CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Harrison House of Georgetown **Provider** **vs.** **BlueCross BlueShield Association/ Empire Medicare Services (n/k/a National Government Services)** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Year Ending: December 31, 1996** **Review of:** **PRRB Dec. No. 2009-D14** **Dated: March 17, 2009**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's decision. CMS' Office of Financial Management (OFM) submitted comments requesting reversal of the Board's decision on Issue No. 2. The Provider submitted comments requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

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 ending (FYE) December 31, 1996 and received a Notice of Program Reimbursement (NPR) from the Intermediary on September 21, 1999.

In 1999, the United States Attorney for the District of Delaware began an investigation of Linda Pappert and Richard Waxler, principals of Whitehorse Rehabilitation, a therapy company that provided speech and occupational therapy services pursuant to a contract with the Provider and five other nursing facilities. It was determined that Pappert, Waxler, and other employees of Whitehorse had fraudulently altered therapy logs to reflect that more

therapy hours had been provided than was actually the case.[1] While the case was successfully prosecuted as a criminal matter, the Office of Inspector General did not pursue the case civilly and requested the Intermediary take administrative action to recover the overpayment of therapy hours. In a letter dated August 21, 2002, the Intermediary notified the Provider that a reopening of its FYE 1996 cost report was necessary due to inflated therapy costs. The Intermediary notified the Provider, in a letter dated March 18, 2003, of the proposed supplemental adjustment amounts. This letter included a spreadsheet prepared by the U.S. Attorney's Office. That spreadsheet described an error rate, expressed as a percentage, found by the Department of Justice on review of therapy documents prepared by Whitehorse for this Provider from the single month of January 1996. The Intermediary used these fraud estimates to determine the amount of overpayment. The Provider was given 30 days to respond and provide additional information and documentation regarding the adjustments. The Provider made no submissions to the Intermediary. The Provider appealed these adjustments to the Board.

ISSUES AND BOARD'S DECISION

ISSUE NO. 1:

Issue No. 1 involved whether the Intermediary's notification of the reopening of the Provider's 1996 cost report was timely pursuant to regulatory standards. The Board majority found that the Intermediary's letter of August 21, 2002 was within the three-year reopening period, but did not meet the requirements of a notice of reopening. The letter 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 U.S. Attorney's Office for the District of Delaware's review. The letter did not provide any opportunity for the Provider to comment, object, or submit additional information in rebuttal, as required by regulation and CMS manual provisions.

---

[1] See Exhibit I-3 in Intermediary's Revised Position Paper. Pappert and Waxler pled guilty to charges of conspiracy to commit wire fraud in September 2002. See Exhibits I-4 and I-5 in Intermediary's Revised Position Paper. Pappert was sentenced to a two-year term of imprisonment, and ordered to pay restitution to the Salisbury Retirement Center, the corporate parent of the Provider. See Exhibit I-4 in Intermediary's Revised Position Paper. Waxler and Pappert were also jointly and severally ordered to pay restitution to the Salisbury Retirement Center. Id. While Waxler made restitution payments to the six defrauded nursing facilities in the amount of $200 per month from 2002 to 2005, in accordance with a sentencing order, no restitution payments have been made by Pappert. See Transcript of Oral Hearing, p. 55.

The Board majority found further support for its conclusion in the language of the Intermediary's letter dated March 18, 2003. Based on these findings, the Board majority found 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. Additionally, the Board noted that the Intermediary's letter dated June 9, 2003, noted in part that: "This letter is a follow-up to my previous letter dated March 18, 2003. At that time EMS informed you of the reopening of your 12/31/95 and 12/31/96 cost reports." Thus, the Board majority concluded that the March 18, 2003 letter was the actual notice of reopening, but was not within the three-year limit. As such, the Intermediary's reopening and adjustments were improper.

The Board majority also noted that the regulation at 42 C.F.R. §405.1885(d)[2] does not apply because 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." The Board majority stated that there is no claim that the Provider procured or in any way contributed to the fraud.

