PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D56

PROVIDER -
Mendocino Community Hospital
Mendocino County, CA

Provider No. 05-0381

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of California

DATE OF HEARING-
April 29, 1998

Cost Reporting Period Ended -
June 30, 1985, June 30, 1986,
and June 30, 1987

CASE NO. 93-0509

INDEX

ISSUE:

Was the Intermediary's refusal to reopen the Provider's cost reports an abuse of discretion?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mendocino Community Hospital ("Provider") is located in Mendocino County, California. The Provider's fiscal intermediary is Blue Cross of California ("Intermediary").

The Intermediary settled the cost reports for FYEs 6/30/85, 6/30/86 and 6/30/87 through the issuance of original Notices of Program Reimbursement (NPRs), dated 8/31/88, 8/29/88 and 1/13/89, respectively.[1] The Provider did not appeal the Intermediary's determinations.

On March 12, 1991, the Provider requested the Intermediary to reopen the cost reports at issue (FYEs 1985, 1986, 1987) and correct certain, what the Provider termed as, "clear and obvious material errors".[2] The request specified that the Provider:

> [f]ormally requests the Medicare intermediary to reopen the cost reports for the above mentioned years to correct the following errors made by HCFA in calculating the Federal and hospital specific portion of the DRG National/Federal rate at the inception of the Prospective Payment System.

Id.

The specific errors mentioned by the Provider in this request included references to the Federal and Hospital Specific portion of the DRG rate as well as mentioning that malpractice insurance costs should be reimbursed under the pre-1979 rule.[3]

On April 8, the Provider filed additional reopening requests,[4] which were specific to each fiscal year, in accordance with 42 C.F.R. § 405.1885 and Medicare Intermediary Manual HCFA Pub. 13-2 § 2631. The Provider requested the Intermediary to reopen the cost reports to incorporate the following issues:

(1) Assignment of Square Footage Statistics to the Mental Health and Public Health Cost

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1 Intermediary Exhibit I-1 and Provider Exhibits P-3 to P-5.

2 See Intermediary Exhibit I-2 and Provider Exhibits P-6 to P-10 for copies of the Provider's reopening request letters.

3 Provider Exhibit P-6.

4 Provider Exhibits P-7, P-8, & P-9.

Centers to Allocate Equipment Depreciation Expenses in the Fiscal Years 1985 through 1987;

(2) Assignment of Square Footage Statistics to the Operation of Plant Cost Center to Allocate Equipment Depreciation Expenses in the Fiscal Years 1985 through 1987;

(3) Assignment of Square Footage Statistics to the Operation of Plant Cost Center to Allocate Maintenance and Repair Costs for the Fiscal Years 1985 through 1987;

(4) Exclusion of Outpatient Clinical Laboratory Charges in the Fiscal Years 1985 through 1987;

(5) Allocation of Dietary Costs to the Cafeteria Cost Center in the Fiscal Years 1985 through 1987;

(6) Computation of the Medicare Inpatient Settlement Data in the Fiscal Years 1985 through 1987;

(7) Netting Down Total Clinic and EKG Charges in the Fiscal Years 1985 through 1987;

(8) Allocation of Housekeeping Costs to the Physical Therapy Cost Center in the Fiscal Years 1985 and 1986;

(9) Understatement of Salaries reported on Worksheet “A” in the Fiscal Year 1985;

(10) Reclassification of Rental Expenses reported on Worksheet “A-6" in the Fiscal Years 1986 and 1987;

(11) Computation of the Federal Specific Portion (FSP) of the DRG Payment Rates in the Fiscal Years 1986 and 1987;

(12) Computation of the Hospital Specific Portion (HSP) of the DRG Payment Rates in the Fiscal Years 1986 and 1987;

(13) Reimbursement of Malpractice Insurance Costs in the Fiscal Years 1985 and 1986;

(14) Allocation of CRNA Costs to the Anesthesiology Cost Center in the Fiscal Year 1986;

(15) Understatement of the Subprovider Unit's Routine Charges in the Fiscal Year 1986;

(16) Adjustment of Physicians' Professional Component Amount in the Fiscal Year 1987;

(17) Reclassification of Fire Insurance Premium Amounts in the Fiscal Year 1987;

(18) Reimbursement of Disproportionate Share Payments in the Fiscal Year 1987;

(19) Combining the EKG and EEG Cost Centers with the Respiratory Therapy Cost Center in the Fiscal Year 1987; and

(20) Understatement of Medicare DRG payment in the Fiscal Year 1987.

