PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2004-D8

PROVIDER –
Heritage Health Care, Inc. d/b/a
Heritage Villa Nursing Center

Provider No. 37-5109

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

Cost Reporting Period Ended
June 30, 1999

CASE No. 03-0666

INDEX

Issue:

Does the Board have jurisdiction over the recoupment of overpayments appealed from a letter from the Centers for Medicare & Medicaid Services?

Background:

The Provider filed this appeal on February 12, 2003, from a letter from the Centers for Medicare & Medicaid Services (CMS). CMS' letter confirms that CMS intends to continue to recoup an overpayment incurred by the prior owner of the provider entity from Heritage's Medicare payments. CMS cites Heritage's having accepted assignment of the seller's Medicare provider agreement as the basis for CMS' action.

In its appeal to the Board, Heritage does not contest the amount of the overpayment determination but rather asserts that, had CMS followed its own procedures, the overpayments would have been discharged in the bankruptcy proceeding of a related entity. Details of the bankruptcy proceeding are not entirely clear; however, the Board finds that those details are not dispositive of jurisdiction.

The Intermediary contends that the Board lacks jurisdiction because the appeal was not timely filed from the Intermediary's assignment of debt. Further, the Intermediary believes that the lack of an audit adjustment precludes Board jurisdiction because there can be no provider dissatisfaction. The Provider did not file a response.

Findings, Conclusions and Discussion:

The Board finds that it lacks jurisdiction over Heritage's appeal of the recoupment action because those matters are specifically excluded from the Board's authority. Further, assuming that the appeal could be construed as an appeal of the underlying reimbursement determination, the Board nevertheless lacks jurisdiction because it was not filed within the 180-day period from a final determination of reimbursement. 42 U.S.C. §1395oo(a) and 42 C.F.R. §405.1835.

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §405.1835(a), a provider may file an appeal with the Board if, among other things, it is dissatisfied with the final determination of the intermediary. Section 405.1801(a) defines a final determination as the determination of the total amount of reimbursement due a provider following the close of the cost reporting period for items and services furnished to Medicare beneficiaries.
A final determination is required to include legal citations that form the basis for the amount of program reimbursement and why it differs from the claim made by the provider. A final determination also informs a provider that it must appeal the notice within 180 days. 42 C.F.R. §405.1803(b). CMS' letter was not identified as a final determination nor did it involve the calculation of Medicare reimbursement. See, Newport Hospital and Clinic v. Sullivan, 1990 U.S. Dist. Lexis 13024 (D.C. Dist. 1990).

Additionally, the Board lacks jurisdiction over the recoupment of overpayments issue. The Provider acknowledges that the disagreement involves an overpayment in the amount of $69,484. There is no dispute over the amount of overpayment. The Provider is only challenging whether the overpayment should have been discharged through a bankruptcy proceeding.

The Board cannot exercise judicial power in cases in which the laws have not extended that power. See, Mansfield, Coldwater & Lake Michigan Railway Company v. Swan, 11 U.S. 379, 384 (1884). The remedy sought by the Provider is to terminate the collection of an overpayment, an action that is not available to the Board. The regulations, 42 C.F.R. §§405.1801(a)(4), 405.376(j) and 401.625, preclude Board appeals over actions taken by CMS regarding compromise of an overpayment claim or termination or suspension of an overpayment. Section 405.1801(a) states that, for purposes of §405.376 concerning claim collection activities, a final determination does not include an action by CMS with respect to a compromise of a Medicare overpayment claim or termination or suspension of a collection action. Section 405.376 is contained in Subpart C of Title 42, which deals with the policies and procedures for handling incorrect Medicare payments and recovery of overpayments. Subpart C explains the procedures for offset and recoupment and 42 §405.376(j) states that "[a]ny action taken by HCFA [now CMS] under this section regarding the compromise of an overpayment claim, or termination or suspension of a collection action on an overpayment claim is not an initial determination for purposes of the appeal procedures under Subpart. . . R." This position is repeated in §401.625, which deals with collection actions under the Federal Claims Collection Act. The Intermediary Manual also states that a definition of a final determination used in conjunction with 42 C.F.R. §405.376ff is not synonymous with the term final determination used in settling a cost report when issuing a Notice of Program Reimbursement under 42 C.F.R. §405.1803. See, Intermediary Manual, Part II (CMS Pub. 13-2) §2219.1.

Further, in this case, the Provider believes the recoupment was precluded by the discharge provisions of Chapter 11 of the Bankruptcy code. This is analogous to the facts in Elk Valley Professional Affiliates v. Sullivan, 1991 U.S. Dist. Lexis 4832 (E.D. Tenn.1991)[1] (Elk Valley). In Elk Valley, the providers entered into a repayment schedule with HCFA subsequent to an overpayment determination. In a subsequent fiscal period, the intermediary determined that the providers had been underpaid and credited the underpayment against the remainder of the overpayment. It sent the providers a check for the remaining amount of the underpayment. The providers sought a temporary restraining order, alleging that HCFA's action violated its own regulations. The Court found that the Board lacked jurisdiction over the matter because the amount of overpayment or underpayment was not at issue, nor were claims about how much the Medicare program should pay the providers for services. The providers in Elk Valley were seeking to compel the defendant to follow the Federal regulations regarding the appropriate method of recouping overpayments. Likewise, in this case, neither the underlying claims nor the amount of the overpayment are in dispute. The Provider is attempting to compel the agency to follow what it believes are the appropriate regulations in its recoupment where a Chapter 11 bankruptcy is involved.

[1] The Magistrate's decision, which was adopted by the Eastern District of Tennessee, is found at 1991 U.S. Dist. Lexis 4643 or the Medicare and Medicaid Reporter (CCH) ¶ 39,045.

Decision and Order

The Board finds that it lacks jurisdiction over the appeal and hereby dismisses the case. Review of this determination is available under the provisions of 42 U.S.C. §1895oo(f)(1) and 42 C.F.R. §§405.1875 and .1877.

Board Members Participating

Suzanne Cochran, Esq.
Gary B. Blodgett, DDS
Martin W. Hoover, Esq.

Date of Decision: Jan 30, 2004

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Enclosures: 42 U.S.C. §1895oo(f)(1) and 42 C.F.R. §§405.1875 and 405.1877.