PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2015-D26

PROVIDER –
The Phoenix Clinic
North Miami, Florida

Provider No.: 10-4993

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Service

DATE OF HEARING -
December 3, 2013

Cost Reporting Period Ended -
March 31, 2009

CASE NO.: 11-0160

INDEX

ISSUES:

ISSUE 1 – Whether a community mental health center ("CMHC") is a "provider of services" entitled to a hearing before the Provider Reimbursement Review Board ("the Board") under 42 U.S.C. § 1395oo.

ISSUE 2 – If a CMHC is a "provider of services," does this finding necessarily implicate other documentation obligations and requirements as a "provider of services"?

DECISION

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board makes the following findings on the two issues:

ISSUE 1 – The Board finds that a CMHC is a "provider of services" entitled to a hearing before the Board under 42 U.S.C. § 1395oo.

ISSUE 2 – The Board reviewed and considered the documentation obligations and requirements of the Medicare program (including but not limited to those specified in 42 C.F.R. §§ 413.20 and 413.24) and finds that there are no Medicare documentation obligations or requirements that can be applied to support the Medicare Contractor's decision to adopt the following recommendations of the PSC: (a) globally disallow the costs claimed by the Phoenix Clinic on its fiscal year ("FY") 2009 cost report, including any bad debts that the Medicare Contractor had already audited and determined were allowable; and (b) recoup all of the Medicare payments made to the Phoenix Clinic during FY 2009 under the hospital outpatient prospective payment system ("OPPS"). Accordingly, the Board reaffirms its prior decision and order published as PRRB Decision No. 2013-D4.

INTRODUCTION:

The Phoenix Clinic ("Provider") is a CMHC located in North Miami, Florida and, during its FY 2009, it received Medicare payment for partial hospitalization services under OPPS. During this time period, the designated Medicare contractor[1] for the Phoenix Clinic was Wisconsin Physicians Service ("Medicare Contractor").

The Medicare Contractor made adjustments to the Phoenix Clinic's FY 2009 cost report that resulted in a recovery of more than $7,000,000. The Phoenix Clinic appealed those adjustments to the Board. Following a hearing, the Board issued its first decision on January 31, 2013; however, the CMS Acting Administrator vacated the Board's decision and remanded the case to the Board for further proceedings to decide the two above issues.[2]

Pursuant to the remand, the Board held a hearing on December 3, 2013. The Phoenix Clinic was represented by Christopher A. Parrella, Esq. of the Health Law Offices of Anthony C. Vitale,

[1] The term "Medicare Contractor" refers to fiscal intermediaries or Medicare administrative contractors as relevant.
[2] *See Phoenix Clinic v. Wisconsin Phys. Servs.*, PRRB Dec. No. 2013-D04, (Jan. 31, 2013), *vacated*, Admin'r Dec. (Mar. 20, 2013).

P.A. The Medicare Contractor was represented by Robin Sanders, Esq. of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS

During FY 2009, the Phoenix Clinic received over $7 million in Medicare reimbursement under OPPS for partial hospitalization services provided to Medicare beneficiaries. As part of its cost report for FY 2009, the Phoenix Clinic claimed approximately $7 million in costs for Medicare-related services and the $7 million claimed costs included approximately $1.7 million in bad debt reimbursement.[3]

The Medicare Contractor audited the Phoenix Clinic's FY 2009 cost report and described it as a "less than full scope audit."[4] During this audit, the Medicare Contractor used statistical sampling to review the $1.7 million claimed by the Phoenix Clinic as bad debts. Based on this review, the Medicare Contractor disallowed approximately 75 percent of those bad debts.[5]

Integriguard LLC is a Program Safeguard Contractor ("PSC") contracted by CMS to provide benefit integrity functions. Subsequent to the Medicare Contractor's audit but prior to the issuance of an NPR, the PSC performed a separate on-site audit of the Phoenix Clinic's FY 2009 cost report. As part of this audit, the PSC requested certain documentation to support the costs claimed on the FY 2009 cost report.[6] The PSC determined that the Phoenix Clinic failed to submit sufficient documentation to support its costs claimed for FY 2009. As a result, the PSC recommended to the Medicare Contractor that the Medicare Contractor globally remove all costs from the FY 2009 cost report (including the remaining bad debts) and to disallow and recoup all of the OPPS reimbursement made to the Phoenix Clinic during FY 2009.[7]

