PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D14

PROVIDER –
St. Francis Hospital, Inc.
Greenville, SC

Provider No.: 42-0023

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Palmetto Government Benefits
Administrators

DATE OF HEARING -
December 20, 2011

Cost Reporting Period Ended –
August 31, 2003

CASE NO.: 08-2778

INDEX

ISSUE:

Whether the Intermediary's determination not to increase certain Medicare cost outlier payments was proper, where the outliers were underpaid because of an erroneous overpayment of DSH, which was a factor in the outlier amount calculation and which the MAC subsequently recouped without recalculating the affected outliers.

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"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. 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[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[3] 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").[4]

A provider dissatisfied with the intermediary's final determination of total reimbursement (*i.e.*, the NPR) 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 is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[5]

Medicare reasonable cost reimbursement is governed by 42 U.S.C. §1395x(v)(1)(A). In part, the statute provides that the "reasonable cost" of any service shall be the actual cost incurred but excluding any part of such costs found to be unnecessary in the efficient delivery of needed health services. The implementing regulation[6] provides that reasonable cost includes all "necessary and proper" costs incurred in furnishing healthcare services.

---

[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1839.
[6] *See* 42 C.F.R. § 413.9.

Effective with cost reporting periods beginning on or after October 1, 1983, short-term acute care hospitals became subject to the prospective payment system for inpatient operating costs ("IPPS"). Under IPPS, Medicare's payment for inpatient Part A operating costs is made according to prospectively set rates per discharge. In general, Medicare discharges are classified into diagnostic related groups ("DRGs") and a specific payment weight is assigned to each DRG based on resource use or intensity.

Payments made to hospitals under IPPS are adjusted (increased) when certain conditions exist. For example, DRG payments are increased when a hospital provides care to a disproportionate number of low income patients, or when a hospital incurs the indirect costs of graduate medical education programs. Relevant to the instant cases is the increase in IPPS payments for "outliers," *i.e.*, discharges for which resource use is unusually high. To qualify for an outlier payment, the inpatient stay must have costs above a fixed-loss threshold established by CMS. In general, a hospital's ratio of its costs to charges (*i.e.*, the ratio of its operating costs to charges in addition to the ratio of its capital costs and charges) are applied to the "covered charges" of a particular costly case to determine if it exceeds the fixed-loss threshold.

At the time that the claims at issue were submitted and processed, 42 C.F.R. § 412.116(e) stated as follows:

> (e) *Outlier payments.* Payments for outlier cases (described in subpart F of this part) are not made on an interim basis. The outlier payments are made based on submitted bills and represent final payment.[7]

This regulatory provision was added by a final rule published on September 30, 1988 ("September 1988 Final Rule"). The preamble to the September 1988 Final Rule described the outlier policy as embodied in § 412.116(e) as follows:

> We proposed to continue our policy that outlier payments would be final and not subject to recalculation based on later data that would affect the hospital specific cost-to-charge ratios, indirect medical education adjustment factors, or disproportionate share adjustment factors. This policy was first set forth in the September 1, 1983 final rule (48 FR 39779) and at that time codified at §405.454(m)(5). This section was subsequently redesignated as §413.64(k)(1)(ii) in a final rule with comment period published on September 30, 1986 (51 FR 34790). However, in a final rule with comment period published on January 21, 1988 (53 FR 1621), when this section was further redesignated as §412.116(e), we inadvertently deleted from that section the sentence that specified that outlier payments are based on submitted bills and represent final payment. As a part of the proposed rule, we corrected that paragraph to include the deleted sentence.[8]

---

[7] 42 C.F.R. § 412.116(e) (2002).

[8] *See* 53 Fed. Reg. 38476, 38503 (Sept. 30, 1988).