On April 9, 1992, the Provider's representative also sent a follow-up letter[5] to the Intermediary regarding the Provider's reopening request.

In a letter dated June 12, 1992,[6] the Intermediary responded to the Provider's April 9, 1992 follow-up letter, indicating that although the requests were submitted within the 3 year period for timely reopening, the requests for the years ended June 30, 1985 through June 30, 1987 were being denied for the following reasons:

(a) The Provider failed to identify the Intermediary's audit adjustments which need to be reopened or corrected.

(b) Due to the above, the Intermediary was unable to determine whether the reopening request involved an Intermediary audit adjustment or Provider's as-filed amounts in the cost report. In case of the later, the Provider is bound by its elections once a cost report is filed and it may not avail itself of an option it did not originally elect.

(c) The Provider failed to submit any new and material evidence to support its request.

On December 8, 1992, the Provider appealed the Intermediary's denial to reopen FYEs 6/30/85 through 6/30/87 cost reports[7] to the Provider Reimbursement Review Board ("Board"). On February 18, 1993, the Board concluded it had jurisdiction over the appeal pursuant to the ruling in State of Oregon, O.B.O. Oregon Health Services v. Bowen, 854 F.2d 346 (9th Cir. 1988) ("Oregon").[8] In keeping with Oregon, the Board has limited its review of this appeal to the issue of whether the Intermediary's denial of the Provider's reopening request was an abuse of discretion.[9]

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5 Intermediary Exhibit I-3.

6 Intermediary Exhibit 1-4 and Provider Exhibit P-10.

7 Provider Exhibit P-11.

8 Provider Exhibit P-2.

9 See Oregon at 350.

The Provider is represented by David S. Kornblum, CPA. The Intermediary's representative is Bernard Talbert, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary abused its discretion in denying the Provider's request to reopen the cost reports to correct for "clear and obvious" material errors. The Provider contends that the Intermediary's action was arbitrary, capricious, and inconsistent with the Medicare Statute, Medicare Regulation and case law. The Provider argued it is entitled to appeal an Intermediary's denial of a reopening request pursuant to Oregon. The Provider also asserts that 42 C.F.R. §405.1885 and Provider Reimbursement Manual, Part 1(HCFA Pub. 15-1) § 2931.2 grant it the right to request the reopening of a cost report to correct for material errors within 3 years of the NPR.

The Provider points out that HCFA Pub. 15-1 § 2131.2 indicates that:

> [w]hether or not the intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions. Information submitted in support of an amended cost report or the audit findings on a previously unaudited cost report could provide new and material evidence on which to base a reopening.

Id.

The Provider asserts the Intermediary premised its refusal to reopen the cost reports on the Provider's failure to provide compelling or convincing evidence that the reopenings were warranted. The Intermediary's position was that the Provider:

1. . . . failed to identify the Intermediary audit adjustments (adjustment number, amount and nature) which need to be reopened or corrected.

2. Failed to submit any new and material evidence to support your (Provider's) request.

The Provider believes that it has furnished substantive evidence to support its position that the Intermediary abused its discretion in denying the Provider's requests to reopen the cost reports for the fiscal years 1985 through 1987 to correct "clear and obvious" material errors. The Provider contends that the reopening requests submitted on March 12, 1991 and April 8, 1991 met all of the criteria governing the reopening of a cost report.

The Provider maintains the requests were filed within the stipulated time period of three years

of the dates of the Intermediary's issuance of the NPRs. The Provider contends that adequate information and material evidence were also submitted in support of the reopening requests.

The Provider further contends that the Intermediary's failure to reopen the cost reports to correct for "clear and obvious" material errors was: (1) arbitrary and capricious; (2) inconsistent with the Medicare Statute, Medicare Regulation and Case Law; and (3) a "clear breach" of fiduciary duty.[10]

The Provider also contends that the Intermediary acted in an unreasonable and unconscionable manner without proper considerations of the facts and HCFA's instructions on the reimbursement of the Malpractice Insurance costs (HCFA Ruling 89-1) in denying the request to reopen the cost reports for the fiscal years 1985 and 1986.