The Medicare Contractor issued a Notice of Program Reimbursement for FY 2009 assessing an overpayment of over $7 million representing the full amount paid to the Phoenix Clinic by the Medicare program for all OPPS clinical services and all bad debts. The Phoenix Clinic objected to this recoupment and filed an appeal with the Board. In filing the appeal, the Phoenix Clinic maintained that the partial hospitalization services that it had furnished to Medicare beneficiaries during FY 2009 had been reimbursed under OPPS and, as a result, any lack of documentation needed to verify the cost of these services was irrelevant to the prospective payments made under OPPS.[8]

The Board held the first hearing on this appeal on November 8, 2011. The Board overturned the Medicare Contractor's global adjustments and the recoupment of the OPPS reimbursement based

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[3] *See* Provider's cost report Worksheet D.
[4] *See* Medicare Contractor Workpapers attached to the Medicare Contractor's Post-Hearing Brief for the Original Hearing.
[5] *See id.* (Medicare Contractor workpapers that include the list of bad debts sampled, an email dated Aug. 27, 2010 notifying the Provider of the bad debt audit results, an Audit Adjustment Report dated Nov. 10, 2010 showing the approximately 25 percent bad debts allowed as a result of the audit, and bad debt audit workpapers including the testing results summary).
[6] *See* Medicare Contractor Position Paper for the Original Hearing, Exhibits I-2, I-3.
[7] Medicare Contractor's Post-Hearing Brief on Remand at 2; Stipulations dated Nov. 25, 2013 at ¶1-3.
[8] Provider's Brief on Remand at 2.

on its finding that these adjustments were not authorized by Medicare statute or regulation.[9] The Board also rejected the Medicare Contractor's disallowance of approximately 25 percent of the bad debts claimed on the cost report based on its findings that: (1) prior to the PSC's audit of the cost report, the Medicare Contractor had audited the bad debt reimbursement claimed for FY 2009 and determined that approximately 25 percent of that bad debt reimbursement was allowable; and (2) the PSC had no basis to recommend disallowance of the remaining 25 percent bad debts because the PSC did not audit (much less request documentation on) the bad debt reimbursement claimed for FY 2009.

The CMS Acting Administrator reviewed the Board's decision on her own motion, vacated the Board's decision, and remanded it back to the Board for further proceedings. In her remand, the Acting Administrator directed the Board to address whether the Phoenix Clinic was a "provider of services" for the purposes of a hearing before the Board under 42 U.S.C. § 1395oo and corresponding regulations governing Board hearings at 42 CFR § 405.1801, *et seq.*, and, if it is, whether this finding necessarily implicates other documentation obligations and requirements as a provider of services.[10]

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

ISSUE 1: PROVIDER OF SERVICES ISSUE

The Parties stipulated that the Phoenix Clinic was a "provider of services" sufficient to satisfy the statutory and regulatory requirements for a hearing.[11] With respect to the question of whether a CMHC is a "provider of services," the Board concurs with the stipulation of the parties and specifically finds that the Phoenix Clinic is a "provider of services" for purposes of a hearing before the Board under 42 U.S.C. § 1395oo(a).

At the outset, the Board notes that 42 U.S.C. § 1395oo does not define the term "provider of services."[12] As a result, the Board reviewed other statutory provisions governing the Medicare program to see where the term "provider of services" is defined. The Board located two different definitions of that term that are relevant, one at 42 U.S.C. § 1395x(u) and the other at 42 U.S.C. § 1395cc. Many Medicare terms are defined in 42 U.S.C. § 1395x and subsection (u) defines the term "providers of services" without including CMHCs as part of that term.[13] However, 42 U.S.C. § 1395cc addresses the enrollment of "[a]ny provider of services" to "be qualified to participate" in the Medicare program and to "be eligible for payments" under the Medicare program "if it files with the Secretary an agreement [*i.e.*, a participation agreement]." Significantly, § 1395cc(e) defines the term "providers of services" to include CMHCs with respect to the provision of partial hospitalization services.[14]

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[9] Medicare Contractor's Corrected Final Position Paper on Remand, Exhibit I-1 at 11.
[10] *Id.*, Exhibit I-2 at 9.
[11] Stipulations dated Nov. 25, 2013 at ¶8.
[12] The only provision in 42 U.S.C. § 1395oo that addresses the term "provider of services" is located in subsection (j) and this sub section only specifies that , "[i]n this section, the term 'provider of services' includes a rural health clinic and a Federally qualified health center."
[13] 42 U.S.C. § 1395x(u) defines the term "provider of services" as "a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1395f (g) and section 1395n(e), a fund."
[14] 42 U.S.C. § 1395cc(e) states:

