# CENTERS FOR MEDICARE AND MEDICAID SERVICES

## *Order of the Administrator*

| | |
|---|---|
| **In the case of:** | **Claim for:** |
| **The Phoenix Clinic** | **Cost Reporting Period Ending: March 31, 2009** |
| **Provider** | |
| **vs.** | |
| **Wisconsin Physician Services** | **Review of: PRRB Dec. No. 2013-D4** |
| **Intermediary** | **Dated: January 31, 2013** |

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in § 1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. § 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision, including the issue of jurisdiction. No comments were submitted. Accordingly, this case is now before the Administrator for final agency review.

## BACKGROUND

The Phoenix Clinic is a community mental health center (CMHC) located in North Miami, Florida. As part of its financial year (FY) 2009 cost report, the Phoenix Clinic claimed approximately $7,023,000 for Medicare-related services. The Intermediary initiated an in-house audit review of the Phoenix Clinic's FY 2009 cost report in the summer of 2010, as a result of which the Intermediary made adjustments to the Phoenix Clinic's settlement data and bad debts claims. CMS also contracted for the services of a program safeguard contractor (PSC)[1] to conduct a separate audit of the Phoenix Clinic's costs claimed for FY 2009. The PSC's audit was conducted on site. During its review, the PSC requested certain

[1] Program safeguard contractors are special contractors engaged to promote the integrity of the Medicare Program. The specialty contractors bring expertise to "develop cases, conduct data analysis, audit, perform medical review and other tasks to detect and deter fraud, waste, and abuse in the Medicare Program. CMS Medicare Manual, Medicare A/B Reference Manual; Chapter 21—Benefit Integrity and Program Safeguard Contractors. See also "Questionable Billing by Community Medical Health Centers" OIG Aug. 2012 OEI-04-00100 at p. 4 (describing oversight by specialty contractors).

documentation to support the costs reported by the Phoenix Clinic for FY 2009. The PSC gave its audit findings to the Intermediary, and after consultation with the PSC, the Intermediary considered the overall documentation inadequate to support any portion of the costs reported by the Phoenix Clinic. As a result of these audits, the Intermediary made adjustments to remove all costs from the cost report. The Intermediary also identified all amounts paid under the outpatient prospective payment system (OPPS) to the Phoenix Clinic during the period as overpayments and issued a repayment demand letter. The Phoenix Clinic disputed both the nature of, and need for, the documentation sought by the PSC and appealed the Intermediary's determination to the Board.

## ISSUE AND BOARD'S DECISION

The issue, as stated by the Board, was whether the Intermediary properly removed total costs and total payments.

The Board found that the Intermediary's acceptance and implementation of the PSC's audit findings and recommendation to adjust and disallow on a global basis all of the costs claimed on the Phoenix Clinic's FY 2009 cost report, and to recoup any OPPS payment relevant to that time period, was improper. The Board further found 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.

The Board noted that the disallowance issue presented required an examination of the circumstances that generated the global cost disallowance. The Intermediary conducted an in-house "less than full scope audit" of the Phoenix Clinic's FY 2009 cost report where the examination was confined to "outpatient bad debts." In particular, the Intermediary audited the Phoenix Clinic's bad debt log. This audit was concluded in September 2010 and, based on that audit, the Intermediary made adjustments to the settlement data and bad debts.

The Intermediary's PSC also conducted an on-site review of the Phoenix Clinic's FY 2009 cost report, and, as part of this on-site review, the PSC requested that the Phoenix Clinic provide certain documentation to support the costs reported on the FY 2009 cost report. The Phoenix Clinic provided the PSC with some but not all of the requested FY 2009 documentation. The PSC made an audit finding that the Phoenix Clinic had failed to maintain adequate documentation, and recommended to the Intermediary that it 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." 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.

The Board noted that during the hearing, it requested that the Intermediary supply the workpapers that supported the adjustments at issue, including the PSC's workpapers, with their post-hearing submission. The Board stated that it requested this information to determine the basis for the PSC's recommendation that all of the Phoenix Clinic's costs for FY 2009 be disallowed in their entirety. The Board claimed that while the Intermediary did submit to some workpapers, 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 approximately 75 percent of the claimed $1.7 million for bad debts based on the Intermediary's audit of the Phoenix Clinic's bad debt log. The Board averred that 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 Phoenix Clinic's FY 2009 cost report and to recoup all OPPS payment relevant to that time period. Thus, the Board stated that its review of the Intermediary's basis to disallow all costs and recoup all OPPS payments on a global basis for FY 2009 was confined to the assertions made by the Intermediary relative to those actions, and that the Intermediary asserted that adjusting total costs and recouping all OPPS payments for FY 2009 was a proper remedy for the Phoenix Clinic's failure to furnish adequate documentation to support the total costs claimed on the FY 2009 cost report.

