PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D4

PROVIDER –
The Phoenix Clinic
North Miami, Florida

Provider No.: 10-4993

vs.

INTERMEDIARY –
Wisconsin Physician Services

DATE OF HEARING -
November 8, 2011

Cost Reporting Period Ended -
March 31, 2009

CASE NO.: 11-0160

INDEX

ISSUE:

Whether the Intermediary properly removed total costs and total payments.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

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

The Medicare program was established under Title XVIII of the Social Security Act, as amended (Act), to provide health insurance to the aged and disabled. The Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program[3]. 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)[4]. 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 receipt of the NPR[5].

In § 4523(a) of the Balanced Budget Act of 1997 (BBA), Congress established the prospective payment system for certain hospital outpatient services (OPPS) by adding a new subsection (t) to 42 U.S.C. § 1395l.[6] Congress later amended the OPPS statutory provisions as part of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA).[7] Prior to OPPS, these services had been subject to reasonable cost reimbursement.

Under OPPS, predetermined amounts are paid for designated outpatient services furnished to Medicare beneficiaries. These services are identified by codes established under the Healthcare Common Procedure Coding System (HCPCS). The OPPS rates are determined in accordance with the methodology described in 42 C.F.R. Part 419, Subpart C. CMS classifies outpatient services and procedures that are comparable, clinically and in terms of resource use, into ambulatory payment and classification (APC) groups. CMS determines the median cost within each APC group by using hospital outpatient claims data from calendar year 1996 plus data from

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

[2] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

[3] *See* 42 C.F.R. § 413.20.

[4] *See* 42 C.F.R. § 405.1803.

[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835 – 405.1837.

[6] BBA, Pub. L. No. 105-33, § 4523(a), 111 Stat. 251, 445-449 (1997).

[7] BBRA, Pub. L. No. 106-113-Appendix F, §§ 201, 202, 204, 113 Stat. 1501A-321, 1501A-336 – 1501A-345 (2000).

the most recently available cost reports. It then assigns a weighting factor to compare median costs within each APC group to all APC groups. CMS standardizes the median cost by adjusting for variations in labor costs across geographic areas. Weights are converted to payment rates using a conversion factor that takes into account group weights, the volume of services for each group and an expenditure target specified in law. Additional payments in the form of outlier adjustments for extraordinarily high cost services are available under OPPS.[8] CMS annually updates payment groups, relative weights, wage indices and other adjustments.

As part of the conforming amendments in BBA § 4523(d), Congress specified that Medicare-covered partial hospitalization services furnished by community mental health centers (CMHCs) as well as certain other Medicare-covered outpatient services that had been previously paid on a reasonable cost basis would be paid under OPPS.[9] Under OPPS, partial hospitalization services are paid on a per diem basis and this per diem amount equals the national median cost of providing partial hospitalization services.[10] Further, "the per diem amount represents the cost of an average day of partial hospitalization because the data used to calculate the per diem were derived from all the partial hospitalization data and includes the most and the least intensive days."[11]

The Medicare regulations governing reasonable cost reimbursement in 42 C.F.R. Part 413 specify certain cost reporting and recordkeeping requirements for providers participating in the Medicare program.[12] In particular, 42 C.F.R. § 413.24(c) (2009)[13] requires that "data be accurate and in sufficient detail to accomplish the purposes for which it is intended."[14] Similarly, CMS' implementing manual guidance in the Provider Reimbursement Manual, (CMS Pub. No. 15-1 (PRM 15-1) requires that: "Cost information as developed by the provider must be current, accurate and in sufficient detail to support payments made for services rendered to beneficiaries."[15] In cases where a provider fails to meet these recordkeeping requirements, 42 C.F.R. § 413.20(e) specifies:

> If an intermediary determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the Medicare program, payments to such providers will be suspended until the intermediary is assured that adequate records are maintained.