One member of the Board dissented on this issue. The dissent found that the Intermediary's letter dated August 21, 2002 was a proper notice of its intent to reopen according to CMS' regulatory instructions. The dissent noted that, while the regulation at 42 C.F.R. §405.1885 speaks to how a request to reopen is to be made, 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, it acts as a place holder until such time as a review can be completed and a determination made. The dissent noted that 42 C.F.R. §405.1887 speaks to what happens next in the process: that the parties will be given written notice of the reopening and that the parties to any such reopening will be allowed a reasonable period of time in which to present any additional evidence or argument in support of their position.

Thus, the dissent noted, if a decision is reached that no reopening is warranted then the intermediary issues a 'notice' to that affect, and if a decision is made to reopen and correct a determination, then the intermediary issues a 'notice' according to the instructions found in the regulations and manuals. In this case, the dissent found, the Intermediary gave the Provider written notice on August 21, 2002, 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 was completed and a re-determination made that a revision was required, would the intermediary then proceed to "reopen" its initial determination and propose any necessary adjustments or corrections.

---

[2] This regulation is now recodified at 42 C.F.R. §405.1885(b)(3) pursuant to the Final Rule in the May 23, 2008 Federal Register. See 73 Fed. Reg. 30190, 30266.

The dissent noted that the Intermediary's 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…" was appropriate and properly notified the Provider of the actions taken on the reopening request initiated on August 21, 2002 which stated that upon review, the Intermediary had determined that a reopening was required and proceeded to provide all the requisite information to the Provider including proposed adjustments, reasons/rationale for the adjustments, and an established time frame to respond to the Intermediary's findings with supporting documentation.

ISSUE NO. 2:

Issue No. 2 involved whether the Intermediary's determination to disallow costs for the Provider's contracted therapy services was proper. The Board found that the facts in this case were different from those in Harbor Healthcare & Rehabilitation Center v. Blue Cross Blue Shield Association/Empire Medical Services, PRRB Dec. No. 2007-D64 (August 24, 2007).[3] The Board noted that in Harbor, the revisions made to that provider's cost report, removing a percentage of therapy costs, were not based upon a determination made with regard to that provider's own records. In addition, 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 based its adjustment on data from the Provider. In addition, the one month sample period was applied to a seven-month period, January 1996 to July 1996, of the Provider's cost reporting period.

The Board noted that, while Medicare rules allow for the use of sampling to support adjustment when proper standards are followed, the Board found 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. The Board stated that based upon Medicare rules with respect to audit standards in the Intermediary Manual (CMS Pub. 13-4) §4112.4(B), 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.

The Board noted that its concerns with the sampling method relied upon by the Intermediary were based on a number of factors. The Board stated that, while they accepted that Whitehorse inflated its therapy service claims and that there is direct evidence of the extent

[3] The CMS Administrator reviewed on October 22, 2007 and affirmed Issue No. 1 regarding timely notice of reopening and reversed Issue No. 2 regarding sampling methodology.

of the problem at the Provider's facility for a period of time, the record provides very little information about how this sampling analysis was actually conducted. All that was said was that the percentages of the therapy costs estimated to be inflated were developed from altered logs for the month of January 1996. The Board claimed that there was no evidence in the record to show that the same level of alteration applied to the entire seven-month period. In addition, the Board pointed out that the time period for "count one" in the indictment was from December 1995 through April 1996 and therefore, provided no basis for the adjustment to services for part of the cost reporting period. The Board found 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, the Board noted that, if their 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 is permitted from the cost year at issue, the Board noted that there should be no offset of restitution made in future years.

SUMMARY OF COMMENTS

The Provider commented, asserting that the Board's decision was both factually and legally correct, and noted the Board's decision should be affirmed for the reasons set forth in their position papers. The Provider also requested that the Administrator take note that there is no claim that the Provider procured or in any way contributed to the fraud for which the unrelated therapy provider pled guilty in Federal court. Thus the challenged adjustments made by the Intermediary, and reversed by the Board, were not based on any fraud committed by, or attributable to, the Provider.

The Intermediary commented, recommending reversal of the Board's decision on both issue for the reasons set forth in the Intermediary's Post-Hearing Memorandum filed with the Board.