As noted above, CMS first set forth its outlier policy in the preamble to the final rule published on September 1, 1983 ("September 1983 Final Rule"). The preamble to the September 1983 Final Rule described the outlier policy as follows:

> Except for hospitals qualifying to receive payments under the PIP method, prospective payments for Part A inpatient operating costs will be made on the basis of a submitted bill. Such payments represent final payments and are not subject to retroactive adjustment at the end of the hospital's fiscal year. Payment for outlier cases may be computed and paid only after the intermediary is assured that the outlier claim is justified. Payment for outliers resulting from extraordinary costs, i.e., cost outliers, must be requested by the hospital and are payable after approval, subject to a medical review determination. Payment for day outliers, i.e., outliers resulting from length of stay exceeding the day outlier threshold criteria for the DRG, need not be specifically requested by the hospital and can be paid after a medical necessity determination is made, along with the prospective payment for the discharge.
>
> We recognize that errors can be made, and adjustment bills to correct errors will be submitted after the initial bill is submitted. Such adjustment bills will be scrutinized closely to ensure correctness and completeness. Copies of medical records or other evidence may be requested to document procedures, diagnoses, etc.[9]

Similarly, in the preamble to the final rule published on March 5, 2003 ("March 2003 Proposed Rule"), CMS described the outlier policy as follows:

> With respect to outliers, it has been CMS's policy that payment determinations are made on the basis of the best information available at the time a claim is processed and are not revised, upward or downward, based upon updated data.[10]

In a final rule published on June 9, 2003 ("June 2003 Final Rule"),[11] CMS removed the second sentence of § 412.116(e).[12]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Francis Hospital ("Provider") is a not-for-profit, general acute care hospital located in Greenville, South Carolina. This appeal concerns the Provider's Medicare program

[9] *See* 48 Fed. Reg. 39752, 39779 (September 1, 1983).
[10] *See* 68 Fed. Reg. 10420, 10425 (Mar. 5, 2003).
[11] *See* 68 Fed. Reg. 34494 (June 9, 2003).
[12] *See* 68 Fed. Reg. 34494, 34515 (June 9, 2003).

reimbursement for the fiscal year ending August 31, 2003 ("FY 2003"). Palmetto Government Benefits Administrators ("Intermediary") issued the Provider's NPR for FY 2003 with the audited cost report on February 25, 2008. By letter dated August 18, 2008, the Provider timely appealed the Intermediary's determinations to the Board pursuant to 42 C.F.R. §§405.1835-405.1841. After mediating this appeal with Board representatives, the parties executed a Partial Mediation Agreement that resolved all of the issues in this appeal except for the outlier issue.[13]

The payment factors specific to a hospital which produce the DRG payments and calculates any outliers change over time. The problem was created on April 4th and fixed on April 24th (all dates are in 2003, unless otherwise indicated). The problem had a delayed impact and affected claims from April 17th through May 6th.

In January, SSI was 7.02% and Medicaid was 4.9% or a total of 11.11%, well short of 15% needed to qualify for operating DSH. On April 4th, the Medicaid proxy changed to 7.61% (a combined 14.63%) which was still shy of the 15 % DSH threshold. However, a data entry error was made and the Medicaid proxy was entered as 76.1%. This made the DSH percentage 83.12%. This error had the effect of generating a DSH add on of approximately $1,700,000 to the DRG payment. It also had the compounding effect of increasing the DRG payment which understated the outlier payment by $170,000. The overpayments caused by the DSH payment of approximately $1,700,000 were recovered. However, approximately $170,000 in outlier underpayment was not paid back or credited to the benefit of the appealing Provider.

The Provider was represented by Robert L. Roth, Esq., of Hooper, Lundy & Bookman, P.C. The Intermediary was represented by Bernard M. Talbert, Esq., of the BlueCross BlueShield Association.

PARTIES' CONTENTIONS:

The Provider contends that after the Intermediary recovered the improper DSH payments that it had made on the Provider's DRG claims that were adjudicated from April 17 through May 6, 2003, the Intermediary was required to recalculate the Provider's outlier claims that were issued during that period to correct the underpayment that had been caused by the improper DSH overpayment. The Provider further contends that: (a) the payment errors here must be corrected because the Intermediary did not base its payment on the best information that was available at the time it made its decision; and (b) the Medicare authorities regarding the finality of outlier payments, even if enforceable, do not apply here, as the payments were based on a processing clerical error.