Additional recordkeeping requirements are located in the Medicare regulations located in 42 C.F.R. Part 412, Subpart C entitled "Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs." As specified in 42 C.F.R. § 412.1(b)(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the inpatient prospective payment systems for operating and capital-

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[8] 42 C.F.R. § 419.43(d).
[9] *See also* 65 Fed. Reg. 18434, 18437, 18444 (Apr. 7, 2000); 42 C.F.R. § 419.21(c).
[10] 65 Fed. Reg. at 18453.
[11] *Id*. at 18455.
[12] *See, e.g*., 42 C.F.R. §§ 413.20 and 413.24.
[13] All citations to the C.F.R. are from the October 1, 2009 edition unless otherwise specified.
[14] 42 C.F.R. §413.24(c).
[15] CMS Pub.15-1 §2304.1.

related costs (IPPS). These conditions include one related to recordkeeping. In this regard, 42 C.F.R. § 412.52 states:

> All hospitals participating in the prospective payment systems [for inpatient operating costs and inpatient capital-related costs] must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this chapter.

Further, 42 C.F.R § 412.40 provides that, where hospitals participating in IPPS fail to fully comply with the conditions specified in Subpart C, CMS may take certain actions, including withholding payment. Specifically, § 412.40 states in pertinent part:

> (a) A hospital must meet the conditions of this subpart to receive payment under the prospective payment systems for inpatient hospital services furnished to Medicare beneficiaries.
> (b) If a hospital fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, CMS may, as appropriate—
> (1) Withhold Medicare payments (in full or in part) to the hospital until the hospital provides assurances of compliance; or
> (2) Terminate the hospital's provider agreement.

The Medicare regulations governing OPPS are located in 42 C.F.R. Part 419. However, they do not contain any similar regulations specifying recordkeeping requirements.

The dispute in this case involves the Intermediary's total disallowance of all costs claimed by the Provider on its cost report for the fiscal year ending March 31, 2009 (FY 2009) due to the lack of available documentation to support those costs.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Phoenix Clinic (Provider) is a CMHC that is located in North Miami, Florida. As part of its FY 2009 cost report, the Provider claimed approximately $7,023,000 for Medicare-related services.

During the summer of 2010, Wisconsin Physician Services (Intermediary) initiated an in-house audit review of the Providers' FY 2009 cost report. As a result, of the in-house audit, the Intermediary made certain adjustments to the Provider's settlement data and bad debts claims.

In addition, CMS contracted for the services of a program safeguard contractor (PSC) to conduct a separate audit of the Provider's costs claimed for FY 2009. The PSC's audit was conducted on site. During its review, the PSC requested certain documentation to support the costs reported by the Provider for FY 2009. In response, the Provider furnished some but not all of the requested supporting documentation. The PSC gave its audit findings to the Intermediary. After consultation with the PSC, the Intermediary considered the overall documentation inadequate to support any portion of the costs reported by the Provider.

As a result of these audits, Intermediary made adjustments to remove all cost from the cost report. The Intermediary also identified all amounts paid under OPPS to the Provider during the period as overpayments and issued a repayment demand letter.

The Provider disputed both the nature of and need for the documentation sought by the PSC and timely appealed the Intermediary's determinations to the Board. The Provider met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 – 405.1840 and was represented by Christopher A. Parrella, Esq. from the Health Law Offices of Anthony C. Vitale, P.A. The Intermediary was represented by Byron Lamprecht of Wisconsin Physician Services.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary is improperly treating the Provider as a cost reimbursement participant in the Medicare program when the Intermediary made adjustments to recoup the OPPS payments at issue.[16] The Provider argues that it received these payments under the OPPS. OPPS has established payment schedules that "are based on national and regional costs for treating particular medical conditions, not on the hospital's actual costs."[17] The Provider further argues that the regulation at 42 C.F.R. §413.24(a) applies only to those providers receiving payment on the basis of reasonable costs and that the guidance at PRM 15-1 § 2304 deals strictly with cost information that pertains to the determination of reasonable cost. Taken collectively, the Provider contends that the PSC/FI's information request does not apply to its OPPS participation in the Medicare program.

The Provider also contends that BBRA, 42 U.S.C. § 1395l(a)(2)(B) and its related regulatory history demonstrate that CMHCs must be paid under OPPS on a per diem amount that is strictly based on national cost data, regardless of the costs actually incurred by that provider.[18] The Provider argues that the Intermediary erred in disallowing total costs based upon the Provider's ostensible failure to produce requested cost information when actual costs are irrelevant to payment of the claims at issue under OPPS.[19]

Assuming arguendo that the requested cost information is relevant to the payment of the OPPS claims at issue, the Provider contends that it supplied the FI's PSC with a substantial amount of the financial documentation that it requested[20] and, thereby, challenges the propriety of assessing a 100 percent disallowance of the OPPS payments in the face of the substantial documentation that it did supply.

