forrest General, the current owner of the provider agreement and number, and that the issues before the Board are whether the NPRs and adjustments were proper.

Issue 1 - Delay in Issuing the NPRs

The Board notes that in its earlier decision in *Woodruff-BD*, it found that there was no statutory or regulatory authority that allowed the Board to set aside an NPR issued after considerable delay. However, the court in *Woodruff* was able to review the timeliness issue under the APA and found that in situations where the delay was not reasonable and resulted in serious prejudice, the agency's determination could be set aside. The Board continues to find that it has no authority to set aside the NPRs and, after reviewing the facts in this case, finds that the portion of the delay relating to the bankruptcy was reasonable and that the delay did not result in serious prejudice to the Provider.

The Board noted that in its decision in *Woodruff-BD,* there was an excessive delay in the time between the filing of the cost report and completion of the field audits and the issuance of the NPRs. The Board further noted that the provisions of 42 C.F.R. § 405.1835 gave providers the right to a hearing before the Board if an intermediary's determination concerning the amount of reasonable cost reimbursement due a provider was not rendered within 12 months after receipt by the intermediary of a provider's perfected cost report or amended cost report, provided such delay was not occasioned by the fault of the provider. The Board, however, found that this provision did not establish a statute of limitation, as suggested by the provider in that case, and that there were no provisions in the Social Security Act or the governing regulations which established a statute of limitation for the intermediary's issuance of the NPR within a specified period of time. Finally, the Board found that the equitable doctrine of laches did not apply in this case. The Board found, and continues to find, that there is no statutory or regulatory authority that allows the Board to set aside NPRs issued after considerable delay.

The Board further noted that the court in *Woodruff* observed that Congress specifically authorized providers "to obtain judicial review of any final decision of the [PRRB]." 42 U.S.C. §1395oo(f)(1).[47] And additionally, "any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the [PRRB] determines . . . that it is without authority to decide the question" is also reviewable in court.[48] The court determined that the judicial review is governed by the Administrative Procedures Act (APA), 5 U.S.C. §§ 701-706 and that the APA directs that "[w]ith due regard for the convenience and necessity of the parties or their representatives and within a reasonable time, each agency shall proceed to conclude a matter presented to it." 5 U.S.C. § 555(b). Finally, relying on the standards for unreasonable delay in an earlier case, *Houseton v. Nimmo*, 670 F.2d 1375, 1378 (9th Cir. 1982) (Houseton), the court noted that "[a] court may find agency inaction the equivalent of a dismissal or denial of a requested agency action only when the delay is unreasonable and results in serious prejudice to one of the parties." Thus, to justify refusing to enforce the Secretary's decision a provider must show both "unreasonable delay and serious prejudice." *Id.*

[47] *Woodruff* §40,108 at 30,109-10.
[48] *Id.*

With regards to the reasonableness of the delay and prejudice to the parties, the Board notes the following: The Provider submitted its FYE 12/31/1997 cost report on May 15, 1998 and its FYE 10/31/98 cost report on approximately June 1, 1999. After the timely filing of both cost reports, the Intermediary did not issue NPRs for 12/31/97 until June 17, 2008, approximately 10 years after the cost report was filed, and it issued the NPR for FYE 10/31/98 on January 7, 2008, nearly 9 years after the cost report was filed. The Board notes the delay in issuing the NPRs was initially caused by the filing of the bankruptcy by the Provider (NAHC at that time) on April 19, 2000.[49] Documentation in the record indicates that with the filing of the bankruptcy, the Intermediary stored the records for these cases until the bankruptcy proceedings were completed. The Board further notes that the record indicates that the Intermediary did not take any action either after the sale of the hospital's assets and provider number on July 31, 2000 or after the closure of NAHC's bankruptcy case on December 31, 2004.[50] Instead, an internal review revealed that the FYE 1997 and 1998 NPRs had not been issued and prompted the Intermediary to proceed with the issuance of NPRs.[51] The Board finds that the Intermediary's actions in delaying the NPRs while the bankruptcy case was proceeding was proper, however, the failure to monitor the progress of the bankruptcy proceedings resulted in several years of delay in issuing the NPRs. The Board finds that the Intermediary's oversight, while unfortunate, appears to be inadvertent, and, unlike the finding in *Woodruff*, short of arbitrary and capricious.

