PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D14

PROVIDER -
Harrison House of Georgetown
Georgetown, Delaware

Provider No.: 08-5029

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
Empire Medicare Services (n/k/a National Government Services)

DATE OF HEARING -
September 14, 2007

Cost Reporting Period Ended -
December 31, 1996

CASE NO.: 04-1293

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ISSUES:

1. Whether the Intermediary's notification of the reopening of the Provider's 1996 cost report was timely pursuant to regulatory standards.

2. Whether the Intermediary's determination to disallow costs for the Provider's contracted therapy services 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 to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and 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 out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal 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). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

The Medicare regulation at 42 C.F.R. §405.1885(a) provides that an intermediary may reopen a previous determination with respect to findings on matters at issue in a cost report. Such a reopening must be made within three years of the date of the notice of the intermediary determination. No Intermediary reopening is permitted after three years unless it is determined to have been procured by fraud. 42 C.F.R. §405.1885(d).

Additional rules concerning intermediary reopenings are addressed in CMS Pub. 15-1 §§2930, 2931 and 2932. CMS Pub. 15-1 §2932(A) states the following with regard to notices of reopening and correction.

> The provider or other party will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it

> was necessary to take such action, and the opportunity to comment, object, or submit evidence in rebuttal.

Medicare rules with respect to audit standards, CMS Pub. 13-4 §4112.4(B), provide the following direction to intermediaries:

> Ensure that evidence obtained during the course of the audit is sufficient to enable the auditor to support conclusions, adjustments, and recommendations. Make sure that there is enough factual and convincing evidence so that a prudent person can arrive at the same conclusion of fact as the auditor. In addition, evidence must be competent and relevant. That is, evidence must be valid and reliable and have a logical relationship to the issue/subject under review.

Medicare rules allow for the use of sampling as evidence in audits. CMS Pub. 13-4 §4112.4(B)(1)(e). It states in relevant part:

> Sampling is the application of an audit procedure to less than 100 percent of the items within an account balance or class of transactions to evaluate some characteristic of the balance or class. On the basis of the facts known to the auditor, decide if all transactions or balances that make up a particular account are reviewed in order to obtain sufficient evidence. In most cases, however, the auditor will test at a level less than 100 percent.
>
> There are two general sampling approaches, nonstatistical and statistical. Either approach, when properly applied, can provide sufficient evidential data related to the design and size of an audit sample, among other factors. A nonstatistical sample may support acceptance of findings, but finding must be scientifically established to support adjustments.
>
> Some degree of uncertainty is inherent in applying audit procedures and is referred to as ultimate risk. Ultimate risk includes uncertainties due both to sampling and other factors. Sampling risk arises from the possibility that when a compliance or a substantive test is restricted to a sample, the auditor's conclusions may be different had the test been applied in the same way to all items in the account balance or class of transactions.

The rules provide further guidance for planning samples, selecting a sample and sampling risk. Id.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Harrison House of Georgetown (the Provider) is a 109-bed acute care skilled nursing facility located in Georgetown, Delaware. The Provider filed a cost report for its fiscal year ended (FYE) December 31, 1996 and received a Notice of Program Reimbursement (NPR) from Empire Medical Services (the Intermediary)[1] on September 21, 1999.

In a letter dated August 21, 2002, the Intermediary notified the Provider that a reopening of its FYE 1996 cost report was necessary because the United States Attorney's Office for the District of Delaware (USAODD)[2] advised there were inflated therapy costs reported for the year in question. Exhibit I-8. Subsequent to the receipt of additional information from the USAODD, the Intermediary notified the Provider in a letter dated March 18, 2003 of proposed supplemental adjustment amounts. Exhibit I-10.

The USAODD review indicated that the owner of Whitehorse/Whiteoak Rehabilitation Services, Inc. (Whitehorse), a therapy services company that contracted with the Provider, had intentionally inflated its claims for therapy services. In the study USAODD reviewed claims at the Provider's facility for one month and concluded that the fraudulent scheme extended to all facilities served by the Whitehorse. Exhibit I-9. The Intermediary used the percentages developed by the USAODD to deny charges on the Provider's cost reports for FYEs 1995 and 1996 and for other providers affected by the fraud. All providers affected were allowed 30 days to respond and provide documentation regarding the adjustments. Exhibit I-10. One of the other affected providers appealed its adjustments to the Board on the same two issues. See Harbor Healthcare & Rehabilitation Center v. Blue Cross Blue Shield Association/Empire Medical Services, PRRB Dec. No. 2007-D64, August 24, 2007, Medicare & Medicaid Guide (CCH) ¶81,775; CMS Administrator, October 22, 2007, Medicare & Medicaid Guide (CCH) ¶81,854 (affirming issue 1 - timely notice of reopening and reversing issue 2 – sampling methodology).