The Provider also contends that the NPR, as issued, did not meet the notice requirements imposed by 42 C.F.R. §405.1803(b).[21] The regulatory section requires that the NPR "explain why the intermediary's determination of the amount of program reimbursement for the period differs from the amount the provider claimed." Further, 42 C.F.R. § 405.1803(c) provides that the intermediary's determination, as contained in the notice, shall be the basis of the recoupment

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[16] *See* Provider Final Position Paper at 5-6.
[17] *U.S. ex.rel.Whitten v. Community Health Sys., Inc.*, 2009 WL 5214308 *3(S.D. Ga. 2009) (citations omitted).
[18] *See* Provider Final Position Paper at 6-8.
[19] *See Bellevue Hospital Ctr. v. Leavitt*, 443 F.3d 163, 168 (2d Cir. 2006).
[20] Provider Exhibits P-12 and P-13.
[21] *See* Provider Final Position Paper at 8-12.

for overpayments. The Provider argues that strict compliance with the applicable regulations mandates that the Intermediary provide both the PPS determination and the explanation of the variance between the Intermediary's determination of program reimbursement and the amounts claimed by the Provider on the FY 2009 as-filed cost report.

The Provider also argues that the successive demands made by the Intermediary/PSC for financial documents amounted to an unconstitutional general administrative search in violation of the Fourth Amendment to the U.S. Constitution.[22] For an administrative search to be valid under the Fourth Amendment, the Provider asserts that a federal agency must show probable cause and that probable cause is established only when there is "specific evidence on an existing violation."[23] Further, the courts require that the proposed search be authorized by statute, properly limited in scope, and initiated in an appropriate manner.[24] The Provider contends that the Intermediary's overly broad demand for internal documents constituted a request to conduct an administrative search that was neither authorized by statute, properly limited in scope, nor initiated in an appropriate manner.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider failed to furnish adequate documentation to support the total costs claimed on the FY 2009 cost report.[25] The Intermediary maintains that the Medicare regulations require that providers participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of 42 C.F.R. §§ 413.20 and 413.24 relating to reasonable cost reimbursement.[26] The Intermediary further maintains that the adequacy of cost information and availability of records is a conditional requirement for payment under the prospective payment systems as set forth in program policy.[27] In particular, PRM 15-1 § 2304 states:

> Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited.

The Medicare statutes give the Secretary broad discretion to determine what "reasonable costs" of services to Medicare beneficiaries may be reimbursed to "providers of services." They also grant the Secretary broad discretion as to what information to require as a condition of payment to providers under the Medicare program. Consequently, the Secretary's documentation

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[22] *See* Provider Final Position Paper at 12-14.
[23] *See Marshall v. Barlow's, Inc.*, 436 U.S. 307, 320 (1978).
[24] *See, e.g., United States v. Mississippi Power & Light Co.*, 638 F.2d 899, 907 (5th Cir. 1981), *cert. denied*, 454 U.S. 892 (1981).
[25] *See* Intermediary Final Position Paper at 5-6.
[26] *See* 42 C.F.R. § 412.52
[27] *See* PRM 15-1 §§ 2304 and 2304.1

requirement is based on a reasonable interpretation of her own regulations, which is entitled to deference because that interpretation is neither plainly erroneous nor inconsistent with the regulatory language. Therefore, the requests for documentation by the PSC were fully justified given the law, regulations, and program policy.