CMS' Office of Financial Management (OFM) commented, recommending that the Administrator reverse the Board's decision on Issue No. 2.[4] Regarding the appropriateness of the sampling methodology used by the Intermediary in determining the rehabilitation costs when fraud was perpetuated on the Provider, OFM stated that it disagreed with the Board's ruling that the removal of therapy costs was not based upon a determination made with regard to relevant audit standards. OFM noted that the Provider argued that the

[4] OFM noted that it could not comment on the first issue, regarding whether the Intermediary had issued a timely reopening notice in accordance with the three-year reopening time limit, as that issue fell outside their scope of authority.

sampling was not appropriate and did not follow the normal audit standards. OFM stated that, while it did not deny that the sampling methodology was unique and departed from normal practices, the Board failed to recognize that this case involved fraud, and that unique methods sometimes are necessary to determine the appropriateness of payments.

In this case, OFM stated that the Provider records alone probably could not show how Whitehorse inflated their invoices. Thus, the Office of the Inspector General (OIG) was forced to rely on different levels of evidence and sampling to reach its conclusion. In addition, OFM noted, based on the findings of the investigation, the Intermediary proposed its adjustments and gave ample opportunity for the Provider to dispute the adjustments or provide documentation refuting the calculations. The Board's narrative shows that no response or information was received from the Provider. OFM asserted that it was the Provider's responsibility to provide adequate support and to furnish documentation to justify its costs as reported on the cost report. OFM stated that in this case, fraudulent costs were known, and the Provider could not or would not refute those fraudulent charges. Thus, even a flawed sampling methodology would be superior to the alternative of the Intermediary disallowing all of the therapy costs until adequate documentation reflecting the actual costs of the therapy services could be provided. OFM concluded that the percentage used by the Intermediary may represent the best data available for making a determination.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. The Administrator has reviewed the Board's decision. All comments timely submitted have been taken into consideration.

ISSUE NO. 1:

The Medicare program was established to provide health insurance to the aged and disabled.[5] 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.[6]

[5] 42 U.S.C. §§1395-1395cc.
[6] See 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

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.[7] 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).[8] 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.[9]

The Medicare regulations at 42 C.F.R. §405.1885(a) provide 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 notice of the intermediary determination. No intermediary reopening is permitted after three years unless it is established that such determination was procured by fraud or similar fault of any party to the determination.[10]

The regulations at 42 C.F.R. §405.1887 note that all parties to any reopening shall be given written notice of the reopening. Upon receiving this notice, the parties must be allowed a reasonably period of time in which to present any additional evidence or argument in support of their positions. Additional written notice must be provided to all parties upon conclusion

---

[7] 42 C.F.R. §413.20.

[8] 42 C.F.R. §405.1803.

[9] 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

[10] 42 C.F.R. §405.1885(d) and (e). As the Provider noted in their comments, the Intermediary in this case did not rely on the fraud or similar fault exception of §405.1885(d). While "fraud or similar fault" has not been defined in the regulation, CMS has noted that the term "was inserted as original language in our reopening regulations, and we are not aware that intermediaries have had any problem in interpreting its meaning." 73 Fed. Reg. 30190, 30233 (May 23, 2008). CMS further stated that while fraud shows intentionally false oral or written representation of a matter or fact, or concealment of a matter that should have been disclosed, "similar fault" covers determinations that do not rise to the level of fraud, for instance, a provider receiving money that it knew or reasonably should have known it was not entitled to. Id. Additionally, 42 C.F.R. §405.902, which provides definitions for all of section 405, states, "Similar fault means to obtain, retain, convert, seek, or receive Medicare funds to which a person knows or should reasonably be expected to know that he or she or another for whose benefit Medicare funds are obtained, retained, converted, sought, or received is not legally entitled. This includes, but is not limited to, a failure to demonstrate that he or she filed a proper claim as defined in part 422 of this chapter." The Administrator notes that evidence in the records suggests that the Provider might have at least reasonably known of the fraud being carried out by Whitehorse. See, e.g., Exhibit I-6 in Intermediary's Revised Final Position Paper.

of the reopening, regarding what matter(s), if any, are being revised, with a complete explanation of the basis for any revisions.

Additional procedures concerning intermediary reopenings are addressed in §§2930, 2931 and 2932 of the Provider Reimbursement Manual (PRM). Section 2932 of the PRM 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 necessary to take such action, and the opportunity to comment, object, or submit evidence in rebuttal.