It should be noted that in Exhibit 13 of the Provider's final position paper, many of the issues that it had characterized as clear and obvious errors in its original requests for reopening and in the body of the Position Paper, were withdrawn by the Provider. See Provider Position Paper at 19-31; Provider Exhibit P-13.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Provider did not demonstrate with compelling or convincing evidence that the reopenings were warranted, pursuant to 42 C.F.R. § 405.1885 and HCFA Pub. 15-1 § 2931 et seq.. The Intermediary also contends that the Provider did not submit sufficient and accurate information and supporting documentation, pursuant to 42 C.F.R. § 413.24, HCFA Pub. 15-1, §§ 2300, 2304 and 2404.2.

The Intermediary maintains that it did not capriciously or arbitrarily make its determination, since it was based on the facts and circumstances disclosed by the Provider and is consistent with the referenced Program regulations and instructions. The Intermediary argues that it did not abuse its discretion in issuing the denial of reopening. The Intermediary refers to Black's Law Dictionary which defines abuse as a "departure from reasonable use" and abuse of discretion as "being synonymous with a failure to exercise a sound, reasonable, and a legal discretion."[11] Under the circumstances, the Intermediary contends it did not make an erroneous conclusion and judgment that is against logic. The Intermediary further contends it did not arrive at an unreasonable and improbable determination or decision, in spite of the Provider's insufficient facts and inaccurate supporting documentation. Furthermore, the Intermediary notes that it has clearly and timely informed the Provider of its review and determination throughout the cost report reopening process.

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[10] Provider Position Paper at 32.

[11] Intermediary Position Paper at 5.

The Intermediary explains that its primary reason for rejecting the Provider's reopening requests was due to the lack of any factual information concerning the issues that the Provider contends were the objects of clear and obvious errors. The Intermediary maintains that it did evaluate and consider the merits of the reopening requests and that the rejection was based on the lack of any factual support for a reimbursement theory. The Intermediary believes that the reopening requests lacked any meaningful factual information for it to find in the Provider's favor. The Intermediary asserts that the Provider's reopening requests were rejected because of factual shortcomings.

The Intermediary points out that the decision in this case is similar to Providence Hospital vs. Blue Cross of California, PRRB Decision No. 95-D22, February 13, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,081, rev'd HCFA Admin. Dec. April 6, 1995,[12] Medicare & Medicaid Guide (CCH) ¶ 43,263 ("Providence") which was overturned by the HCFA Administrator. In Providence, the Administrator found that "as no factual documentation was submitted with the request, the intermediary reasonably found, applying § 2931.2 of the PRM, that the provider had not furnished "new and material" evidence to support a reopening."

In summary, the Intermediary contends that it did not abuse its discretion by determining that the Provider failed to demonstrate a case for reopening under the governing standards of HCFA Pub. 15-1 § 2931.2. The Intermediary requests the Board to affirm its decision.

CITATION OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law - 42 U.S.C.:

§ 1395x(v)	-	Reasonable Costs

2. Regulations - 42 C.F.R.:

§ 405.1885	-	Reopening a Determination or Decision
§ 413.24	-	Adequate Cost Data and Cost Finding

3. Program Instructions - Provider Reimbursement Manual, Part 1, (HCFA Pub. 15-1):

§ 2300	-	Adequate Data and Cost Finding: Principle
§ 2304	-	Adequacy of Cost Information

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[12] Intermediary Exhibit 1-5.

§ 2404.2	-	Examination of Pertinent Data and Information
§ 2931.1G	-	Time Limits for Reopening/When Reopening Period Begins to Run
§ 2931.2	-	Reopening Final Determination

4. Intermediary Manual-(HCFA Pub. 13-2):

§ 2631	-	Reopening

5. Cases:

State of Oregon, O.B.O. Oregon Health Services v. Bowen, 854 F.2d 346 (9th Cir. 1988).

Providence Hospital v. Blue Cross of California, PRRB Decision No. 95-D22, February 13, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,081, rev'd HCFA Admin. Dec. April 6, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,263.