The Intermediary also contends that the Provider did not fully cooperate even though by signing the certification on the as-filed cost report, the Provider formally certified that the subject cost report is "a true, correct and complete report prepared from the books and records of the provider(s) in accordance with applicable instructions."[28] The Intermediary contends further that the Provider certified on that cost report that they are "familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such law and regulations." The Intermediary argues that the cost information requested will confirm this signed statement and asserts that, contrary to the Provider's position, data from recent cost reports is utilized in determining OPPS rates as stated in 42 C.F.R. Part 419, Subpart C. In addition, the Medicare regulations require that CCRs which are used in determining outlier payments be continuously updated using the most recent full year audited cost report.[29] The Intermediary concludes that in the absence of cost information[30] its disallowance was proper

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Intermediary's acceptance and implementation of the PSC's audit finding and recommendation to adjust and disallow on a global basis all of the costs claimed on the Provider's cost report for FY 2009 and to recoup any OPPS payments relevant to that time period was improper. Further, the Board finds that the Intermediary properly made adjustments to the settlement data and bad debts based on its earlier audit findings from the Intermediary's in-house audit that was concluded in September 2010.[31]

The disallowance issue presented for the Board's consideration requires an examination of the circumstances that generated the global cost disallowance. The Intermediary conducted an in-house "less than full scope audit" of the Provider's FY 2009 cost report where the examination was confined to "outpatient bad debts."[32] In particular, the Intermediary audited the Provider's bad debt log. The Intermediary concluded this audit in September 2010 and, based on that audit, made adjustments to the settlement data and bad debts.[33]

On a separate basis, the Intermediary's PSC also conducted an on-site review of the Provider's FY 2009 cost report. As part of this on-site review, the PSC requested that the Provider provide certain documentation to support the costs reported on the FY 2009 cost report. The Provider

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[28] *See* Intermediary Final Position Paper at 6.
[29] *See* 42 C.F.R. § 419.43
[30] *See* Intermediary's Post Hearing Brief at 4-5.
[31] *See* letter dated September 3, 2010 from the Intermediary to the Provider and Intermediary's audit workpapers N-1 and APN-3 (copies included in the Intermediary audit workpapers attached to the Intermediary's Post-Hearing Brief).
[32] *See id.*
[33] Intermediary's Final Position Paper, p.3.

provided the PSC with some but not all of the requested FY 2009 documentation. Notwithstanding, the PSC made an audit finding that the Provider had failed to maintain adequate documentation and made a recommendation to the Intermediary to globally remove all costs from the FY 2009 cost report due to "the *overall* lack of adequate documentation to support the costs associated with furnishing services to Medicare beneficiaries."[34] Based on the PSC's audit finding and recommendation, the Intermediary globally removed the total costs and any payments from the FY 2009 cost report including any bad debt and OPPS payment relevant to that time period.[35]

The functions that a program integrity contractor such as a PSC may perform are identified in the Medicare regulations. Specifically, 42 C.F.R. § 421.304 states, in pertinent part, that these functions may include:

> (a) Conducting medical reviews, utilization reviews, and reviews of potential fraud related to the activities of providers of services and other individuals and entities . . . furnishing services for which Medicare payment may be made either directly or indirectly.
> (b) Auditing, settling, and determining cost report payments for providers of services or other individuals or entities . . . as necessary to help ensure proper Medicare payment.
> (c) Determining whether a payment is authorized under title XVIII, as specified in section 1862(b) of the Act, and recovering mistaken and conditional payments under section 1862(b) of the Act.

The language of the regulation makes clear that the PSC's activities may include "[a]uditing, settling, and determining cost report payments for providers of services." Based on the information presented at the hearing, the Board understands that the Intermediary relied on the PSC's cost report audit finding and recommendation when the Intermediary made the cost report adjustments at issue.[36]

During the hearing, the Board requested that the Intermediary supply the workpapers that supported the adjustments at issue, including the PSC's workpapers, with their post-hearing submission.[37] The Board requested this information to determine the basis for the PSC's recommendation that all of the Provider's costs for FY 2009 be disallowed in their entirety.[38] In response to the Board's request, the Intermediary did submit to the Board some workpapers; however, these workpapers only related to the Intermediary's in-house "less than full scope audit" which was confined to "outpatient bad debt" and resulted in a disallowance of

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[34] Intermediary's Final Position Paper at 2 (emphasis added). *See also* Transcript (Tr) at 48-50.
[35] Intermediary's Final Position Paper at 2; Tr. at 48-50
[36] The Intermediary's representative stated during the hearing that he believed that the Intermediary relied on the PSC's findings to make the adjustments at issue and would double check that post hearing. The Intermediary did not provide any additional information in the post hearing submission. *See* Tr. at 106-107; Intermediary's Post Hearing Brief (including the attached cover letter dated Dec. 30, 2011 and the attached Intermediary audit workpapers).
[37] Tr. at 87-88, 106-107.
[38] Tr. at 87-88.