Turning to the issue of prejudice, the Board observes that the Intermediary conducted timely reviews of the cost reports and issued proposed audit adjustment reports to the Provider for FYE 1997 on March 15, 2000,[52] and for FYE 1998 on June 21, 2001.[53] For FYE 1997, the record indicates that the Intermediary proposed removing all of the Provider's bad debt claims because there was insufficient documentation and requested that the Provider submit additional information.[54] The Provider responded by submitting a new bad debt list.[55] Furthermore, the record indicates that the Intermediary revised its adjustment to allow the amounts claimed on the Provider's new bad debt list.[56] The Board notes that the final adjustments in the FYE 1997 NPR for bad debts did not change from what was modified as a result of the earlier exchange. With respect to unduplicated count, the Board finds that the Provider did not submit any documentation concerning this issue.

For FYE 1998, the Board notes that there was a small bad debt adjustment for $1,680 and an adjustment for the HHA unduplicated count.[57] The Intermediary requested that the Provider review their proposed adjustments on June 21, 2001.[58] The Board notes that the Provider did not submit any response to the adjustments and indicated in writing that it agreed with the all of the proposed audit adjustments.[59] The Board also notes that prior to the issuance of the final NPR

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[49] *See* PE 11.
[50] *Id.*
[51] *Id.*
[52] IE 9 for FYE 1997.
[53] IE 8 for FYE 1998.
[54] IE 17 for FYE 1997.
[55] *See* IE-10 for FYE 1997.
[56] IE 8 for FYE 1998.
[57] IE 4 for FYE 1998.
[58] IE 8 for FYE 1998.
[59] IE 5 for FYE 1998.

for 1998, the Provider apparently questions the calculation of the HHA unduplicated count.[60] In response, the Intermediary provided a detailed explanation of the methodology for the calculation and asked that the Provider present any questions or concerns.[61] The Board notes that the Provider did not subsequently indicate any basis for its appeal of the HHA unduplicated census counts.

The Board finds that for both FYEs 1997 and 1998, the Intermediary gave the Provider sufficient notice of the proposed audit adjustments and opportunity to respond with additional information. The Board also finds that the Provider, at that time, either responded to the audit adjustments with additional information in 1997 or indicated its agreement with the adjustments in 1998. As a result, the Board finds that the Provider was not seriously prejudiced by the delay in issuing the NPRs. While not excusing the additional delay, there is nothing in the record that indicates that the Provider had additional concerns with the proposed audit adjustments that ultimately were included in the delayed NPRs. The Board also questions what, if any objections, SRC could have in this case because, after the execution of the lease agreement with NAHC, it no longer took a role in the day to day operations of the hospital, did not retain any records from the hospital and left any negotiations on reimbursement matters to the operator of the hospital.[62]

Issue 2 – Bad Debt Claim and Unduplicated Census

The Board notes that the Provider claims that its ability to contest the audit adjustments related to bad debts and HHA unduplicated census has been compromised by the delay in issuance of the NPRs. The Provider points out that Medicare regulations only require the retention of documents for 5 years, that there have been three CHOWs and that records were lost as a result of Katrina. The Intermediary asserts it timely presented audit adjustments to the Provider for both years and gave it an opportunity to present additional information to refute them. The Intermediary indicates that for FYE 1997, the Provider submitted additional information concerning bad debts but raised no objection concerning the unduplicated HHA census. For FYE 1998, the Provider indicated in writing that it accepted all of the audit adjustments. The Intermediary asserts that the Provider had an opportunity to object to the audit adjustments and if it continued to be dissatisfied with the proposed adjustments, it should have maintained the documentation needed to support its appeal.

As noted above, the Board agrees with the Intermediary that the Provider was presented with the proposed audit adjustments for both years and was given an opportunity to present additional information to refute them. The Board observes that for FYE 1997, the Provider presented additional information concerning bad debts but did not raise any objections concerning the unduplicated census; and for FYE 1998, the Provider agreed with the proposed adjustments. The Board also agrees with the Intermediary that providers are obligated to maintain documentation concerning audit adjustments they plan to appeal. Nevertheless, the Board reviewed the evidence in the record to determine if there is any basis to find that the Intermediary adjustments were not proper.

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[60] IE 20 for FYE 1988.
[61] *Id.*
[62] Tr. at 36 and 57.