The Provider notes that the Intermediary's refusal to correct the effect of its DSH mistake on the outlier payments at issue, and CMS' refusal to allow the Intermediary to do so, is arbitrary and capricious, not based on substantial evidence, and otherwise unlawful under the Administrative Procedure Act[14] and other laws. The Provider also contends that CMS is acting inconsistently by refusing to correct the outlier payments at issue here on the basis of "finality" while simultaneously recovering millions from hospitals for indistinguishable outlier payments

[13] Included as Exhibit P-3.
[14] 5 U.S.C. Ch. 5.

that also should be "final" under the alleged CMS interpretation of § 412.116(e). The first real-life example comes from a report on outlier payments issued by the Office of the Inspector General ("OIG") of the U.S. Department of Health and Human Services on June 18, 2001 entitled "Review of Medicare Outlier Payments at Roger Williams Medical Center for Fiscal Year 1999."[15] The OIG audited the Medicare outlier payments at Roger Williams Medical Center ("RWMC") because they increased from $880,029 in FY 1998 to $4.3 million in FY 1999. After review, the OIG found that RWMC had, in fact, received an outlier overpayment, which was caused (as here) by a "clerical error":

> Our review found that RWMC received additional outlier payments of about $3.1 million in FY 1999 because the inpatient operating cost-to-charge ration used to calculate the payments was incorrect. We found a clerical error on the hospital's FY 1996 cost report that was not identified by the hospital or by Blue Cross Blue Shield of Rhode Island, the FI, during its review of the cost report. As a result, the FI calculated an incorrect FY 1999 inpatient operating cost-to-charge ratio, which resulted in a significant payment error to the hospital.[16]

Specifically addressing the response by CMS, (then "HCFA"), the OIG noted:

> It is our understanding that HCFA has requested that all of RWMC's outlier claims with dates of discharge in FY 1999 be reprocessed.[17]

Consistent with that understanding, the OIG asked RWMC to "[r]epay the overpayment related to its FY 1999 outlier payments (estimated at $3.1 million)." The Provider also notes that the incorrectness of the Intermediary's position that pre-August 8, 2003 outlier payments are not subject to post-payment correction is also shown by the government's real-life recovery from providers of more than $1.2 billion in alleged outlier overpayments from various healthcare systems.[18] The Provider does not agree with the Intermediary's hypothetical example about how an incorrect outlier overpayment based on an error would be retained by the provider under 42 C.F.R. § 412.116(e) as it existed during the time at issue.

The Intermediary contends that it complied with 42 C.F.R. § 412.116(e) as it existed during the time at issue. Under the regulation, outlier payments are not made on an interim basis. Rather, outlier payments are made based on submitted bills and represent final payments. For the Intermediary "final" means "final" as it points out the potential for errors resulting from erroneous update entries goes in both directions. Consider the example of a hospital with an SSI of 7 percent and a newly computed Medicaid ratio of 21 percent. If that latter figure was erroneously entered at 12 percent, we would have the converse of the fact pattern presented here (a 19 percent DSH instead of 28 percent). That hospital would get the later benefit of the

---

[15] OIG, OIG Report No. A-01-01-00517, *Review of Medicare Outlier Payments at Roger Williams Medical Center for Fiscal Year 1999* (June 2001) (excerpts include at Provider Exhibit P-17).
[16] *Id.* at 2-3.
[17] *Id.* at 4.
[18] *See* Provider Final Position Paper at Exhibit P-16.

increased DSH payment once the problem was caught and corrected. It would retain the outlier overpayment.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

PROCEDURAL FINDINGS-JURISDICTION

The Board has jurisdiction over this appeal under its authorizing statute, 42 U.S.C. 1395oo(a) over any provider of services which has filed a required cost report and is dissatisfied with the final determination of the fiscal intermediary as to the total amount of program reimburse due to the provider if the amount in controversy is $10,000 or more and a request for a hearing is made within 180 days after the notice of the intermediary's final determination. There is no question that the Provider timely filed its request for a hearing and is dissatisfied with the Intermediary's final determination with respect to its outlier payments.