approximately 75 percent of the claimed $1.7 million for bad debts based on the Intermediary's audit of the Provider's bad debt log.[39] The Intermediary did not submit any PSC or Intermediary workpapers related to the Intermediary's acceptance and implementation of the PSC's audit finding and recommendation to globally disallow all of the costs claimed on the Provider's FY 2009 cost report and to recoup all OPPS payment relevant to that time period.

As a result, the Board's review of the Intermediary's basis to disallow all costs and recoup all OPPS payments on a global basis for FY 2009 is confined to the assertions made by the Intermediary relative to those actions. The Intermediary asserts that adjusting total costs and recouping all OPPS payments for FY 2009 is a proper remedy for the Provider's failure to furnish adequate documentation to support the total costs claimed on the FY 2009 cost report.[40] The Intermediary asserts that 42 C.F.R. § 412.52 requires that providers participating in the prospective payment systems must meet the recordkeeping and cost reporting requirements of 42 C.F.R. §§ 413.20 and 413.24 as a condition of their participation. The Intermediary maintains that the adequacy of cost information and availability of records is a conditional requirement for payment under the prospective payment systems as set forth in program policy, CMS Pub.15-1 §§ 2304 and 2304.1.[41] The Intermediary also contends that the Secretary holds wide discretion relative to the information that is required as a condition of payment to providers under the Medicare program.[42]

At the outset, the Board notes that, contrary to the Intermediary's assertion, the recordkeeping requirements in 42 C.F.R. § 412.52 and CMS' authority in 42 C.F.R. § 412.40(b) to withhold (*i.e.*, suspend) payments for failure to comply with this requirement are not applicable to this case.[43] These regulations are located in Subpart C of 412 and, pursuant to 42 C.F.R. § 412.40, Subpart C only pertains to hospitals receiving payment under IPPS.[44] However, the Provider neither is a hospital nor received payment under IPPS, rather the Provider is a CMHC and only furnishes certain outpatient services payable under OPPS.

As a result, the Board reviewed the regulations applicable to OPPS which are located in 42 C.F.R. Part 419. 42 C.F.R. Part 419 does not contain any regulations that require providers (*e.g.*, hospitals or CMHCs) who receive payments under OPPS to meet certain conditions such as recordkeeping requirements. Moreover, Part 419 does not contain any regulations allowing CMS to withhold or recoup OPPS payments.[45]

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[39] *See* Intermediary's audit workpapers attached to the Intermediary's Post Hearing Brief (workpapers N-1 and APN-3 documenting an allowance of approximately 25 percent of the $1.7 million claims as bad debts on the Provider's as filed cost report for FY 2009).

[40] Tr. at 13.

[41] Tr. at 13-17.

[42] Tr. at 17.

[43] Even if these regulations were applicable, they only authorize withholding (*i.e.*, suspension) of payment rather than a retroactive recoupment of prior payments. The regulations at 42 C.F.R. Part 405, Subpart C provide a process and procedure for suspending payments.

[44] Similarly, 42 C.F.R. § 412.1(b)(3) confirms that Subpart C only applies to IPPS.

[45] The Board also reviewed the regulations generally addressing "conditions for Medicare payment" that are located in 42 C.F.R. Part 424. Part 424 does specify, in pertinent part, at § 424.5(a)(6) that "[t]he provider, supplier or beneficiary, as appropriate, must furnish to the intermediary . . . sufficient information to determine whether payment is due and the amount of payment." The Board has not identified any regulation in Part 424 that requires providers of partial hospitalization services to maintain documentation of "costs associated with furnishing services to Medicare beneficiaries." In this regard, the Board notes that 42 C.F.R. § 419.41(c)(5) specifies that payment

The Board next reviewed the regulations in 42 C.F.R. Part 413 governing the "principles of reasonable cost reimbursement." Part 413 is applicable to CMHCs as CMHCs still receive certain reimbursement on a reasonable cost basis (*e.g.*, bad debts). Further, CMS uses aggregate cost report data from all providers to periodically review OPPS rates. As such, the Medicare program still requires CMHCs to file cost reports on an annual basis.

