PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D20

PROVIDER –
John H. Stroger, Jr. Hospital of Cook County
Chicago, Illinois

Provider No.: 14-0124

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, Inc.

DATE OF HEARING –
October 6, 2011

Cost Reporting Period Ended –
November 30, 2004

CASE NO.: 08-1417

INDEX

ISSUE(S): Whether the Intermediary's exclusion of the physician malpractice expense from Worksheets A-8-2 and D-9 of the cost report 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),[1] to provide health insurance to the aged and disabled. 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[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the prospective payment system for operating-costs.[4] Similarly, the capital-related costs of inpatient hospital services are reimbursed by Medicare generally through the prospective payment system for capital-related costs.[5] The operating and capital base payment rates for both of these prospective payment systems are adjusted for area wages using the wage index.[6] The wage index is updated annually based on wages and wage-related costs reported by short-term, acute care hospitals[7] on Worksheet S-3 Parts II and III of the cost report.[8]

Certain inpatient hospital costs are reimbursed by Medicare on a reasonable cost basis rather than through the prospective payment systems. Providers are required to submit cost reports annually, with cost reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[9] Each 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).[10]

A provider dissatisfied with the intermediary's final determination of total reimbursement 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 for a single provider must exceed $10,000 for an individual appeal (or $50,000 for a group); and (3) the appeal must be filed with the Board

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[1] *See* 42 U.S.C., Ch. 7, Subch. XVIII.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* §§ 1816 and 1874A of the Act, 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[4] *See* § 1886(d) of the Act, 42 U.S.C. § 1395ww(d); 42 C.F.R. § 412.1(a).
[5] *See* § 1886(g) of the Act, 42 U.S.C. § 1395ww(g); 42 C.F.R. § 412.1(a).
[6] *See* § 1886(d)(3)(E) of the Act, 42 U.S.C. § 1395ww(d)(3)(E); 42 C.F.R. §§ 413.64(h) and 412.316.
[7] *See* § 1886(d)(3)(E)(i) of the Act, 42 U.S.C. § 1395ww(d)(3)(E)(i); 42 C.F.R. § 412.64(h)(1).
[8] *See* Provider Reimbursement Manual (PRM) Part II §§ 3605.2 and 3605.3.
[9] *See* 42 C.F.R. § 413.20.
[10] *See* 42 C.F.R. § 405.1803.

within 180 days of the receipt of the final determination.[11]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

John H. Stroger, Jr. Hospital (Provider) is a public teaching hospital, owned and operated by Cook County in Chicago, Illinois. The Provider timely filed its cost report for fiscal year ending (FYE) 11/30/2004 with National Government Services, Inc. (Intermediary). The Provider did not claim the physician malpractice expenses at issue on any of the forms in the as-filed cost report, including Worksheets A-8-2, D-9, and S-3 Part II.

In connection with the prospective payment systems for inpatient hospital services under 42 C.F.R. Part 412, the Intermediary conducted a wage index audit of FYE 11/30/2004 and issued a Wage-Index Adjustment Report. The Intermediary made Adjustment #7 in the Wage Index Adjustment Report "to reflect physicians' malpractice insurance" on Lines 18, 18.01 and 19 of Column 1 of Worksheet S-3 Part II.[12]

Subsequently, the Intermediary conducted a Medicare cost report audit of FYE 11/30/2004. On September 20, 2007, the Intermediary issued a Notice of Program Reimbursement (NPR), which did not include any adjustments related to the Provider's physician malpractice expense at issue.[13]

On March 13, 2008, the Provider filed a request for a hearing before the Board. The Provider was represented by Brian D. Nichols, Esq. of Drinker Biddle & Reath, LLP. The Intermediary was represented by Bernard Talbert, Esq. of the Blue Cross Blue Shield Association.

PARTIES' CONTENTIONS:

The Provider asserts that, while it did not include the physician malpractice expenses at issue in the "as-filed" cost report, the jurisdictional requirements for a Board hearing have been satisfied because the inclusion of the physician malpractice expenses was appropriately raised to the Intermediary during both the wage index and cost report audits.[14] Specifically, the Provider maintains that the physician malpractice expenses at issue were included in Worksheet S-3 Part II as part of the wage index data adjustments that the Intermediary made during the wage index audit. The Provider understood that these adjustments would automatically flow through to Worksheets A-8-2 and D-9 of the cost report.[15] Further, the Provider maintains that, during both the wage index and cost report audit processes, the Provider requested that the physician malpractice expenses be included in the cost report.[16] The Intermediary declined the requests.[17]

The Intermediary asserts that the Board does not have jurisdiction in this matter as no adjustment