The Board stated that, contrary to the Intermediary's assertion 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 42C.F.R. §§ 413.20 and 413.24 as a condition of their participation, the recordkeeping requirements in 42 C.F.R. § 412.52 and CMS' authority in 42 C.F.R. § 412.40(b) to withhold payments for failure to comply with this requirement are not applicable to this case. The Board noted that these regulations are located in Subpart C of 412 and, pursuant to 42 C.F.R. § 412.40, and that Subpart C only pertains to hospitals receiving payment under IPPS. In this case, the Phoenix Clinic it not a hospital, and did not receive payment under IPPS, rather, the Phoenix Clinic is a CMHC and only furnishes certain outpatient services payable under OPPS.

The Board reviewed the regulations applicable to OPPS, located in 42 C.F.R. Part 419, and noted that the there are no regulations that require providers who receive payments under OPPS to meet certain conditions such as recordkeeping requirements, and further does not contain any regulations allowing CMS to withhold or recoup OPPS payments. The Board next reviewed the regulations in 42 C.F.R. Part 413 governing the "principles of reasonable cost reimbursement," noting that Part 413 is applicable to CMHCs as CMHCs still receive certain reimbursement on a reasonable cost basis *(e.g.,* bad debts). The Board stated that it did not dispute the recordkeeping requirements of 42 C.F.R. §§ 413.20 and 413.24, or CMS' authority to interpret these regulations, but that it disagreed with the Intermediary's application of these regulations to support the Intermediary's cost disallowance and found no CMS guidance to support this application.

First, the Board noted, these regulations only pertain to reasonable cost reimbursement and do not pertain to any payments under OPPS. As recognized by the Intermediary during the hearing and pursuant to 42 C.F.R. § 419.41(c)(5), 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, but rather, the Intermediary only considered such OPPS payments in the aggregate as part of the cost report settlement process.

Second, the Board found, 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.

Thus, the Board found, in implementing the PSC's audit findings, the Intermediary did not take the prescribed prospective remedy but rather took a retrospective remedy. The Board noted that, during the PSC's audit, the Phoenix Clinic 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 claimed, prior to the PSC's audit finding and recommendation, the Intermediary also received from the Phoenix Clinic 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.

The Board surmised that despite the Intermediary and PSC's receipt of Phoenix Clinic cost documentation (some of which was acceptable), the Intermediary did not limit its adjustments to the specific costs that were not adequately supported. Rather, the Intermediary made adjustments on a global basis to disallow the total costs claimed by the Phoenix Clinic 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" and determined that there was an "overall lack of adequate documentation to support the costs associated with furnishing services to Medicare beneficiaries." The Board noted that it could not identify any statutory or regulatory authority that permits the Intermediary on a global basis to disallow the FY 2009 total costs claimed by the Phoenix Clinic or recoup all FY 2009 OPPS payments as a result of the Intermediary/PSC's finding that the Phoenix Clinic

"overall" failed to maintain adequate records notwithstanding production of acceptable documentation to support a portion of the costs claimed. Further, the Board claimed, it believed that the remedies for an "overall" failure to maintain adequate records are limited to the prospective remedies articulated in the regulations.

The Board noted that bad debts was one of those areas where the Phoenix Clinic 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 Phoenix Clinic'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. However, by letter dated November 18, 2010, the Intermediary subsequently reversed that decision based on the PSC's audits 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 noted that it attempted to establish why these remaining bad debts were disallowed even though the Intermediary had previously determined that the bad debts were adequately supported. 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. The Intermediary's post hearing submission did not include these workpapers or address the issue. Thus, the Board concluded 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, but rather, the PSC's disallowance of the "remaining bad debt" appeared 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." The Board thus found 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.

## DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Section 1878 of the Social Security Act states that:

> (a) Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board…and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts

> computed under subsection (b) or (d) of section 1886 and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this title for the period covered by such report, or
>
> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1886,….[2]

Relevant to the determination of jurisdiction, a "provider of services" is defined at 1861(u) of the Act as:

> [A] hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund.[3]

Further, regarding the services at issue in this case, §1861 defines "Partial Hospitalization Services" as:

> (ff)(1) The term "partial hospitalization services" means the items and services described in paragraph (2) prescribed by a physician and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate

---

[2] Section 1886 of the Act deals with exclusively with "Payment to Hospitals for Inpatient Hospital Services".