Specifically, it is undisputed that the NPR sets forth the "total of the outlier payment amounts determined to be payable to the hospital for the cost reporting period" and that the Provider disputes the amount of outlier payment and, as such, has a right to a Board hearing.[19] Further, even if the Board's determination of jurisdiction under § 1395oo(a) were to be overturned, the Board would exercise its discretionary jurisdiction under § 1395oo(d).[20]

Prior administrative and judicial decisions confirm the Board's jurisdiction over this appeal. For example, in 1996 in *Herrick Hospital and Health Center v. Blue Cross and Blue Shield Association* ("*Herrick*"),[21] the Board decided a case with facts similar to the current appeal. In *Herrick*, the Intermediary experienced problems with its claims processing system and the provider's outlier payments were denied even though they should have been paid. The Board found that it had jurisdiction over the outlier claims at issue in *Herrick* and granted the provider relief on the merits. The Administrator reversed the Board's decision in *Herrick* finding that the Board lacked jurisdiction.[22] However, the U.S. District Court for the Northern District of California reversed the Administrator's decision and reinstated the Board's decision.[23] Subsequent to *Herrick*, the Board has accepted jurisdiction in other cases involving outlier reimbursement issues and the Administrator had declined to review them. Examples include a decision from 2000 in *The Ohio State University Hospital v. Blue Cross and Blue Shield Association*[24] and a decision from 2010 in *Penrose/St. Francis Health Services v. Wisconsin Physician Services, Inc.*[25]

---

[19] PRM § 2906.B.3, Provider Exhibit P-19.

[20] The Board notes that the Provider appealed other issues outside of the outlier issue before the Board and that the Board had jurisdiction under § 1395oo(a) for these other issues. As noted in *Bethesda Hosp. Ass'n, v. Bowen*, 485 U.S. 399, 406 (1988), 42. U.S.C. § 1395oo(d) "allows the Board, *once it obtains jurisdiction pursuant to subsection (a)*, to review and revise a cost report with respect to matters not contested before the fiscal intermediary." (Emphasis added.)

[21] PRRB Dec. No. 96-D41 (July 11, 1996).

[22] *Herrick*, Administrator Dec. (Mar. 23, 1998), *reversing*, PRRB Dec. No. 96-D41 (July 11, 1996).

[23] *See Herrick Hosp. v. Shalala*, Case No. 3:96-cv-03693-WHO (N.D. Cal. Jan. 28, 1998). A copy of the docket is included as Provider Exhibit P-25.

[24] PRRB Dec. No. 2000-D27 (March 8, 2000), *declined to review*, Administrator (Apr. 25, 2000)

[25] PRRB Dec. No. 2011-D2 (October 7, 2010) , *declined to review*, Administrator (Nov. 30, 2010).

OUTLIER PAYMENT ISSUE

After consideration of Medicare law and guidelines, parties' contentions, and evidence presented, the Board finds and concludes that the Intermediary did not use the best available data to calculate the outlier payments. The Intermediary did not meet its obligation to use the "best available data" when calculating the Provider's outlier payments. Even though the Intermediary had the correct factor, the Intermediary used an erroneous DSH factor. The Intermeidary's usage of erroneous DSH factor was inconsistent with the regulatory requirement that it use the "best available data."

CMS discussed in the September 1988 Final Rule that outlier payments would be final and not subject to recalculation based on "later data":

> We proposed to continue our policy that outlier payments would be final and not subject to recalculation based on *later data* that would affect the hospital specific cost-to-charge ratios, indirect medical education adjustment factors, or disproportionate share adjustment factors.[26]

Similarly, in the 2003 Final Rule, CMS stated that outlier payments are made on the "best information available":

> With respect to outliers, it has been CMS's policy that payment determinations are *made on the basis of the best information available at the time a claim is processed* and are not revised, upward or downward, based upon updated data.[27]

These two final rules make it clear that an outlier payment must be made using the best available data at the time of processing and that it cannot be recalculated based on "later" or "updated" data.

