PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D22

PROVIDER –
Holy Redeemer Hospital and Medical Center
Philadelphia, PA

Provider No.: 39-0097

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Highmark Medicare Services

DATE OF HEARING -
February 11, 2011

Cost Reporting Period Ended -
June 30, 2000

CASE NO.: 02-1305

INDEX

ISSUE:

Whether the Intermediary's adjustment disallowing therapy services claims pursuant to a comprehensive medical review was proper?

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. 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, regulations, and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. 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 (*i.e.*, the NPR) may file an appeal with the Provider Reimbursement Review Board ("Board") provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of receipt of the final determination.[5]

COMPREHENSIVE MEDICAL REVIEW

A Comprehensive Medical Review ("CMR") is a thorough post-payment evaluation of the supporting medical documentation underlying claims for payment under Medicare Parts A or B. During the fiscal period at issue, CMRs involving providers were performed by intermediaries. The Medicare Intermediary Manual, CMS Pub. No. 13-3 ("MIM 13-3"), contained Medicare program guidance for intermediaries on how to conduct CMRs involving claims under Medicare

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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] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 - 405.1839.

Parts A and/or B. Specifically, that guidance was located in MIM 13-3 §§ 3940 to 3940.12.[6] This case involves a CMR of only Part B claims.

The purpose of a CMR is to determine: whether services are reasonable and necessary under Medicare law; adherence to program requirements (*e.g.*, physicians' orders and certifications; plans of treatment); adherence to coverage requirements (*e.g.*, beneficiary confined to home for home health services, or services are not excluded); and the presence of documentation to support that services were furnished.[7] The eight major steps involved in conducting a CMR include:

1) selecting providers,
2) selecting the period to be reviewed,
3) defining the universe and the sampling frame,
4) designing and selecting the sample,
5) adjudicating the sample,
6) calculating the estimates,
7) notifying the appropriate persons of the CMR results, and
8) referring results to the Audit/Reimbursement unit for recovery of the overpayment.[8]

MIM 13-3 contains detailed instructions to intermediaries for completing each of the above steps.[9]

The intermediary must notify the provider of the results of a CMR in writing. The notification letter must contain specific information regarding the CMR that includes but is not limited to: (1) an explanation of sampling methodology; (2) a list of all claims and the specific reasons the claims were not covered; and (3) a list of all provider appeal rights.[10] To ensure the notification letter contains each of the required information elements, CMS provided form letters in MIM 13-3 § 3940.12 for an intermediary to use when notifying a provider of CMR results. Exhibit 4 of that section provides a sample letter for use with providers regarding CMR results on Part B claims and it contains the following language to notify the provider of its right to challenge the results of a CMR:

> This letter serves as our revised determination of the claims listed in the Attachment. If you disagree with this determination, you must request a review (if the amount in controversy is $100 or less, or a Hearing Officer hearing if the amount in controversy is greater than $100) within 6 months of the date of this letter. You have the

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[6] As amended by MIM 13-3 Transmittal No. 1770 (Mar. 1, 1999) (a copy of the transmittal is included at Provider's Final Position Paper, Exhibit P-4). All references to MIM 13-3 §§ 3940-3940.12 shall be to the version as amended by MIM 13-3 Transmittal 1770 unless stated otherwise.

[7] *See* MIM 13-3 § 3940(B).

[8] MIM 13-3 § 3940(D).

[9] *See generally* MIM 13-3 §§ 3940-3940.12.

[10] MIM 13-3 § 3940.7.

> right to raise the same issues under this procedure as you would have in the context of non-sampling claims determinations of Part B services billed to the Fiscal Intermediary, and Overpayment recovery (See 42 C.F.R. §405.801, et seq. and 42 C.F.R. §405.701, et seq.) You may ask for a review of the denials for which you are determined to be liable under § 1879 of the Act or for which the beneficiary is determined to be liable under § 1879 of the Act, but decline in writing, to exercise his/her appeal rights, and determinations for which you are found to be not without fault under § 1870 of the Act. You may also challenge the validity of the sample selection and the validity of the statistical projection of the sample results to the universe.