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[11] *See* § 1878(a) of the Act, 42 U.S.C. §1395oo(a); 42 C.F.R. §§ 405.1835-1837.
[12] *See* Provider Exhibit P-1 at 4.
[13] *See* Intermediary Exhibit I-1 at 19-22.
[14] Provider Position Paper at 3; Transcript (Tr.) at 10-11 and 29-30.
[15] Provider Position Paper at 2-5; Tr. at 10-11 and 78-80.
[16] Provider Position Paper at 2-5; Provider Exhibit P-3 at 2; Tr. at 10-11, 29-30, 79-80, 83-84.
[17] Provider Exhibit P-3 at 2.

was made to the cost report regarding physician malpractice expenses.[18] The Intermediary acknowledges that it made an adjustment during the wage index audit to include certain physician malpractice expenses on Worksheet S-3.[19] However, the Intermediary maintains that it made this adjustment only for wage index purposes as part of the wage index audit process which is a separate and distinct process from a cost report audit process.[20] The Intermediary advised that the Provider failed to include the physician malpractice expenses as part of physician salaries on Worksheets A-8-2 and D-9 in the original cost report filing or, in the alternative, in an amended cost report filing.[21] The Intermediary's documentation reflects that, during the cost report audit process, the Provider initially raised the matter to the Intermediary at the exit conference prior to the issuance of the NPR and that the Intermediary declined to review the malpractice expenses because the audit deadline for submission of documentation had expired.[22]

The Intermediary acknowledges that the Board has taken discretionary jurisdiction under § 1878(d) of the Act,[23] but maintains that the Board has no jurisdiction in this matter under § 1878(a) of the Act.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of Medicare law and guidelines, the parties' contentions, and the evidence presented, the Board finds and concludes that the Provider does not have a right to a hearing under § 1878(a) of the Act.[24]

The Board's jurisdiction is established under § 1878(a) and it provides, in relevant part:

> 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 . . . if –
>
> (1) such provider –
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 [42 U.S.C. § 1395h] 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 . . . .

The issue appealed in this case pertains to physician malpractice expenses. The Provider notes that, while it neglected to include the physician malpractice expenses on Worksheets A-8-2 and D-9 of its as-filed cost report, the Intermediary adjusted Worksheet S-3 Part II to include the

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[18] Intermediary Position Paper at 3-4.
[19] Intermediary Position Paper at 3.
[20] Intermediary Position Paper at 3; Tr. at 15.
[21] Intermediary Position Paper at 3-4.
[22] Provider Exhibit P-3 at 2.
[23] 42 U.S.C. § 1395oo(d).
[24] 42 U.S.C. § 1395oo(a).

physician malpractice expenses during the wage index audit. As a result, the Provider maintains that the physician malpractice expenses should automatically flow from Worksheet S-3 Part II through to these other worksheets of the cost report.

The Board disagrees. As specified in the Provider Reimbursement Manual (PRM) Part II § 3605.2, the purpose of Worksheet S-3 Part II is for "the collection of hospital wage data which is needed to update the hospital wage index applied to the labor-related portion of the national average standardized amounts *of the prospective payment system.*"[25] Thus, the Intermediary audited Worksheet S-3 Part II only for the purpose of updating the wage index as it relates to the prospective payment system for hospital inpatient services. In this regard, the wage index audit process is separate and distinct from the cost report audit process.[26]

In addition, the Provider has not cited or furnished any policy or guidance to support its contention that Worksheet S-3 Part II flows automatically through to other worksheets on the cost report. Indeed, and contrary to the Provider's contentions, CMS instructions indicate that such data flows between Worksheets A and S-3 Part II. For example, the PRM Part II § 3605.2 currently states "The required source for costs on Worksheet A is the general ledger . . . Worksheet S-3, Part II (wage index) data are derived from Worksheet A; therefore, the proper source of costs for the wage index is also the general ledger."

Examination of the Worksheet S-3 Part II instructions associated with the Wage Index adjustment at issue suggests that there is no direct nexus between the information entered on these lines and Worksheet A. The Wage Index adjustment at issue, Adjustment 7 on the Wage Index Adjustment Report, increases physician Part B salaries in Lines 18, 18.01 and 19 of Column 1 of Worksheet S-3 Part II "to reflect physicians' malpractice insurance." PRM Part II § 3605.2 specifies that Lines 13 through 20 of Worksheet S-3 Part II address "wage-related costs" for the wage index. In connection with Lines 16 through 20 of Column 1, § 3605.2 provides the following instruction:

> Enter from your records the wage-related costs for each category of employee listed. The costs are the core wage-related costs plus the other wage-related costs. Do not include wage-related costs for excluded areas reported on line 15. Do not include wage-related costs for Part A teaching physicians on line 18. These costs are reported separately on line 18.01 (10/97). On line 19, do not include wage-related costs related to non-physician salaries for patient care services reported for Hospital-based RHCs and FQHCs services included on Worksheet A, column 1, line 63. These wage-related costs are reported separately on line 19.01 (10/99).