The regulations implementing the Medicare statute reflect the expansive definition of "provider of services" contained in 42 U.S.C. § 1395cc(e). First, similar to 42 U.S.C. § 1395x, the Medicare regulations define many Medicare terms in 42 C.F.R. § 405.202 which is entitled "Definitions specific to Medicare." This section mirrors 42 U.S.C. § 1395cc(e) and defines the term "provider" to include CMHCs with respect to the provision of partial hospitalization services. Similarly, the regulations governing provider appeals of individual claims in effect during FY 2009 defined the term "provider" to include CMHCs with respect to the provision of partial hospitalization services.[15]

More importantly, the Board analysis of the Medicare regulations governing Board hearings located at 42 C.F.R. Part 405, Subpart R demonstrate that the term "provider" as used therein includes CMHCs and are entitled to Board review of cost report determinations. Specifically, 42 C.F.R. § 405.1801(b)(1) (2009) addresses the scope of Board appeal rights for "providers" as follows:

> (1) Providers. In order to be paid for covered services furnished to Medicare beneficiaries, a provider must file a cost report with its intermediary as specified in § 413.24(f) of this chapter. *For purposes of this subpart, the term ''provider'' includes* a hospital (as described in part 482 of this chapter), hospice program (as described in § 418.3 of this chapter), critical access hospital (CAH), comprehensive outpatient rehabilitation facility (CORF), renal dialysis facility, Federally qualified health center (FQHC), home health agency (HHA), rural health clinic (RHC), skilled nursing facility (SNF), and *any other entity included under the Act*. (FQHCs and RHCs are providers, for purposes of this subpart, effective with cost reporting periods beginning on or after October 1, 1991).[16]

This regulation states that the term "provider" is one that "must file a cost report . . . as specified in § 413.24(f)" in order to be paid for covered services and includes "any other entity included under the Act." When this meaning was adopted, CMS explained that: "Our proposed revision to § 405.1801(b)(1) would also recognize as a provider any other entity treated as a provider under the Act, in order to ensure recognition in subpart R of any other entity that may qualify as

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> For purposes of this section, the term ''provider of services'' shall include—
> (1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title . . ., or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title . . ., but only with respect to the furnishing of outpatient physical therapy services . . ., . . . with respect to the furnishing of outpatient occupational therapy services, or . . . with respect to the furnishing of outpatient speech-language pathology; and
> (2) *a community mental health center* (as defined in section 1395x(ff)(3)(B) of this title), but only with respect to the furnishing of partial hospitalization services (as described in section 1395x(ff)(1) of this title).

(Emphasis added.)

[15] *See* 42 C.F.R. § 405.900 (2009).

[16] (Underline emphasis in original and italics added.)

a provider under the act for purposes of provider reimbursement appeals."[17] To confirm that CMHCs with respect to partial hospitalization services are "a provider under the act for purposes of provider reimbursement appeals," the Bo ard reviewed the 42 C.F.R. § 413.24(f) and confirmed that the Secretary included CMHCs in the definition of "providers" who are required to file cost reports in an electronic format.[18] Based on the preamble discussion and the cross-reference to this section in 42 C.F.R. § 405.1801(b), the Board concludes that CMHCs are included within the phrase "*any other entity included under the Act*" and are entitled to a hearing before the Board in connection with their cost reports. This conclusion is supported by the fact that the Secretary did not include CMHCs in the definition of "nonprovider entities" located at § 405.1801(b)(2) for which Board hearings are not available for appeal notwithstanding the fact that "[s]ome of these nonprovider entities are required to file periodic cost reports and are paid on the basis of information furnished in these reports."[19]

In summary, the Board concludes that, inasmuch as a CMHC is specifically identified as a "provider of services" for purposes of participation in the Medicare program, is specifically identified for purposes of electronic cost report filing, and is not excluded as a nonprovider entity, the Phoenix Clinic is entitled to a hearing before the Board under 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840. Indeed, consistent with these rights, the Medicare Contractor notified the Phoenix Clinic of its entitlement to a hearing before the Board in the NPR issued for FY 2009 and the Phoenix Clinic relied on that notification by filing an appeal with the Board.[20]

Issue 2: Documentation obligations and requirements as a Provider of Services

The Medicare Contractor contends that as a "provider of services" CMHCs must file and submit "adequate documentation" like any provider of services. The Medicare statutes give the Secretary broad discretion as to what information a provider must produce as a condition of payment under the Medicare program. 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.[21] In particular, 42 C.F.R. § 413.24(c) requires that "data be accurate and in sufficient detail to accomplish the purposes for which it is intended."[22] Similarly, CMS' Provider Reimbursement Manual 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."[23] In cases where a provider fails to meet these recordkeeping requirements, the Medicare Contractor may suspend payments to the provider until the intermediary is assured that adequate records are maintained.[24] Therefore,