The MIM 13-3 § 3940.10 further specifies that providers and beneficiaries must be informed of their administrative and judicial appeal rights in all overpayment final notification letters and determinations. The appeal rights stem from the fact that a CMR conducted on a sample of claims is considered a reopening of the final determination on those claims[11] and "[t]he provider may challenge both the claims determinations and the sampling methodology in the administrative process."[12] As a result, the intermediary must notify the parties of any change to the initial determination made on the claims in the sample based on the reopening and reconsideration process, and issue a revised determination to the parties.[13] For Part B claims, the provider may request a hearing before a Hearing Officer ("HO") if the amount in controversy is $100 or more (based on the extrapolated amount), and the request for hearing is filed within six months from the date of the notice of the review determination.[14]

The second level of appeal is a hearing before an Administrative Law Judge ("ALJ") if the applicable filing requirements are met and the amount in controversy is $500 or more [15] The third level of appeal is review by the Medicare Appeals Council of the Departmental Appeals Board if the ALJ decision is unfavorable (fully or partially), the amount in controversy remains $500 or more, and the filing requirements are met.[16] Finally, the provider may seek review in federal district court of the Appeals Council decision (or ALJ decision if the Appeals Council does not review the ALJ decision) if the amount in controversy is $1,000 or more.[17] The complaint for court review must be timely filed in accordance with Section 205(g) of the Act and 20 C.F.R. § 422.210.[18]

Finally, the CMR instructions in MIM 13-3 state that, when the CMR results in an overpayment,

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[11] MIM 13-3 § 3940.10(A)(2)(a).
[12] MIM 13-3 § 3940.8.
[13] *Id.*.
[14] MIM 13-3 § 3940.10(A)(2)(b).
[15] MIM 13-3 § 940.10(A)(2)(c).
[16] *Id.*
[17] *Id.*
[18] *Id.*

the provider must be given notice of the overpayment, the reasons for recoupment and an opportunity to submit a rebuttal in accordance with 42 C.F.R. § 405.374.[19] When the CMR results in an overpayment or underpayment adjustment to the final cost report as reflected in the written "Notice of Program Reimbursement (NPR)," and the provider or other entity is dissatisfied with the cost report adjustment, the provider or other entity may request an intermediary or Board hearing for a very limited purpose.[20] Specifically, the CMR instructions state:

> The provider may dispute to the PRRB the methodology for determining provider costs in the cost reporting process that are reflected on the NPR. As a general matter, the individual claim determination, sampling methodology, and the amount of the over/underpayment extrapolation related to the CMR should not be appealed to the PRRB.[21]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Holy Redeemer Hospital and Medical Center ("Provider") is a 271-bed hospital located in Philadelphia, Pennsylvania. On November 11, 2000, the Provider submitted its cost report to Veritus Medicare Services ("Intermediary") for fiscal year ending June 30, 2000 ("FY 2000"). The cost report was finalized with the issuance of an NPR on February 21, 2002. The NPR included Adjustment No. 818 that disallowed therapy claims pursuant to a CMR.[22] The Provider timely appealed the NPR to the Board on March 21, 2002.

Earlier, during March 2001, the Intermediary had conducted a CMR on therapy services reimbursed under Medicare Part B that were furnished from January 1, 2000 through December 31, 2000. This defined universe totaled 1,279 Part B therapy service claims. A statistical sample of 100 claims was selected from the universe of these Part B claims.[23] Based on its readjudication of the claims in the sample, the Intermediary Medical Review Department determined that there were 93 errors in the 100 claim sample. Based on the number of errors, the Intermediary Medical Review Department disallowed 1,272 therapy claims (allowing only the seven in the sample that were determined to be correct).[24] The Intermediary's Provider Audit Department prepared the overpayment assessment as a cost reporting adjustment and communicated that to the Provider by letter dated October 8, 2001.[25] As the Provider's fiscal year ends June 30th, the Intermediary split the adjustment between two cost reports – $244,162 for FY 2000 and $165,069 for FY 2001. Only the adjustment for FY 2000 is at issue in this case. In making the adjustments, the Intermediary did not send the Provider any revised determinations on the individual claims included in the sample or the universe.