In this case, the NPR for the FYE 12/31/96 cost report was issued on September 21, 1999. The Administrator finds that the August 21, 2002 letter was within the three-year time limit established in the regulation and was adequate notification of a reopening.

The Administrator does not agree with the Board's characterization of certain language in the August 21, 2002.[11] The language in the letter clearly indicates that it is a notice of reopening. The Intermediary specifically identified in the subject line of the August 21 letter that it was regarding "Reopening of the 1996 and 1997 cost reports for Medicare purposes." In addition, the first line of the letter states that "a reopening of the 1995 and 1996 cost reports are (sic) necessary."

Thus, the subject line and first line clearly indicated that this was a reopening notice. Additionally, the Intermediary pointed out in the second paragraph that the three year window to reopen would not expire until September 21, 2002. Therefore, "it is still within the three year reopening limit." The March 18, 2003 letter confirmed that the cost report would be reopened and adjustments made.

The Intermediary provided an explanation of the basis for the reopening in the August 21, 2002 letter, noting that: "Our review of the correspondence we have received indicates that the Provider reported inflated therapy costs for those cost reports (sic) years." The Intermediary also stated:

> EMS reserves our right to reopen these cost reports when we have completed our review of the details of the OIG review. At this writing, we are unsure whether additional information will be necessary from the provider.

---

[11] For example, the Board ruled that the language, "EMS [the Intermediary] reserves our right to reopen these costs reports when we have completed our review of the details of the OIG review," was an indication that the Intermediary may reopen at a later date.

This clearly indicated that the Intermediary, by this letter, was notifying the Provider of its "intention to reopen" and/or correct the indicated cost reports, subject to the completion of its review of the OIG report and that additional information may be needed from the Provider before a final adjustment could be made. The Administrator finds that a notice of reopening may indicate that further analysis is needed to determine the extent of any corrections.[12] Section §2932.A of the PRM, provides that, after a notice of reopening is issued, it may be determined that no correction is warranted, and if so, the provider will be notified accordingly. As no final adjustment was being made at the time of issuance of the letter, it would have been premature for the Intermediary to have given the Provider the "opportunity to comment, object, or submit evidence in rebuttal." The Provider was given an opportunity to respond to the Intermediary's findings, once they were made, and before the Intermediary calculated the revised settlement.[13]

Thus, as the August 21, 2002 letter was within the three-year limit for reopening and was adequate notice of reopening according to the regulations and manual provisions, the Administrator finds that the reopening of the Provider's cost report was proper.

ISSUE NO. 2:

The Intermediary's adjustment reduced the Provider's allowable contract therapy costs based upon the results of a statistical sample of the documentation of their therapy services.

The Medicare procedures with respect to filed audit standards, set forth in the Intermediary Manual (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 procedures allow for the use of sampling as evidence in audits. Section 4112.4(B)(1)(e) of the Intermediary Manual states in relevant part:

---

[12] See, e.g., §2932.A of the PRM, which provides that after a notice of reopening is issued, it may be determined that no correction is warranted, and if so, the provider will be notified accordingly.

[13] See Intermediary's March 28, 2003 letter to Provider.

> 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 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 findings 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 procedures provide further guidance for planning samples, selecting a sample and sampling risk.

The Administrator finds that the Intermediary properly adjusted the Provider's subject cost reports to remove the inappropriate therapy costs. The Administrator notes that the dispute in this case involves the propriety of the Intermediary's adjustments to disallow certain therapy costs based on percentages derived from a sample, developed by the United States Attorney's office. The Provider argued and the Board agreed that the methodology used by the Intermediary was not valid as it did not meet certain audit standards. However, the Administrator finds that the circumstances surrounding the adjustments involved fraud, thus, unique methods were necessary to determine the appropriateness of payments.

Generally, standard audit and sampling methodology are measurements of payment errors. However, these methodologies are not measurements of fraud. Fraud, by its very definition, involves a knowing misrepresentation or concealment of a fact. Thus, given the covert nature and level of evidence necessary to meet the definition of fraud, methods used to establish fraud might be considerably different than those used to detect other payment errors and are not necessarily addressed by typical auditing procedures.