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[25] (Emphasis added.) The wage index survey consists of wages and wage-related costs data derived from providers' cost reports and used as part of the methodology in determining the rates under the prospective payment systems for inpatient hospital services.

[26] The wage index is governed under 42 C.F.R. § 412.64(h) –(m), and it is a separate and distinct process from cost report reimbursement, which is governed under 42 C.F.R. Part 413. *See also* Medicare Financial Management Manual § 20.4. The Provider has acknowledged the wage index audit is a different process from that used for cost report reimbursement. *See* Tr. 77-78. The issue before the Board relates to cost report reimbursement.

Thus, the instructions do not tie the data entered on these lines (including Lines 18, 18.01 and 19 of Column 1) back to Worksheet A, but rather require the provider to "enter from your records."

The Board notes that the Provider initially raised the matter to the Intermediary during the settlement of the cost report and that the Intermediary declined to review the malpractice expenses. The statute does not provide for corrections to the cost report submissions after the filing deadline established by regulation. Nevertheless, the Secretary, by regulation and policy, established two avenues to correct a cost report filing: (1) filing an amended cost report; and (2) reopening a cost report.[27] Neither is relevant here because the Provider did not seek relief through either process.[28] A reading of § 1878(a) of the Act[29] to permit use of the appeal process as the vehicle for completing or correcting an otherwise incomplete or incorrect cost report as the Provider would have us do in this case,[30] undermines not only the statute's threshold requirement for appeal of a timely filed cost report, but also the Secretary's regulatory and policy framework for making corrections.

The Intermediary notes that once jurisdiction is obtained under § 1878(a), subsection (d) gives the Board discretionary power to review additional issues and matters not considered by the Intermediary.[31] In this case, however, the only issue appealed relates to expenses omitted by the Provider. Specifically, the Provider's appeal request does not mention dissatisfaction with disallowances of any other costs on the as-filed cost report. Consequently, as a jurisdictionally valid appeal under § 1878(a) has not been established, the Board does not have any discretionary power under § 1878(d) to review additional issues or matters.

DECISION AND ORDER:

The Provider does not have a right to a hearing under § 1878(a) of the Act.[32] As this is only issue under appeal, the case is dismissed.

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[27] *See* § 1878(a)(1)(C) of the Act, 42 U.S.C. § 1395oo(a)(1)(C); 42 C.F.R. §§ 405.1835, 405.1885, and 413.24(f); PRM Part I §§ 2931.B and 2931.2A.

[28] *See* Tr. at 78-79.

[29] 42 U.S.C. § 1395oo(a).

[30] In connection with amended or supplementary cost reports, § 1878(a)(1)(C) of the Act, 42 U.S.C. § 1395oo(a)(1)(C) gives a provider certain appeal rights if "such provider . . . has not received such final determination on a timely basis after filing a *supplementary cost report*, where such cost report did not so comply and such supplementary cost report did so comply." (Emphasis added.)

[31] *See MaineGeneral Medical Ctr. v. Shalala*, 205 F.3d 493 (1st Cir. 2000); *Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007); and *UMDNJ-Univ. Hosp. v. Leavitt*, 539 F. Supp. 2d. 70 (D.D.C. 2008). These cases discuss the application of *Bethesda Hospital Assoc. v. Bowen*, 485 U.S. 399 (1988) to costs inadvertently omitted from the cost report. *See also Kingsbrook Jewish Medical Center (Brooklyn, NY) v. BlueCross BlueShield Association,* PRRB Hearing Dec. 2011-D43 6, n. 14 (Sept. 14, 2011) (*available at* www.cms.gov/PRRBReview/downloads/2011D43.pdf (last visited Mar. 21, 2012)).

[32] § 1395oo(a)

BOARD MEMBERS PARTICIPATING:

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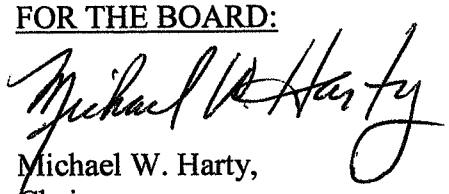
FOR THE BOARD:



Michael W. Harty,
Chairman

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