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[19] MIM 13-3 § 3940.10(B).
[20] MIM 13-3 § 3940.11(A).
[21] *Id.*
[22] *See* Intermediary Exhibit I-3.
[23] Intermediary Exhibit I-6.
[24] Intermediary Exhibits I-6 and I-9.
[25] Intermediary Exhibit I-8.

By letter dated December 20, 2001, the Provider stated that it disagreed with the Intermediary's plan to recoup the projected overpayment through adjustment of its FY 2000 and FY 2001 cost reports. The Provider explained that the Board was not the proper forum for appealing denied claims, and that, as a result, the Provider was resubmitting the claims for reprocessing in order to actively pursue and preserve its appeal rights. The Provider's intent was for the claims to be individually denied (or approved), so that it could then individually appeal the claims before an ALJ. Accordingly, it submitted a list of the claims it desired to pursue and appeal.[26]

By letter dated January 23, 2002, the Intermediary denied the Provider's request and, in support of this denial, quoted MIM 13-3 § 3940.1(C) as follows:

> Medical review is to coordinate activities with Audit/Reimbursement so that they may determine the overpayment to be recovered based on Medical Review's findings and pursue the recovery of the overpayment. In addition, to preserve the integrity of Provider Statistical and Reimbursement Report (PS&R) data relative to the paid claims and shared systems data relative to denied claims, and to ensure proper settlement of costs on provider cost reports, the same date must be used when the projection is made as was used when the sample was selected. **Individual claims will not be adjusted.**[27]

In addition, the Intermediary noted that MIM 13-3 § 3940.4(C) further specifies: "Do not adjust the 'individual claims' since the overpayment will be handled as a lump sum adjustment."[28]

In a letter dated April 4, 2002, the Provider rebutted the Intermediary's argument and noted that, while an overpayment may be placed on the cost report, the Provider was never afforded the right to appeal the results of the CMR before an ALJ as required in MIM 13-3 § 3940.10.[29] The Provider then asked the Intermediary to reopen the cost report, remove the overpayment, issue a revised NPR, and respond to the Provider's December 20, 2001 request to individually deny or accept each submitted claim with instruction regarding any appeal rights.[30]

On June 7, 2002, the Intermediary responded to the Provider and agreed that MIM 13-3 § 3940.10 does allow certain appeal rights to an ALJ. The Intermediary stated that it was awaiting guidance from CMS on how to address the Provider's appeal rights issue as the Intermediary maintained that the available written guidance did not address the handling of all claims within the claims universe. The Intermediary further stated that it was pursuing approval from CMS to cancel all claims in the universe to allow the Provider to resubmit them for

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[26] Intermediary Exhibit I-11.
[27] Provider's Final Position Paper, Exhibit P-3 (quoting MIM 13-3 § 3940.11 (emphasis in quote)).
[28] *Id.* (quoting MIM 13-3 § 3940.4(C)).
[29] Provider's Final Position Paper, Exhibit P-5.
[30] *Id.* at 3.

reprocessing and denial so that the Provider could then have an opportunity to pursue its appeal rights for each claim in the universe.[31]

Several months later, on September 12, 2003, due to inaction by the Intermediary, the Provider again requested the Intermediary to issue denials on individual claims so that they may be further appealed to an ALJ. The Provider noted that, approximately 6 months earlier, it had contacted the Program Integrity Branch of CMS and CMS had instructed the Intermediary to reprocess the 93 claims in the sample that had not been reprocessed following the CMR.[32] However, the Intermediary responded that the claims determinations did not qualify for reconsideration.[33]

The Provider was ultimately able to obtain an appeal before an ALJ of 20 claims, which resulted in a reversal of the Intermediary's denials in approximately 25 percent of the 20 claims.[34]