6. Other:

HCFA Ruling 89-1	-	Malpractice Insurance Costs
HCFA Ruling 91-1	-	Malpractice Insurance Costs

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and documentary evidence presented, finds and concludes as follows:

With respect to the Intermediary's denial of reopening in this case, the Board notes that, generally, an intermediary decision not to reopen a cost report(s) is unreviewable under 42 C.F.R. § 405.1885(c), which grants exclusive jurisdiction for reopening to the last administrative body that rendered a determination. However, the Provider is located in the Ninth Circuit, where the U.S. Court of Appeals, in Oregon, supra, held that the Board could review, for abuse of discretion, an intermediary decision not to reopen. Therefore, the issue before the Board in this case is whether the Intermediary abused its discretion in denying the Provider's reopening requests. The Board looked to HCFA Pub. 15-1 § 2931.2 for guidance in determining whether, 1) new and material evidence exists; 2) a clear and obvious error exists; or 3) the determination is found to be inconsistent with the law regulations, and rules or general constructions. Id. The Board believes that the standard of review is whether an

intermediary exercised sound, reasonable, and legal discretion, or whether an intermediary's conclusions and judgement were clearly erroneous. The Board notes that the primary issue in this case is whether there were clear and obvious errors made by the Intermediary in the settlement of the Provider's FYE 1985-1987 cost reports.

The Board finds the Provider's March 12, 1991 request to reopen the Provider's cost reports was timely. The Provider filed its request within the 3 year limitation as required by 42 C.F.R. 405.1885(a). The Intermediary also agrees this request was timely.[13]

The Board notes that the Provider originally claimed that the Intermediary made twenty (20) clear and obvious errors in the settlement of its cost reports.[14] The Board further notes that the Provider subsequently withdrew eleven (11) of these issues.[15] The Board did not detect any clear and obvious errors on the withdrawn issues. In analyzing the remaining issues, the Board concentrated on whether any clear and obvious errors were made in the published NPRs. The Board took special note of the Intermediary's arguments regarding the lack of detailed explanations/documentation that was submitted by the Provider to support its allegations of clear and obvious errors.

The Board has examined several of the Provider's remaining issues and does not find any clear and obvious errors that were committed by the Intermediary in the settlement of the cost reports.

In particular, the Provider's first reopening request of March 12, 1991[16] which consolidated FYs 1985-1987, had indicated that clear and obvious errors were made by the Intermediary in its reimbursement of malpractice insurance costs. The Provider's subsequent requests for reopening,[17] which were specific to each fiscal year, did not mention the malpractice issue. The Provider subsequently withdrew this issue for FYs 1985 and 1986,[18] apparently leaving FY 1987 as the clear and obvious error. The Provider had requested the Intermediary to resolve the issue in accordance with HCFA Rule 91-1.[19] The Board notes that in order for HCFA Rule 91-1 to be applicable, the Provider must have filed an appeal of the

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13 Intermediary Exhibit I-4.

14 Provider Position paper at Pgs. 5-8.

15 Provider Exhibit P-13

16 Provider Exhibit P-6.

17 Provider Exhibits P-7-9.

18 Provider Exhibit P-13 at Pg. 2.

19 Id.

Intermediary's malpractice adjustment on its NPR. The Board notes that the record is void of evidence that any appeals of the malpractice insurance issue were filed by the Provider. Therefore, the Board concludes that a clear and obvious error was not made by the Intermediary in the malpractice insurance area when it settled the Provider's cost reports. In addition, the Board notes that the Provider alleged there were clear and obvious errors in the assignment of square footage and settlement data areas. The Board finds that the Provider failed to support its allegations with documentation at the time of its reopening requests.

The Board concludes that the Intermediary considered that merits of the Provider's requests to reopen its cost reports and properly set forth its reasons for denial in its denial letter of June 12, 1992.[20] The Board finds that based on the reasons and lack of documentation supplied by the Provider in its reopening requests, the Intermediary offered a reasonable rationale as to the basis of its denial. Therefore, the Board finds that the Intermediary exercised sound and reasonable judgement in denying the Provider's reopening request and did not abuse its discretion when it refused to reopen the Provider's FYs 1985-1987 cost reports.

DECISION AND ORDER:

The Board finds the Provider's appeal was filed timely. The Board concludes that the Intermediary did not abuse its discretion when it refused to reopen the Provider's cost reports. The Intermediary's determination is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: May 22, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman

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[20] Intermediary Exhibit I-4.