The Provider appealed the Intermediary's adjustments to the Board and has met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The amount of Medicare reimbursement in controversy is approximately $57,579.

The Provider was represented by Susan A. Turner, Esquire, of Ober, Kaler, Grimes & Shriver. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of the Blue Cross Blue Shield Association.

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[1] This Intermediary is currently know as National Government Services.

[2] The Intermediary's position papers and exhibits in the record often attribute the investigation is this case to the Office of the Inspector General (OIG) of the Department of Health and Human Services. This is incorrect. The investigation was conducted by the United States Attorney's Office for the District of Delaware.

PARTIES' CONTENTIONS:

Issue 1 – Timely Notice of Reopening

Medicare regulations provide that the Intermediary has three years to reopen a cost report. CMS manual instructions also state when a notice of reopening is sent, it must meet certain standards. CMS Pub. 15-1 §2932(A). The Provider points out that the notice must contain a "complete explanation" of the basis of the revision and offer the provider an opportunity to comment, object or submit evidence in rebuttal.

The Provider alleges that the Intermediary's letter of August 21, 2002, that was within the three year reopening period does not meet the regulatory or manual requirements for a valid reopening notice. It does not contain a complete explanation of the proposed revision to the original settlement nor does it provide the Provider with the opportunity to comment, object or submit evidence in rebuttal. The Provider asserts that the letter itself indicates that it is not a notice of reopening, citing the following language from the August 21, 2002 letter: "[b]ased upon this letter, EMS [the Intermediary] reserves the right to reopen these cost reports when we have completed our review of the details of the OIG review." Exhibit P-4 (emphasis added).

The Provider further argues that the Intermediary has no legal authority to unilaterally extend the three year reopening window set by the regulation. The Provider points out that the Intermediary did not receive the documents describing the results of the audit until November 13, 2002, Exhibit I-9, and could not have made a determination to reopen until after that date. The Provider relies on the Board's previous determination that a prior notice to a provider indicating that an adjustment might be made was not an acceptable notice of reopening. See Norristown State Hospital v. Blue Cross Blue Shield Association/Blue Cross of Western Pennsylvania, PRRB Dec. No. 98-D67, June 19, 1998, Medicare & Medicaid Guide (CCH) ¶80,007; CMS Administrator, declined review, August 5, 1998. The Provider states that the August 21, 2002 letter reserving its right to reopen is not an acceptable notice of reopening. A subsequent Intermediary letter sent March 18, 2003 arguably met the CMS requirements, i.e., it notified the Provider that its cost reports were in fact being reopened; however, the March 18, 2003 letter was issued beyond the three year time limit for reopenings.

The Provider also points out that the provision extending the three year time limit for fraud does not apply in this case because Whitehorse committed the fraud without any knowledge of the Provider.

The Intermediary argues that the August 21, 2002 letter notifies the Provider that the Intermediary intends to reopen its FYE 1996 cost report. This letter was within the three year time limit provided for in the regulation and provided the necessary reason for the reopening, i.e., inflated therapy costs. The Intermediary notes the facts in Harbor, supra, were essentially the same as this case and that the majority of the Board found the August 21, 2002 letter to be adequate notice under the rules.

Issue 2 – Sampling Methodology

The Provider contends that the Intermediary's sampling methodology was fatally flawed. The Provider acknowledges that it may be appropriate to use sampling as a basis for an intermediary's adjustment, however, proper standards must be followed. The sampled evidence must be reliable and have a logical relationship to the issue/subject under review. In this case, the "universe" was all the Provider's rehabilitation costs for the years under review, but the cost report adjustments were based on review of only a single month's worth of therapy logs. The Provider points out that the Intermediary's witness testified that he "could not do any form of random statistical sample" in this case, Tr. at 102:13-15, and also conceded that "[t]here is no GAAP or genuinely accepted auditing standard that permits judgmental sampling" – the level of sampling performed in this case. Tr. at 103:6-9. The Provider contends that a judgmental, non-scientific sample is not permitted under CMS Pub. 13-4 §4112 et seq., where it states that "[a] nonstatistical sample may support acceptance of findings, but findings must be scientifically established to support adjustments."[3]

The Intermediary maintains that it used the best and only evidence available in order to make the adjustments. The Intermediary notes that in the Harbor case, the CMS administrator recognized the covert nature of fraud but that the level of evidence in this case was sufficient to meet the high standard needed for a criminal conviction. The CMS Administrator also noted that the criminal fraud finding supported the finding of a pattern of fraudulent billing and found it reasonable to rely on this methodology to support the adjustment.