The Provider was represented by Katherine Karker-Jennings, Esq., of the Law Offices of Katherine Karker-Jennings, P.A. The Intermediary was represented by Bernard M. Talbert, Esq., of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider contends that the CMR was not conducted as required by the instructions at MIM 13-3 § 3940.7 that were in effect at that time, and the Provider was never properly notified in writing of its appeal rights nor afforded actual access to them. According to the Provider, the Intermediary should have notified the Provider of the results of the CMR utilizing a "form letter" similar to that contained in the CMS instructions located in MIM 13-3 § 3940.12. Such a notification letter would have explained the Provider's appeal rights and included the name and address of the entity assigned to the next level of appeal. The Provider states that the Intermediary does not dispute that a proper notification letter was never sent.[35] The Provider claims that "[t]he Intermediary forced the Provider to bring a coverage issue to the wrong forum."[36]

The Provider challenges the statistical sampling technique used in the CMR, stating that there is no evidence that the overpayment is based on a proper extrapolation or that a qualified statistician approved the proposed statistical sampling method used in the CMR as required by MIM 13-3 § 3940(F).[37] The Provider also asserts the Intermediary did not properly follow its own sampling methodology guidelines in that it did not utilize the lower bound of the 90 percent confidence interval to determine the total amount of the extrapolated overpayment to be recovered.[38] Instead, the Intermediary disallowed all claims other than the 7 that it found to be

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[31] Provider's Final Position Paper, Exhibit P-8.
[32] Provider Exhibit P-9.
[33] Provider's Final Position Paper, Exhibit P-10.
[34] *See* Transcript ("Tr.") at 13-14, 82-84.
[35] Provider's Post Hearing Brief at 9.
[36] Tr. at 14.
[37] *See* Provider's Post Hearing Brief at 2, 9; Tr. at 9-10.
[38] Tr. at 47-50. *See also* Intermediary Exhibit I-7 at 3.

correct.[39] The Provider claims that the Board has jurisdiction over the audit adjustment on the FY 2000 cost report which resulted from the CMR, and it asks the Board to reverse the audit adjustment.[40] The Provider adds that it was eventually able to appeal "20 of the medical necessity cases and secured a reversal rate of approximately 25 percent";[41] however, it has never received credit for these reversed cases. Specifically, the reduction in the overpayment amount for the 100 claim sample was never extrapolated to the universe of claims to determine how much the initial extrapolated overpayment amount was reduced.

The Intermediary's position is that the Board may only provide limited relief in this case. The Intermediary does not dispute that a proper notification letter regarding the CMR findings was never sent; however, it contends that the Board lacks a basis for directing or facilitating a claims review in a different forum. The Intermediary also concedes that a confidence level extrapolation was not used and the overpayment adjustment should be reduced;[42] however, it claims that there was an "extensive background on the methodology used."[43] The Intermediary acknowledges the Provider's efforts in obtaining appeals before an ALJ on 20 of the denied claims; however, the Intermediary's position is that these results should not be deemed as favorable to the Provider.[44]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

JURISDICTION

The Board, after consideration of the Medicare laws and guidelines, the parties' contentions, and evidence presented, finds and concludes that it has jurisdiction over this appeal. The CMR resulted in an overpayment adjustment which was included on the NPR for the FY 2000 cost report. The Provider has demonstrated its dissatisfaction with the overpayment adjustment (*i.e.*, "final determination" of the intermediary), and has met the timely filing and "amount in controversy" prongs of the Board's jurisdictional requirements.[45] Although the issue in this appeal initially involved claims review, it is now a cost report reimbursement issue properly before the Board as explained below.