[17] 73 Fed. Reg. 30190, 30194 (May 23, 2008).
[18] 42 C.F.R. 413.24(f)((4)(i). All citations to the C.F.R. are from the October 1, 2009 edition unless otherwise specified.
[19] Section 405.1801(b)(2) specifically identifies health maintenance organizations and competitive medical plans as examples of "nonprovider entities" for which Board hearings are not available for appeal.
[20] *See* Provider's Request for PRRB Hearing dated Dec. 15, 2010, Exhibit 1 (copy of NPR dated Nov. 15, 2010).
[21] *See, e.g.*, 42 C.F.R. §§ 413.20, 413.24.
[22] 42 C.F.R. §413.24(c).
[23] CMS Pub.15-1("PRM 15-1") §2304.
[24] 42 C.F.R. § 413.20(e).

the Medicare Contractor's requests for documentation were fully justified given the law, regulations, and program policy. [25]

The Medicare Contractor further contends that the record includes the PSC audit work papers and correspondence between the Phoenix Clinic and the PSC and that these documents make clear that the Phoenix Clinic failed to produce information and other documentation to support numerous expense categories as requested by the PSC. The Medicare Contractor maintains that the regulatory recordkeeping and documentation obligations stated in 42 C.F.R. §§ 413.20 and 413.24 required the Phoenix Clinic to produce this information when requested by the PSC. Therefore, the Medicare Contactor argues that it appropriately adjusted the cost report and that the Board should affirm this decision.[26]

The Board rejects the Medicare Contractor's position. The Board does not dispute these recordkeeping requirements. However, the Board disagrees with the Medicare Contractors' application of these regulations to support the global denial of all costs and all payments. As explained below, the Board's rejection of the Medicare Contractor's position is based in large part on the fact that, in connection with partial hospitalization services, the Phoenix Clinic participates in the Medicare program as a CMHC and receives reimbursement for these services under OPPS.

In § 4523(a) of the Balanced Budget Act of 1997 ("BBA"), Congress established the prospective payment system for certain hospital outpatient services by adding a new subsection (t) to 42 U.S.C. § 1395l.[27] The OPPS rates are determined in accordance with the methodology described in 42 C.F.R. Part 419, Subpart C. As part of the conforming amendments in BBA § 4523(d), Congress specified that Medicare-covered partial hospitalization services furnished by CMHCs would be paid under OPPS.[28] Under OPPS, these services are paid on a per diem basis equal to the national median cost of providing partial hospitalization services[29] rather than being paid based on the provider's reasonable costs.

The Board reviewed the regulations applicable to OPPS located in 42 C.F.R. Part 419 to determine documentation and recordkeeping requirements imposed on hospitals and CMHCs. In short, 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 document their reasonable cost *as a condition* of receiving payment under OPPS. Moreover, Part 419 does not contain any regulations allowing CMS to either withhold or recoup OPPS payments for any failure to provide cost information requested by either the Medicare Contractor or the PSC in this case.[30]

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[25] Medicare Contractor's Corrected Final Position Paper on Remand at 7.
[26] Medicare Contractor's Post-Hearing Brief on Remand at 3-4.
[27] BBA, Pub. L. No. 105-33, § 4523(a), 111 Stat. 251, 445-449 (1997).
[28] *See also* 65 Fed. Reg. 18434, 18437, 18444 (Apr. 7, 2000); 42 C.F.R. § 419.21(c).
[29] 65 Fed. Reg. at 18453.
[30] 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 under OPPS is "the final Medicare payment amount" and, accordingly, is not subject to settlement. Further, the PSC

CMHCs are required to file cost reports even though they are paid based on the OPPS because they receive certain reimbursement on a reasonable cost basis (*e.g.*, bad debts). In addition CMS uses aggregate cost report data from all providers to periodically review OPPS rates. For this reason the Medicare Contractor may rely on the Part 413 recordkeeping requirements located in 42 C.F.R. §§ 413.20 and 413.24. The Phoenix Clinic is in agreement with this conclusion.[31] However, the Board disagrees with the Medicare Contractor's application of these regulations to support its *total* cost disallowance and retroactive recovery of all Medicare OPPS payments. 42 C.F.R. §§ 413.20 and 413.24 are applicable to CMHCs in connection with establishing a provider's reasonable cost and establishing the amount of any Medicare payments that are to be made using the principles of reasonable cost reimbursement (*e.g.*, the bad debts at issue). However, based on the PSC's recommendation, the Medicare Contractor globally removed all costs and all bad debt reimbursement —even those costs and bad debts which had been sufficiently documented as allowable.[32] The Board finds no statutory or regulatory guidance to support this action.