First, with respect to FYE 1997, the Board notes that the Provider was notified that all bad debts were being disallowed and was given an opportunity to submit additional documentation.[63] The Provider had its consultant, Horne CPA Group, submit a revised bad debt list for consideration.[64] The record indicates that the Intermediary allowed all of the bad debts claimed on the revised list.[65] The Provider claims that it complied with all applicable regulations regarding collection practices concerning bad debts. However, the Board notes that the Intermediary disallowance related to the fact that the list of bad debts submitted or provided did not match the bad debts claimed on the cost report.[66] The Board notes that the Intermediary requested that the Provider supply a revised bad debt list,[67] and that this information was provided by the Provider's consultant four months after the Intermediary request.[68] While the Board cannot be certain that the Provider did not have additional information, the cover sheet to the revised list submitted by the Provider's consultant indicated that it was "the completed bad debt list for L.O. Crosby FY 97."[69] The Board observes that at the time the revised bad debt list was submitted, all of the hospital's records would have been available to the Provider. The Board finds no evidence that the Intermediary's adjustment was improper.

The Board also notes that, with respect to FYE 1997, the HHA unduplicated census count and program visits were adjusted to the balances as accumulated on the PS&R. The Board notes that the Provider did not object to the unduplicated census when the adjustment was proposed. The Board further observes that the Provider did not dispute the Intermediary statement that the unduplicated census did not affect the Provider's 1997 cost report.[70] The Board finds no evidence that the Intermediary's adjustment was improper.

Second, with respect to FYE 1998, the Board first notes that the Provider indicated in writing that it agreed with all of the audit adjustments proposed by the Intermediary.[71] With respect to the adjustment for bad debts, the Board notes that the amount of the adjustment was for only $1,680. As with the bad debts in FYE 1997, the Provider claims that it complied with all applicable regulations regarding collection practices concerning bad debts. The Board, however, notes that the reason for the disallowance was not related to collection efforts but because these bad debts were written off in another fiscal period.[72] Again, the Board cannot be certain that the Provider did not have additional data to refute the adjustment but believes that data would have been readily available to the Provider at the time it agreed with the audit adjustments. The Board finds no evidence that the Intermediary's adjustment was improper.

With respect to the HHA unduplicated count for FYE 1998, the Board notes that the Provider was in possession of the records at the time of the initial proposed audit adjustments and indicated that it agreed with all of the proposed adjustments including those related to the unduplicated HHA census count. The Board notes that the Intermediary, prior to the issuance of

[63] IE 17 for FYE 1997.
[64] IE 10 for FYE 1997.
[65] IE 8 for FYE 1997.
[66] IPP at 15 for FYE 1997.
[67] IE 17 for FYE 1997.
[68] IE 10 for FYE 1997.
[69] IE 10 for FYE 1997.
[70] Tr. at 27.
[71] IE 5 for FYE 1998.
[72] IPP at 15 for FYE 1998.

the 1998 NPR, updated the HHA unduplicated census and program visits with data current through August 31, 2007.[73] The Board notes the unduplicated HHA census count from the initial PS&R in 2000 and the later in 2007 was a difference of one.[74] The Board also notes that the Intermediary gave the Provider a detailed explanation of the method of calculation of the unduplicated HHA census and also copies of the data it used to review visits and patients.[75] The Board believes that if the Provider had data to refute the adjustments, that data would have been readily available to the Provider at the time it agreed with the audit adjustments. In addition, the Board finds no evidence that the Intermediary did not properly utilize the detailed PS&R data to determine the unduplicated HHA census.

DECISION AND ORDER:

Issue 1 - Delay in Issuing the NPRs

The Board finds that there is no statutory or regulatory authority that allows the Board to set aside NPRs issued after considerable delay. The Board also finds that the delay in issuing the NPRs was not arbitrary and capricious and did not result in prejudice to the Provider.

Issue 2 - Bad Debt Claim and Unduplicated Census

The Board did not find any evidence in the record to indicate that the Intermediary's adjustments with respect to Medicare bad debts or unduplicated census were improper.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Yvette C. Hayes
Board Member

DATE: December 9, 2011

[73] IE 20 for FYE 1998.
[74] IE 4 at 1 for FYE 1998.
[75] IE 20 for FYE 1998.