The U.S. District Court for the District of Columbia discussed the issue of the "best available data" standard at length in *Baystate Medical Center v. Leavitt* ("*Baystate*").[28] In particular, the Court stated as follows:

> This articulation of the agency's duty is consistent with the repeated recognition in the case law that the agency must use "the most reliable data available" to produce figures that can be considered sufficiently "accurate." *See Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1230 (D.C. Cir. 1994) (holding that, where the agency had used "the most reliable data available" in determining a regional wage index, the agency was

[26] 53 Fed. Reg. at 38503 (emphasis added).
[27] 68 Fed. Reg. at 10420 (emphasis added).
[28] *See* 545 F. Supp. 2d 20 (D.D.C. 2008).

> not required to recalculate Medicare payments for past years based on subsequently corrected data); *Mt. Diablo Hosp. v. Shalala*, 38 F.3d 1226, 1233 (9th Cir. 1993) (holding that, where the agency had used "the most reliable data available at the time," the agency was not required to recalculate a different wage index although data failed to account for part-time workers); *see also County of Los Angeles v. Shalala*, 192 F.3d 1005, 1020-23 (D.C. Cir. 1999) (holding that agency must explain why a more recent database it had considered "reliable" for certain purposes was not used in calculating other Medicare payments where "accurately forecasting" payments depended on use of updated hospital stay data); *Alvarado Community Hosp. v. Shalala*, 155 F.3d 1115, 1125 (9th Cir. 1998) (approving standard requiring "the most reliable data available," and noting that the most recent data available was "highly significant to an accurate determination"). These cases teach that the accuracy of any particular index, payment or, in this case, the SSI fraction, cannot be weighed in a vacuum, but instead must be evaluated by reference to the data that was available to the agency at the relevant time.[29]

Applying this standard to the case before the Board, the Board concludes that the Intermediary had the duty to use the correct DSH figure when it processed and calculated the outlier claims at issue because that correct figure was, in fact, "available" to the Intermediary at the time these outlier claims were processed and calculated.

Per the Intermediary, outlier payments are made based on submitted bills and represent final payments. However, the Medicare program instructions in the manuals provide for a process to adjust bills previously submitted and processed by the Medicare program and the "adjustment bill" process explicitly applies to outlier claims. Section 50 of the Medicare Claims Processing Manual, CMS Pub. No. 100-04 ("MCPM 100-04"), sets forth the process for "changing a previously accepted bill." That guidance is entitled "Adjustment Bills" and states, in relevant part:

> Under prospective payment, adjustment requests are required from the hospital where errors occur in diagnoses and procedure coding that change the DRG, or where the deductible or utilization is affected.[30]

The next section, § 50.1, explicitly addresses outlier claims:

> When a bill is submitted and the hospital or the FI discovers an error, the hospital submits an adjustment request using the Form CMS-1450, if the error is a change in the: . . .

---

[29] *See* 545 F. Supp. at 41 (Italics in original and underline emphasis added).
[30] MCPM 100-04 § 50(B) (copy included as Provider Exhibit P-28).

> • Outlier payment amount.
>
> The provider submits most adjustment requests as debits, using bill type XX8. . . .
>
> The FI then submits the adjustment to the CWF.[31]

Moreover, one of paper-based manuals that was precursor to the internet manuals such as the MCPM is the Medicare Intermediary Manual, CMS Pub. 13-3 ("MIM 13-3"), and § 3664.1 of MIM 13-3 provided instructions regarding outliers to the Intermediary similar to that in MCPM § 50.1. Thus, the "adjustment bill" process is longstanding and explicitly applies to outlier claims. Accordingly, the Intermediary's position that outlier claims are in all circumstances necessarily "final" once made does not withstand scrutiny.

DECISION AND ORDER:

The Board finds that it has jurisdiction over this appeal and hereby orders the Intermediary to recalculate the Provider's FY 2003 outlier payments without including the Operating DSH payment.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: MAY 02 2013

[31] *See* MCPM 100-04 § 50.1 (copy included as Provider Exhibit P-29).