MIM 13-3 § 3940.8 specifies that "[t]he provider may challenge the claim determinations and sampling methodology in the administrative process." The Board recognizes that MIM 13-3 § 3950.11 explains that "[a]s a general matter, the individual claims determination, sampling methodology and the amount over/under payment extrapolation related to the CMR should not be appealed to the PRRB." Rather, the Provider is required to follow the administrative and judicial review processes which exist for the appeal of individual claims, including CMR results, as delineated in 42 C.F.R. Part 405, Subpart G, for Part B claims during the time at issue. In this

[39] Intermediary Exhibit I-4.
[40] Provider's Post Hearing Brief at 11.
[41] Tr. at 10-14, 74-77.
[42] Tr. at 77.
[43] Intermediary's Post Hearing Summary at 4.
[44] *See* Intermediary's Post Hearing Summary at 5.
[45] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-405.1839.

regard, the Board recognizes that it does not have jurisdiction to review the medical necessity of individual claims for service.[46]

However, pursuant to 42 C.F.R. Part R, the Board does have jurisdiction over the methodology used to determine provider costs which are reflected on an NPR. In this appeal, the overpayment which resulted from the CMR was placed on the cost report, and the Provider was not properly given notice of its administrative appeal rights under 42 C.F.R. Part 405, Subpart G, regarding the CMR claims determinations and the extrapolation of those determinations to the defined universe of claims. The Board concludes that, while it does not have jurisdiction to review the medical necessity findings of the CMR on individual claims, it does have jurisdiction over the adjustment in this appeal as it relates to the extrapolation of those CMR findings to other claims not reviewed for medical necessity, because the Provider was not notified nor afforded appeal rights to challenge and obtain review of this overpayment extrapolation. As a result, the Board finds that adjustment for the extrapolated overpayment amount on the NPR at issue is the final determination on this issue and the Provider's appeal rights on this issue flow from that NPR.

EXTRAPOLATED OVERPAYMENT ADJUSTMENT RESULTING FROM CMR

The Board finds that the sampling methodology the Intermediary used to determine the extrapolated overpayment was fatally flawed, and contained several fatal errors. First, the Intermediary did not consult with a statistical expert when developing the sampling methodology used in this case. MIM 13-3 § 3950(F) requires the Intermediary to consult with a statistical expert to review and approve *in writing* the proposed statistical sampling method to be used:

> F. Consultation With a Statistical Expert.--Before undertaking a CMR that uses statistical sampling methods, *you must consult with a statistician* or other person with expertise in statistical sampling and extrapolation methods *to review and approve proposed statistical sampling methods to be used in the CMR. The statistician must submit to you a* ***written approval*** *of the methodology for the type of study to be performed.* At a minimum, the individual consulted should possess a master's degree in statistics or equivalent in experience with statistical sampling methods at the level of Cochran's well-known textbook, or those of Kish or Deming. If you do not have staff who have previously conducted statistical studies, you must obtain expert assistance prior to conducting a CMR that uses statistical sampling methods.[47]

Significantly, a consideration in developing a sampling method is the planned level of precision which necessarily affects the bounds for the standard 90 percent confidence interval (*i.e.*, the lower the level of precision, the wider the bound of a 90 percent confidence interval). However,

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[46] *See* 42 C.F.R. § 405.1840(b)(1).
[47] (Emphasis added.)

the record does not contain the required written approval from the statistician nor any other evidence that the Intermediary consulted with a statistical expert.

Second, the record reflects that the Intermediary did not determine the CMR sample size consistent with guidance in MIM 13-3. Specifically, MIM 13-3 3940.3(C) provides the following guidance on the determining the sample size and using strata:

> C. Determining Sample Size.—For simple random sampling, the recommended minimum sample size is 100 sampling units. Use of larger sample sizes usually has the advantage of yielding estimates with better estimated precision. *Better precision results in a larger lower bound for the confidence interval of the estimate.* Experience will determine the necessity for larger sample sizes.
>
> For stratified random sampling, the recommended minimum sample size is 100 sampling units with a minimum of 30 sampling units per stratum. If fewer than 30 are present, then all units are used. There are various methods for allocating sample items among the strata including proportional allocation and optimal allocation. The sample sizes for the strata do not have to be identical or multiples of each other.
>
> For multistage sampling, at least 8 primary sample units must be selected with a sample of at least 30 transactions for each primary sample unit.
>
> Variances and coefficients of variation (CVs) needed to guide more refined estimates of sample size may be drawn from experience such as:
>
> 1. Previous overpayment samples (e.g., sample reviewed to confirm existence of a problem); or
>
> 2. Prepayment reviews resulting in payment denials. These can be used to determine the potential correct payment amount and the CV of the potential overpayment.[48]