The Intermediary relies on the Part 413 recordkeeping requirements located in 42 C.F.R. §§ 413.20 and 413.24. The Board does not dispute these recordkeeping requirements or CMS' authority to interpret them. However, the Board disagrees with the Intermediary's application of these regulations to support of the Intermediary's cost disallowance and finds no CMS guidance to support this application.

First, these regulations only pertain to reasonable cost reimbursement and do not pertain to any payments under OPPS.[46] As recognized by the Intermediary during the hearing[47] and pursuant to 42 C.F.R. § 419.41(c)(5),[48] an OPPS payment is not an interim payment but rather "the final Medicare program payment amount." However, none of the OPPS payments at issue were reopened and reconsidered on a claim-by-claim basis under the reopening process outlined in 42 C.F.R. §§ 405.980 – 405.986. Rather, the Intermediary only considered such OPPS payments in the aggregate as part of the cost report settlement process.[49]

Second, these regulations prescribe specific remedies in those cases where a provider fails to maintain adequate records for determining "reasonable cost" and the Intermediary failed to follow any of the prescribed remedies. Specifically, in cases where a provider fails to meet the recordkeeping requirements, 42 C.F.R § 413.20(e) states in pertinent part:

> If an intermediary determines that a provider does not maintain or no longer maintains adequate records *for the determination of reasonable cost* under the Medicare program, payments to such providers will be suspended until the intermediary is assured that adequate records are maintained.[50]

In implementing the PSC's audit findings, the Intermediary did not take the prescribed prospective remedy[51] but rather took a retrospective remedy.

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under OPPS is "the final Medicare payment amount" and, accordingly, is not subject to settlement. Further, the PSC review was confined to cost and did not review medical records or the medical necessity or Medicare coverage of the underlying services. *See* Tr. at 34-35. Accordingly, the Board finds that § 424.5(a)(6) is not applicable to this case because OPPS rates are set prospectively and any documentation of the costs associated with furnishing such services would necessarily not be relevant to determining "whether payment is due and the amount of payment" for any of the OPPS claims at issue.

[46] Similarly, the Board finds that the recordkeeping requirements in PRM 15-1 §§ 2300 and 2304 are not applicable to the OPPS payments at issue.

[47] *See* Tr. at 64

[48] *See also* 65 Fed. Reg. at 18449, 18492-18493.

[49] *See* Tr. at 75-76.

[50] (Emphasis added.)

[51] *See also* PRM 15-1 § 2404.3 (tracking this regulation and providing for similar prospective remedies).

The Board notes that, during the PSC's audit, the Provider did respond to the PSC's request for documentation and did submit documentation to the PSC to support a portion of the claimed costs for FY 2009. In addition, the Board notes that, prior to the PSC's audit finding and recommendation, the Intermediary also received from the Provider bad debt documentation that the Intermediary determined was adequate or acceptable documentation to support a portion of the bad debt claimed on the FY 2009 cost report.[52]

Notwithstanding the Intermediary and PSC's receipt of Provider cost documentation (some of which was acceptable), the Intermediary did not limit its adjustments to the specific costs that were not adequately supported.[53] Rather, the Intermediary made adjustments on a global basis to disallow the total costs claimed by the Provider on the FY 2009 cost report and to recoup any OPPS payments covered by that time period based on the PSC's audit where the PSC "did not reach a satisfactory comfort level with what [documentation] was provided and what it was finding"[54] and determined that there was an "overall lack of adequate documentation to support the costs associated with furnishing services to Medicare beneficiaries."[55] However the Board cannot identify any statutory or regulatory authority that permits the Intermediary on a global basis to disallow the FY 2009 total costs claimed by the Provider or recoup all FY 2009 OPPS payments as a result of the Intermediary/PSC's finding that the Provider "overall" failed to maintain adequate records notwithstanding production of acceptable documentation to support a portion of the costs claimed. Further, the Board believes that the remedies for an "overall" failure to maintain adequate records are limited to the prospective remedies articulated in the regulations.