Finally, the Intermediary recognized that the Provider had not engaged in any misconduct but noted that it was required to furnish documentation to justify its costs by the regulations at 42 C.F.R. §§413.20 and 413.24. The Provider was given an opportunity to furnish documentation to dispute the adjustment, Exhibit I-10, but the Provider never justified further reimbursement.

The Provider further contends that Medicare law and policy require that the restitution payments received in this case from late 2002 to 2005 be offset against therapy expense incurred in the year in which the payments are received, rather than disallowing of the entirety of the estimated restitution through an adjustment to its FYE 1996 cost report. The Provider contends that the regulation at 42 C.F.R. §413.98 is clear that any monies received from a vendor as a return of overpayments must be offset against comparable purchases in the cost reporting period in which the refund is received. Id. at §413.98(c). See also CMS Pub. 15-1 §804. The Provider indicates that it treated the restitution in this manner on the Provider's parent company, Salisbury Retirement Center's cost report for FYE 12/31/2003. Exhibit P-8.

The Intermediary states that even if it accepted the Provider's assertion that it offset the money it received in later years, it notes that the Provider is under PPS in later years so the refunds are not reducing their Medicare costs and they have no effect. Tr. at 38:9-18.

[3] See, CMS Pub. 13.4, §4112.4(B)(l)(e).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and program instructions, the parties' contentions, and evidence presented, finds and concludes as follows:

Issue 1 – Timely Notice of Reopening

The regulation at 42 C.F.R. §405.1885(a) provides that any request to reopen must be made within three years of the date of notice of the intermediary determination. The regulation at 42 C.F.R. §405.1887(a) provides that all parties to any reopening shall be given written notice of the reopening with a complete explanation of the basis for the revision and 42 C.F.R. §405.1887(b) provides that the parties shall be allowed a reasonable period of time in which to present any additional evidence or arguments in support of their position. The Medicare manual further delineates requirements of a notice of reopening. At CMS Pub. 15-1 Section 2931 entitled: Reopening and Correction. The section states in relevant part:

> . . . the term "reopening" means an affirmative action taken by an intermediary . . . to reexamine or question the correctness of a determination or decision otherwise final.

And CMS Pub. 15-1 §2932.A states that:

> When any determination or decision is reopened as provided in § 2931 or it is decided not to reopen, notice of such reopening (or refusal to reopen -- see § 2931.1 below) will be mailed to the provider or other parties to the determination or decision at their last known address. The notice of reopening will be issued by the intermediary, intermediary hearing officer the PRRB, or the Secretary making the reopening as required by § 2931.1. The provider or other party will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it was necessary to take such action, and the opportunity to comment, object, or submit evidence in rebuttal.

The Board majority finds that the Intermediary letter dated August 21, 2002, which was within the 3-year reopening period, did not meet the requirements of a notice of reopening because it only indicated that the Intermediary "reserves [its] right to reopen" the 1995 and 1996 cost reports when it had completed its review of the details of the USAODD's review and did not provide any opportunity for the Provider to comment, object, or submit additional information in rebuttal. Exhibit I-8.

We find further support for our conclusion in the Intermediary's own letter dated March 18, 2003, which reads in part as follows:

> This letter is a follow-up to my letter dated August 21, 2002 in reference to the potential reopening of your 1995 and 1996 cost reports. Please be advised that a reopening of those cost reports are (sic) necessary per HCFA Pub. 15-1 section 2931. . . . The cost report is being reopened to remove from your cost report inappropriate therapy costs that were determined to be unallowable as a result of a U.S. Attorney's office audit. . . .
>
> However, it is EMS' policy to allow you 30 days to respond to these findings before calculating a revised settlement. (emphasis added.)

The Board majority finds that it was not until the March 18, 2003 letter that the Intermediary affirmatively notified the Provider that it would reopen the cost reports and provided the requisite opportunity for the Provider to respond.

Finally, the Board also refers to the Intermediary letter dated June 9, 2002,[4] Exhibit I-11. It states the following:

> This letter is a follow-up to my previous letter dated March 18, 2003. At that time EMS[the Intermediary] informed you of the reopening of your 12/31/95 and 12/31/96 cost reports. The purpose of the reopening is to recoup the overpayments made by the Medicare program for services rendered by the Whitehorse Rehabilitation Services.