In addition, the Medicare Contractor followed the PSC's recommendation and disallowed all the OPPS payments that were made to the Phoenix Clinic for FY 2009. Again the Board finds no statutory or regulatory basis in 42 C.F.R. §§ 413.20 and 413.24 to support the disallowance of the OPPS payments, as these regulations pertain to reasonable cost reimbursement and do not pertain to the individual claim payments made under OPPS. In this regard, the Board notes that the regulations at 42 C.F.R. Part 405, Subpart I (2009) govern the reopening and audit of individual OPPS claims. However, neither the Medicare Contractor nor the PSC reopened the initial claim determinations on the OPPS claims at issue in accordance with 42 C.F.R. § 905.980 to avail itself of potential recovery options related to the OPPS payment.[33] Accordingly, the original payment determination on the OPPS claims at issue remains in effect.

Finally, 42 C.F.R § 413.20(e) prescribes the specific remedy in cases where a provider fails to maintain adequate records for determining "reasonable cost," and the Medicare Contractor failed to follow the prescribed remedy. Specifically 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

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review was confined to cost and did not reopen the initial claim determinations under 42 C.F.R. § 405.980 to review medical records or the medical necessity or Medicare coverage of the underlying services. 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.

[31] Provider's Brief on Remand at 4.

[32] Both prior to and following the remand, the Board has repeatedly requested that the Medicare Contractor produce the PSC workpapers in order to determine the specific adjustments made based on the documentation submitted. *See, e.g.*, Tr. at 49-50 (Hearing on Remand). Contrary to the Medicare Contractor's assertion in its post hearing brief on remand PP. 3-4, the Medicare Contractor failed to provide the PSCs' workpapers to the Board. The Board finds that the Medicare Contractor violated 42 C.F.R. 405.1853 (a)(3) which requires that it "ensure that the evidence it considered in making its determination, or, where applicable, the Secretary used in making his or her determination, is included in the record."

[33] The regulations at 42 C.F.R. Part 405, Subpart I (2009) govern the reopening and audit of individual OPPS claims.

> providers will be **suspended** until the intermediary is assured that adequate records are maintained.[34]

The language of this provision does not authorize a retroactive recovery of all reimbursement for failure to keep adequate records. Rather, *under this regulation*, the Medicare Contractor's appropriate response should have been the suspension of *future* payments.[35]

The Board notes that it did not identify any other statutory or regulatory provisions to relevant to the Medicare Contractor's action to recoup all OPPS payments made to the Phoenix Clinic. In particular, the Board notes that 2 C.F.R. Part 412, Subpart C which includes certain recordkeeping requirements in 42 C.F.R. § 412.52 and certain remedial actions in 42 C.F.R. § 412.40 for failure to comply with the requirement is not applicable to the Phoenix Clinic because Subpart C only pertains to hospitals receiving payment under IPPS.[36]

In summary, the Board finds that the Medicare Contractor's *global* disallowance of all costs and the retroactive recovery of all Medicare OPPS payments is contrary to Medicare regulations and must be reversed consistent with its Decision and order as noted in PRRB Decision No. 2013-D04.

DECISION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board makes the following findings on the two issues:

ISSUE 1 – The Board finds that a CMHC is a "provider of services" entitled to a hearing before the Board under 42 U.S.C. § 1395oo.

ISSUE 2 – The Board reviewed and considered the documentation obligations and requirements of the Medicare program (including but not limited to those specified in 42 C.F.R. §§ 413.20 and 413.24) and finds that there are no Medicare documentation obligations or requirements that can be applied to support the Medicare Contractor's decision to adopt the following recommendations of the PSC: (a) globally disallow the costs claimed by the Phoenix Clinic on its fiscal year ("FY") 2009 cost report, including any bad debts that the Medicare Contractor had already audited and determined were allowable; and (b) recoup all of the Medicare payments made to the Phoenix Clinic during FY 2009 under the hospital outpatient prospective payment system ("OPPS"). Accordingly, the Board reaffirms its prior decision and order published as PRRB Decision No. 2013-D4.

[34] (Emphasis added.)
[35] *See supra* note 33 and accompanying text.
[36] A more in depth discussion of these regulations and this finding is included in PRRB Dec. No. 2013-D04 at 3-4, 9.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty, Chairman
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 23, 2015