Based on the above analysis, the Board finds and concludes that the Intermediary improperly accepted the PSC's audit finding and recommendation to adjust and disallow on a global basis all of the costs claimed on the Provider's cost report for FY 2009 and to recoup the OPPS payments relevant to that time period.

Bad debts is one of those areas where the Provider did submit adequate documentation to support a portion of the bad debts claimed on the FY 2009 cost report. Specifically, as part of the in house "less than full scope audit" that was concluded in September 2010, the Intermediary audited and reviewed the Provider's documentation supporting its bad debts claims and made an initial adjustment that allowed approximately 25 percent of the $1.7 million claimed as bad debts on the FY 2009 cost report.[56] However, by letter dated November 18, 2010,[57] the Intermediary subsequently reversed that decision based on the PSC's audit[58] and made Adjustment #7 to the NPR at issue "to remove *remaining* bad debt for lack of documentation per IntegriGuard's audit [i.e., the PSC's audit]." At the hearing, the Board attempted to establish why these remaining

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[52] Tr. at 47-49, 84-87.
[53] Tr. at 47-48.
[54] Tr. at 47-48. *See also* Tr. at 48-49 ("*[O]verall* they did not reach a comfort level and made the decision not to allow any costs . . . ." (Emphasis added)).
[55] Intermediary Position Paper at 2 (emphasis added).
[56] *See* Intermediary's audit workpapers attached to the Intermediary's Post-Hearing Brief (workpapers N-1 and APN-3 documenting an allowance of approximately 25 percent of the $1.7 million claimed as bad debts on the Provider's as-filed cost report for FY 2009).
[57] Provider Exhibit P-1 (emphasis added). *See also* Intermediary's audit workpapers attached to the Intermediary's Post-Hearing Brief.
[58] *See* Tr. at 46-48; 82-84.

bad debts were disallowed even though the Intermediary had previously determined that the bad debts were adequately supported.[59] As a result, the Board exercised its discretionary powers under 42 U.S.C. § 1395oo(d) to review Adjustment #7 involving bad debt expenses and asked the Intermediary to submit the workpapers supporting Adjustment #7 as part of the post hearing submission.[60] The Intermediary's post hearing submission did not include these workpapers or address the issue. The Board concludes that the PSC never specifically reviewed the "remaining bad debt" covered by Adjustment #7 as demonstrated by the fact that none of the PSC document requests included requests for documentation on bad debts.[61] Rather, the PSC's disallowance of the "remaining bad debt" appears to be covered by the global disallowance of total cost based on "the overall lack of adequate documentation to support the costs associated with furnishing services to Medicare beneficiaries."[62] Accordingly, the Board finds that the Intermediary had no basis to disallow and remove the remaining bad debt amount from the FY 2009 cost report and that the disallowance and removal of this amount was improper.

Finally, the Board also acknowledges that the Provider asserts that the information requested by the Intermediary constituted an unlawful Fourth Amendment search. The Board finds that, as part of the audit of the Provider's FY 2009 cost report, the PSC properly followed the regulations in requesting documentation from the Provider to support its FY 2009 costs.[63] Any further review of the Provider's assertion would require a constitutional analysis of the agency's regulations that is beyond the scope of the Board's authority.[64] Accordingly, the Board reaches no conclusions relative to the Provider's Fourth Amendment argument.

DECISION AND ORDER:

The Intermediary's acceptance and implementation of the PSC's audit finding and recommendation to adjust and disallow on a global basis all of the costs claimed on the Provider's cost report for the fiscal year ending March 31, 2009 and to recoup the OPPS payment relevant to that time period was improper and, accordingly, is reversed. Further, the Board affirms the adjustments to the settlement data and bad debts that the Intermediary made based on its earlier audit findings from the "less than full scope audit" concluded in September 2010.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty, Chairman
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Clayton Nix, Esq.

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[59] *Id.*
[60] Tr. at 82-84.
[61] *See* Intermediary Exhibits I-1 – I-4.
[62] Intermediary's Final Position Paper at 2. *See also* Tr. at 48-50.
[63] *See* 42 C.F.R. § 421.304.
[64] *See* 42 C.F.R. § 405.1867.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: JAN 31 2013