The record reflects that, without consulting a statistical expert, the Intermediary merely selected the minimum number of 100 claims that the MIM 13-3 guidance requires for a sample, and then stratified the sample into four groups or strata based on the claim reimbursement amount resulting in 4 strata consisting of 10, 30, 30, and 30 claims.[49] Specifically, the Intermediary's

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[48] (Emphasis added.)

[49] Intermediary Exhibit I-7 at 2.

documentation of its sampling methodology includes the following discussion on its selection of the sample size:

> Based on the above HCFA guidelines, ideally, *if the sampling error is within the acceptable level*, the minimum sample size would be achieved by stratifying the universe into four strata, with one stratum consisting of 10 claims with the highest reimbursement amounts and being sampled at 100%, and the other three strata with random sample of 30 claims each. This procedure was followed in this case, which resulted in a total sample size of 100.[50]

Significantly, within this discussion, the Intermediary recognizes that "sampling error" would affect the precision of the planned sampling methodology. Despite that recognition, plus the use of a complex stratified sampling methodology, the Board could not find any discussion in the record where the issue of the sampling error was reviewed and resolved. As a result, the Board concludes that it is unclear whether the sampling methodology used for this case had an acceptable level of sampling error. There was no review and approval by a statistical expert and there is no discussion of the sampling error notwithstanding the Intermediary's recognition of it as a relevant factor.

Further, the Board notes that the Intermediary could have utilized the RAT-STATS program to develop a sampling methodology by entering all of the claims data into RAT-STATS and using RAT-STATS to set confidence intervals and sample size, set strata, and properly select a random sample based on the strata.[51] For whatever reason, this was not done.[52]

Indeed, the *only* reference to the Intermediary's actual use of RAT-STATS was the use of that program to generate random numbers for selecting samples items from the strata.[53] However, simply using RAT-STATS to generate random numbers to select the 30-claim samples for the 3 strata being sampled does not mean that the sampling methodology was valid (*e.g.*, had an acceptable level of sampling error). Selecting a random sample is only one component of establishing a statistically-valid sampling methodology. The Intermediary's limited use of RAT-STATS in this case illustrates why the MIM 13-3 requirement of written approval by a statistical expert is a critical part of developing and implementing a proper sampling methodology.

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[50] *Id.* at 1 (emphasis added.)

[51] *See* MIM 13-3 § 3940.3(B). *See also* Program Integrity Manual, CMS Pub. 83, Exhibit 7, § 7.4.1 (as amended Rev. 17, Dec. 12, 2001).

[52] Intermediary Exhibit I-7 at 2. The Board recognizes that the Intermediary stated it had planned to use RAT-STATS Variable Appraisal Program to make certain sampling variability calculations including the 90 percent confidence interval. *Id* at 3. However, there is no evidence in the record that the Intermediary ever used RAT-STATS to make these calculations. Presumably, once the Intermediary decided to disallow all claims in the defined universe of claims (other than the 7 claims in the sample found to be correct) rather than extrapolating the results from the 100 claim sample onto the defined universe of claims, the Intermediary concluded that doing these calculations would be irrelevant. *See* Intermediary Exhibit I-4; Intermediary Exhibit I-6 at 1.

[53] *See* Intermediary Exhibit I-7 at 2.