The Board majority finds that the March 18, 2003 letter constituted the actual notice of reopening, with the requisite request for documentation, but that this notice was not received by the Provider until after the three year limit. As a result, the Intermediary's adjustments stemming from the improper reopening should be reversed.

The regulation, 42 C.F.R. §405.1885(d), does not apply to the circumstances in this case to extend the three year reopening period. The extended reopening period for fraud is only applicable where the decision was "procured by fraud or similar fault of any party to the determination or decision." There is no claim that the Provider procured or in any way contributed to the fraud.

Because another decision arising from the same circumstance indicates the Board majority's decision regarding the reopening issue may be reversed, for purposes of judicial economy, the Board will also address the sampling issue.

Issue 2 – Sampling Methodology

The Board finds that the facts in this case are different than those in our previous decision in Harbor, supra. In Harbor, the revisions made to that provider's cost report, removing a

[4] The date on letter was incorrect, it should read June 9, 2003.

percentage of therapy costs, were not based upon a determination made with regard to that provider's own records. Also in Harbor, the Intermediary used a limited one month sample to support an adjustment that applied to two full cost reports. In this case, the Intermediary has based its adjustment on data from the Provider. In addition, the one month sample period was applied to a 7 month period, January 1996 through July 1996, of the Provider's cost reporting period.

Medicare rules allow for the use of sampling to support adjustments when proper standards are followed. CMS Pub. 13-4 §4112 et seq. The Board finds that the sampling method used by the Intermediary in this case did not meet the relevant audit standards and should not be applied beyond the time period of the sample.

Medicare rules with respect to audit standards in CMS Pub. 13-4 §4112.4(B) provide that "evidence must be competent, and relevant . . . valid and reliable and have a logical relationship to the issue/subject under review." The manual describes four categories of evidence that may be used: physical, documentary, analytical and testimonial. Under the analytic category, it allows for the use of statistical methods. Under the testimonial category, it notes that this type of evidence is the least reliable and should be corroborated with additional evidence. Id.

The manual describes "sampling" as the application of audit procedures to less than 100 percent of the items within an account balance or class of transactions to evaluate some characteristic of the balance or class. The sampling approach may be statistical or nonstatistical; however, a nonstatistical sample may support "acceptance" of findings, but when non-statistical, the findings "must be scientifically established to support adjustments." After obtaining and testing the various types of evidence considered, an auditor should retain documentation and where materiality is a factor, the auditor should define materiality within the scope and objective of the audit. The auditor is required to document the evidence obtained and the procedures applied to support the audit conclusions. Id.

Based upon the above stated rules, the Board finds that the Intermediary may utilize a sampling methodology to determine the propriety of the costs claimed by the Provider but must use competent evidence sufficient to support its adjustments. The evidence must be relevant, reliable and logically related to the issue under review and the evidence obtained and procedures used to support the audit results should be documented.

Testimony at the hearing indicated that there were records for only one month found to support the prosecution of Whitehorse employees and the analysis on which the adjustments are based. Tr. at 50-51 and 60-61.

The following facts are documented in the record. First, the USAODD conducted an investigation of a therapy services company – Whitehorse/Whiteoak Rehabilitation Services. Exhibit I-9. The investigation resulted in the indictment of two Whitehorse employees in January 2001. Exhibit I-3. The indictment states that employees of Whitehorse recorded the time they spent providing services at nursing homes in monthly

logs and that the two employees who created and ran the company caused these logs to be altered to increase the number of units listed. Id. at 1-4. Using these altered, inflated logs, the two employees prepared invoices to the nursing homes they served requesting payment in excess of the amount actually due in or around the period of December 1995 through April 1996. Id. at 5-6. No copies of the monthly logs used to support the indictment or the sample were in the record. See Intermediary Post Hearing Brief at 11, fn. 2. The only information in the record that states the basis for the adjustments to the Provider's costs is contained in a letter from an auditor in the U.S. Attorney's Office for the District of Delaware. Exhibit I-9. It states in relevant part:

> Enclosed are the spreadsheets which represent the process for estimating the amount of unearned therapy costs billed by Whitehorse/Whiteoak to four nursing homes in Delaware. The percentage of the therapy estimated to be bad was developed from altered logs at one location for the month of January 1996. Witness interviews indicated that the same thing occurred at all four facilities during the entire time the company served those locations. The percentage bad from the one month at the one facility was then applied to all speech and occupational therapy invoices to all four facilities.