[3] In addition, § 1815(a) regarding "Payment to Providers of Services" states that: "The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it… except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

staff participating in such program), which plan sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

*****

(3)(A) A program described in this paragraph is a program which is furnished by a hospital to its outpatients or by a community mental health center (as defined in subparagraph (B)), and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care other than in an individual's home or in an inpatient or residential setting.

(B) For purposes of subparagraph (A), the term "community mental health center" means an entity that—

(i)(I) provides the mental health services described in section 1913(c)(1) of the Public Health Service Act; or

(II) in the case of an entity operating in a State that by law precludes the entity from providing itself the service described in subparagraph (E) of such section, provides for such service by contract with an approved organization or entity (as determined by the Secretary);

(ii) meets applicable licensing or certification requirements for community mental health centers in the State in which it is located;

(iii)[provides at least 40 per cent of its services to individuals who are not eligible for benefits under this title; and

(iv) meets such additional conditions as the Secretary shall specify to ensure

(I) the health and safety of individuals being furnished such services, (II) the effective and efficient furnishing of such services, and (III) the compliance of such entity with the criteria described in section 1931(c)(1) of the Public Health Service Act.

Regarding the "enrollment process" for community mental health centers, § 1866 "Agreements with Providers of Services; Enrollment Processes"; describes at paragraph (e) that:

(e) For purposes of *this section*, the term "provider of services" shall include—

*****

> (2) a community mental health center (as defined in section 1861(ff)(3)(B)), but only with respect to the furnishing of partial hospitalization services (as described in section 1861(ff)(1)). (Emphasis added.)

The regulation at 42 C.F.R. § 400.202 provides general definitions "as used in connection with the Medicare program, unless the context indicates otherwise" that:

> *Provider* means a hospital, a CAH, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, or a hospice that has in effect an agreement to participate in Medicare, or a clinic, a rehabilitation agency, or a public health agency that has in effect a similar agreement but only to furnish outpatient physical therapy or speech pathology services, or a *community mental health center that has in effect a similar agreement but only to furnish partial hospitalization services*. (Emphasis added.)

The general rules for "Provider Reimbursement Determinations and Appeals", which are set forth at 42 C.F.R. § 405.1801(b) states that:

> (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).
>
> (2) *Other nonprovider entities participating in Medicare Part A.* (i) Providers of services, as well as, other entities (including, but not limited to health maintenance organizations (HMOs) and competitive medical plans (CMPs) (as described in § 400.200 of this chapter)) may participate in the Medicare program, but *do not qualify as provider under the Act or this subpart*.
>
> (ii) Some of these nonprovider entities are required to file periodic cost reports and are paid on the basis of information furnished in these reports.

> Except as provided at § 413.200(g), these nonprovider entities may not obtain an intermediary hearing or a Board hearing under section 1878 of the Act or this subpart.
>
> (iii) Some other hearing will be available to these nonprovider entities, if the amount in controversy is at least $1,000.
>
> (iv) For any nonprovider hearing, the procedural rules for a Board hearing set forth in this subpart are applicable to the maximum extent possible.

After a review of the record, the Administrator finds that, after a review of the statutes and regulations, there is a question as to whether a CMHC is a "provider of services" for purposes of a hearing under § 1878 of the Act, and the corresponding regulations at 42 C.F.R. § 405.1801 *et. seq*. However, this issue was not raised or briefed before the PRRB. Accordingly, the Administrator orders:

THAT the Board's decision is hereby vacated;

THAT this case is remanded for further consideration;

THAT the Board will determine whether a CMHC is a "provider of services" entitled to a hearing before the Provider Reimbursement Review Board under § 1878 of the Act and 42 CFR § 405.1801 *et. seq.*;

THAT the Board will provide sufficient opportunity for the parties to submit written arguments on this issue;

THAT, if the Board finds that the CMHC is a "provider of services" for purposes of § 1878 of the Act, the Board shall also determine whether this finding necessarily implicates other documentation obligations and requirements as a "provider of services";

THAT the Board's decision, on remand, is subject to 42 C.F.R. § 1875.

Date: 3/20/13

/s/
Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services