Additionally, the Board finds that the Intermediary failed to properly extrapolate to the universe of claims. It is clearly erroneous to conclude that, based on the results of a 100 claim sample, there is absolute certainty that all claims in the universe should be denied except for the 7 in the sample that were reviewed and found to be without flaw (*i.e.*, payment was proper).[54] The Board notes that the Intermediary acknowledged that the extrapolation was incorrect and proposed to change the final disallowance – presumably under the assumption that the Board will remand the case back to the Intermediary.[55] Given the errors in both the extrapolation of the sample results and the underlying sampling methodology, the Board finds that the Intermediary's extrapolation of the CMR audit results from the 100 claim sample to the defined universe of claims was improper and fatally flawed. Accordingly, the FY 2000 adjustment must be reduced to the overpayment based on the seven claims sampled which pertain to that cost reporting period and which the Intermediary found to be valid and an ALJ did not reverse.[56]

Finally, as the Board has rejected the Intermediary's extrapolation method, the Board must review the Intermediary's method to apportion the overpayment between the two cost reporting periods – FYs 2000 and 2001. Specifically, as all claims in the defined universe of claims (except for the 7 claims from the sample determined to be correct) were denied and assessed as overpayments, the Intermediary simply apportioned the overpayment between the relevant cost reporting periods based on how the claims were distributed between these fiscal years. As explained below, the Board finds that this simple apportionment method is contrary to the MIM 13-3 guidance and any remedial action to correct it could have an adverse material effect on the sampling methodology.

The CMR instructions clearly state that "all claims reviewed must be drawn from within a provider's defined cost reporting year."[57] In this instance, contrary to these instructions, the Intermediary defined a universe of claims subject to review that straddled two of the Provider's defined cost reporting periods – FYs 2000 and 2001. Notwithstanding, the Intermediary did not stratify the universe so that one stratum was for FY 2000 and the other for FY 2001 (which would, in essence, create two separate mini universes of claims – one for FY 2000 and one for FY 2001). Instead, the Intermediary created 4 strata that appear to straddle both cost reporting periods. Remedial action to correct this error would result in breaking out each of these strata into 2 (*i.e.*, one for each fiscal year) resulting in 8 strata in total (*i.e.*, 4 strata for each fiscal year). However, taking this remedial action would mean that each stratum would have less than the minimum recommended claim sample size of 30 as specified in MIM 13-3 § 3940.3(C) and, as such, could adversely affect the statistical validity of the sample methodology. The Board finds

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[54] The Board notes that impact of not using a proper extrapolation is further complicated by the Intermediary's use of a stratified sample spanning 4 strata. In this regard, the Board also notes that it is unclear from the record whether the 7 correct claims were evenly distributed across all 4 strata or whether the 7 claims did not appear in one or more of the 4 strata. Moreover, it is unclear whether any or all of these 7 claims pertain to the FY 2000 adjustment that is at issue in this case (as opposed to the FY 2001 adjustment).

[55] Tr. at 74-77.

[56] The Board again notes that only FY 2000 cost reporting period is under review and that the Board's findings in this decision have no effect on the FY 2001 cost reporting period.

[57] MIM 13-3 § 3940.2(A).

that this further confirms that the methodology the Intermediary used to determine the extrapolated overpayment was fatally flawed.

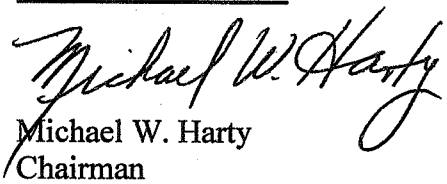
DECISION AND ORDER:

The Board finds it has jurisdiction over the overpayment placed on the FY 2000 cost report which resulted from the Intermediary disallowing therapy service claims pursuant to a comprehensive medical review. The Board also finds that the Intermediary's extrapolation of the CMR audit results from the 100 claim sample to the defined universe of claims was improper and fatally flawed. Accordingly, the extrapolation is reversed. The amount of the overpayment adjustment on the FY 2000 cost report shall be reduced to that portion of the overpayment that the Intermediary assessed on the 100 claims sampled which pertain to claims for FY 2000 and to overpayment assessments on claims that were not subsequently reversed by an Administrative Law Judge.

BOARD MEMBERS PARTICIPATING:

Michael C. Harty, Chairman
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: JUL 31 2013