None of the witnesses referred to appeared to testify nor were they identified. Likewise, the author of the letter did not appear.

The Board's concerns with the sampling method relied upon by the Intermediary is based on a number of factors. While the Board accepts that Whitehorse inflated its therapy service claims and that there is direct evidence of the extent of the problem at the Provider's facility for a period of time, the record provides very little information about how this analysis was actually conducted. All that is said is that the percentages of the therapy costs estimated to be bad were developed from altered logs for the month of January 1996. There is no evidence in the record to show that the same level of alteration applied to the entire seven month period. In addition, the Board points out that the time period for "count one" in the indictment was from December 1995 through April 1996 and therefore, adjustments for seven months have no basis. Exhibit I-3 at 6. The Board finds that there was insufficient evidence in the record to support the sample being a competent and valid basis for determining overpayments at the Provider's facility beyond one month and certainly, not for the months outside the indictment.

Finally, if the Board's decision not to permit a reopening is upheld, the Intermediary should nevertheless be permitted to recoup any funds the Provider receives from the ordered restitution. If the reopening is permitted and the recoupment of funds permitted from the cost year at issue, the Board finds that there should be no offset of restitution made in future years.

DECISION AND ORDER:

Issue 1 – Timely Notice of Reopening

The Board majority finds that the August 21, 2002 letter was not adequate notice of reopening within the three-year time limit. The reopening of the Provider's cost report was improper and the Intermediary's adjustments should be reversed.

Issue 2 – Sampling Methodology

The Board finds that the use of the Intermediary's one month sample should not be applied beyond that one month period. The Intermediary's adjustment's should be modified.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes (Dissenting as to Timeliness of Notice)
Michael D. Richards, C.P.A.

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairperson

DATE: March 17, 2009

Dissenting Opinion of Yvette C. Hayes: (Issue 1: Timely Notice of Reopening)

I find the Intermediary's letter dated August 21, 2002 was a proper notice of its intent to reopen according to CMS' regulatory instructions. The Board majority concluded that the Intermediary's letter dated August 21, 2002 did not meet the CMS requirements for a reopening notice because the notice included the following language "reserved [its] right to reopen" and because it did not instruct the Provider of its right to comment, object, or submit information. I respectfully dissent.

A "request" to reopen must be made within three (3) years, according to CMS regulations at 42 C.F.R. §405.1885, which state:

> . . . Any such request to reopen must be made within 3 years of the date of the notice of the intermediary or Board hearing decision or where there has been no such decision, any such request to reopen must be made within 3 years of the date of the notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

The above regulation speaks to how a request is to be made; however, it does not infer or suggest that such a request will be granted or that a reopening will (or will not) actually occur.

If the request is made within the timeframe established, then it does act as a place holder until such time as a review can be completed and a determination made. 42 C.F.R. §405.1887 speaks to what happens next in this process:

> (a) All parties to any reopening described above [in § 405.1885] shall be given written notice of the reopening. When such reopening results in any revision in the prior decision notice of said revision or revisions will be mailed to the parties with a complete explanation of the basis for the revision or revisions. . . .
>
> (b) In any such reopening, the parties to the prior decision shall be allowed a reasonable period of time in which to present any additional evidence or argument in support of their position.

If a decision is reached that no reopening is warranted then the fiscal intermediary issues a 'notice' to that affect. And if a decision is made to reopen and correct a determination then the fiscal intermediary issues a 'notice' according to the instructions found in the regulations and manuals.

In this case, the Intermediary gave the Provider written notice on August 21, 2002 (well within the 3-year time period) that it had initiated the process of taking another look at its determination in light of new evidence that had been brought to its attention. If and only if, after the intermediary's review is completed and a re-determination is made that

a revision is required would the intermediary then proceed to “reopen” its initial determination and propose any necessary adjustments or corrections.

The use of the words “reserve our rights to reopen” and references to “potential reopening” are not contrary to the regulations or manual provisions regarding “how to” reopen an intermediary’s determination. The language found in the March 18, 2003 letter stating: “[t]he cost report is being reopened to remove...” is appropriate and properly notifies the Provider of the actions taken on the reopening request initiated on August 21, 2002 which states that upon review, the Intermediary has determined that a reopening is required and proceeds to provide all the requisite information to the Provider to include: 1) proposed adjustments; 2) reasons/rationale for adjustments; and 3) an established a time frame to respond to the Intermediary’s findings with supporting documentation.

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Yvette C. Hayes