In this case, the United States Attorney's office established that there was a pattern of fraudulent billing by Whitehorse. The percentages of the therapy costs estimated to be bad were developed from altered logs for the Provider for the month of January 1996. The

methodology developed for the recoupment of the overpayment for therapy services made to the Provider as a result of the fraudulent activity of Whitehorse was based on the only evidence available to the Intermediary. The January 1996 documentation was the only available source by which the percentage of overpayment could be determined. As such, its use was consistent with generally accepted professional standards. Additionally, the auditor from the U.S. Attorney's Office for the District of Delaware testified that the January log was "in the early goings of Whitehorse…and they ramped it up from later on. They were actually billing more a half year later…"[14] Thus, the extrapolations made, based on the January 1996 data, were reasonable estimates of the fraud being conducted at later periods.

The Administrator takes judicial notice of the criminal fraud proceedings and the factual and legal findings therein contained. The standard of proof for criminal fraud is significantly higher than the burden of proof for an Administrative Procedures Act guided administrative hearing. Therefore, the factual findings in the criminal matter, that this same pattern of fraud occurred during the entire time at issue involving the same criminal defendants, need not be readjudicated in this administrative case, and those findings are herein adopted. The Administrator finds that there was sufficient evidence in the record to support the sample being a competent and valid basis for determining overpayments at the Provider's facility for the time period at issue. Thus, the Administrator finds that the methodology applied by the Intermediary in this case was valid and reasonable under the circumstances of this case, was appropriate and is supported by the record.

Additionally, the Administrator notes that with respect to payments, §1815 of the Act states that:

> [N]o such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Further, §1816(a) of the Act states that the Secretary has delegated to the fiscal intermediary the responsibility of determining the amount of any such payments due a provider under the Program. Thus, a provider must submit the documentation necessary to satisfy the intermediary as to the amount due for services rendered under the program.

Consistent with the Act, the regulation at 42 C.F.R. §413.20, provides that:

> The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payment under the program….

[14] See Transcript of Oral Hearing, pp. 69-70.

Further, the regulation at 42 C.F.R. §413.24, states that:

> Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This data must be based on their financial and statistical records which must be capable of verification by qualified auditors.

In addition, the PRM at §2300 states that providers must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The PRM at §2304 notes that cost information must be current, accurate, and in sufficient detail to support costs claimed by providers in rendering services to beneficiaries. Documentation to substantiate costs is to include, among others things, ledgers, books, records and original evidences of cost.

In this case, the Provider did not subsequently provide documentation to support the therapy hours actually provided once it was established that the logs were altered and could not be used to support the claimed contracted therapy service costs. Thus, the Intermediary used the best available data to estimate allowable therapy costs. The Administrator finds this was a reasonable alternative to the disallowance of all the costs that were associated with therapy services provided by Whitehorse which could not be substantiated. Consequently, the Intermediary's adjustment is affirmed.

Finally, with respect to the restitution issue, the Provider had argued that the PRM requires that a provider report any payments received as a reduction in its expense incurred in providing therapy services in the year that the "discounts", "allowances", or "refunds" of expenses are received, and noted that this is the method the Intermediary should have been using for the restitution payments.[15] However, in this case, regardless of any restitution payments, CMS appropriately determined that Medicare would not share in the payment for inflated fraudulent cost of services.[16]

Accordingly, after review of the record and applicable law, the Administrator finds that the Intermediary's notification of the reopening of the Provider's 1996 cost report was timely pursuant to regulatory standards, and that the Intermediary's determination to disallow costs for the Provider's contracted therapy services was proper.

---

[15] The Provider noted in its Revised Final Position Paper at p. 17 that documentation it had been offsetting restitution payments received on its cost reports was provided to the Intermediary in February 2006 in an effort to resolve the appeal administratively.

[16] Moreover, the Intermediary pointed out that, as the Provider was operating under PPS for the year at issue, there was no offset of expenses affecting Medicare reimbursement.

DECISION

ISSUE NO. 1:

The Administrator reverses the decision of the Board in accordance with the foregoing opinion.

ISSUE NO. 2:

The Administrator modifies the decision of the Board in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: **5/8/2009** **/s/**

Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services