PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D100

PROVIDER - St. Francis Memorial Hospital San Francisco, California	**DATE OF HEARING-** January 9, 1998
Provider No. 05-0152	Cost Reporting Period Ended - June 30, 1982 and 1983
vs.	
INTERMEDIARY - Blue Cross and Blue Shield Association/ Blue Cross of California	**CASE NO.** 93-1013

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ISSUE:

Did the Intermediary abuse its discretion in refusing to reopen the Provider's cost reports for the fiscal years ("FYE") ended June 30, 1982 and 1983?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Francis Memorial Hospital ("Provider") is a 307 bed, short-term, non-profit hospital serving the San Francisco area since July 1, 1966. Blue Cross of California ("Intermediary"), issued a Notice of Program Reimbursement ("NPR")[1] for the fiscal years ("FY") 1982 and 1983 on January 30, 1984, and September 4, 1984, respectively.

The Provider filed two timely reopening requests for FYEs 1982 and 1983 to correct material errors in the cost reports pursuant to the Medicare regulation at 42 C.F.R. § 405.1885, Reopening a Determination or Decision. The requests were filed on January 30, 1987 and September 3, 1987 which in both instances was on the last day or next to last day of the three (3) year reopening period, i.e., 3 years from the date of the NPRs.[2]

The January 30, 1987 reopening request for the FY 1982 cost report identified 8 issues with a brief comment and stated that:

> Additional data will be forthcoming upon completing a review of the audited workpapers in your office. The effect on reimbursement is estimated to be in excess of $150,000.

Id.

On March 16, 1987, the Intermediary acknowledged receipt of this reopening request for FY 1982 stating:

> We will proceed with the reopening as time permits. When the reopening is completed, you will be notified by means of a revised Notice Of Program Reimbursement of any changes resulting from this reopening.[3]

Id.

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1 Provider Exhibits 3A & 3B.

2 Provider Exhibits 4A and 4B.

3 Provider Exhibit 5

The Provider's September 3, 1987 reopening request for FY 1983 included the following documentation:

- Documentary evidence that the cafeteria costs reported on Worksheet “A” of the cost report were understated by $187,746 due to the misclassification of salaries and employee benefits for personnel in the dietary cost center who also performed functions in the cafeteria; and

- Supporting computations showing the Medicare settlement data were not correctly allocated to the various ancillary cost centers.

On September 23, 1987, the Intermediary denied the FY 1983 reopening request for insufficient documentation; and then cited examples of required information to make a comprehensive review.[4]

On March 23, 1992, the Provider requested the Intermediary to proceed with the reopening of the cost reports for the fiscal years 1982 and 1983; and provided the following information:

- Identified salaries and employee benefits of $224,549 that should be reclassified from the dietary cost center to the cafeteria cost center for the FY 1982;

- Withdrew the Emergency Room Admitting Clerk Issue (Issue #2), the Interest Income Issue (Issue #4), the Medical Supply Issue (Issue #5), and the Employee Benefits Issue (Issue #6) from the reopening request for FY 1982; and

- Submitted a list of employees showing salaries and employee benefits that should have been reclassified from the dietary cost center to the cafeteria cost center, amounting to $187,746, for FY 1983.

On February 5, 1993, the Intermediary denied[5] the Provider's requests to reopen the cost reports for the FYs 1982 and 1983 because: “Sufficient supporting documentation detailing the issues in question was not submitted to enable the Intermediary to make a reopening decision within the 3 year statute of limitations.” Id.

On March 15, 1993, the Provider filed a timely request to the Provider Reimbursement Review Board (“Board”) appealing the Intermediary's denial to reopen the cost reports for FY

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[4] Intermediary Exhibit 1, second letter.

[5] Provider Exhibit 7; and Intermediary Exhibit 1, first letter.

1982 and 1983 as an abuse of discretion, and has met all of the jurisdictional requirements of 42 C.F.R.
§§ 405.1835-.1841. The amount of Medicare reimbursement in dispute is approximately $150,000.

The Provider was represented by James C. Ravindran, C.P.A. and David S. Kornblum, C.P.A.. The Intermediary's representative was Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

Background of Relevant Medicare Statutory, Regulatory, and other Authorities:

Pursuant to the Medicare regulations and Provider Reimbursement Manual ("HCFA Pub. 15-1"), a provider of services has two avenues to seek reimbursement adjustments. Both avenues are referred to as a "reopening." The most common type is a formal appeal to the Provider Reimbursement Review Board ("Board") [or intermediary if the amount is less than $10,000] after the intermediary has issued a final notice of program reimbursement ("NPR") which results in a reopening of the NPR if the appeal is ultimately successful. Under this procedure, the provider must make a timely appeal within 180-days of the NPR pursuant to 42 C.F.R. § 1801 et seq. The second avenue is to seek a "reopening of the cost report" either after the cost report has been filed or where an appeal was not pursued. Where an appeal was not pursued, then a reopening of both the cost report and the NPR is involved. 42 C.F.R. § 405.1885 and HCFA Pub. 15-1 § 2931.2 govern requests to reopen NPRs and cost reports.

Under the above regulation, jurisdiction is granted exclusively to the entity making the last NPR determination. This provision states:

> (c) Jurisdiction for reopening a determination or decision rests exclusively with that administrative body the rendered the last determination or decision.

42 C.F.R. § 405.1885(c).

All circuit courts reviewing this provision have agreed that it grants "discretionary authority" to reopen a decision or determination, such as an NPR. All but one circuit court have ruled that an intermediary's discretionary decision refusing to reopen is not reviewable by either the Board or a Court. However, the Ninth Circuit, where this Provider is located, holds that the Board has limited jurisdiction to review for an abuse of discretion by the intermediary when refusing to reopen. The Ninth Circuit Court stated:

> Thus, on the basis of section 2931.2, the Board can decide whether or not the fiscal intermediary abused its discretion because either (1) new and material evidence exists; (2) a clear and obvious error was made; or (3) the determination is found to be inconsistent with the law, regulations, and rules or general construction.

State of Oregon v. Bowen, 854 F. 2d 346 349-50, (9th Cir. 1988).

Under section 405.1885, the NPR must be reopened within three (3) years from the date of notice of the NPR. This provision states:

> no such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

42 C.F.R. § 405.1885(a).

The filing of an appeal under § 405.1801 et seq. or the Intermediary's formal issuance of a Notice of Reopening that it intends to reopen an NPR pursuant to § 405.1887, have both been held by the Board and the courts to suspend or toll the running of the 3-year statute of limitations period.[6] There have been no rulings of the effect of a timely filed reopening request on the 3-year period, i.e, whether the 3-year period is suspended.

The manual instructions regarding a reopening state:

> Whether or not the Intermediary will reopen a determination, otherwise final, will depend upon whether new and material evidence has been submitted, or a clear and obvious error was made, or the determination is found to be inconsistent with the law, regulations, and rulings, or general instructions.

HCFA Pub. 15-1 § 2931.2 (emphasis added).

The provider has the burden of proving that its reimbursement claim is allowable;[7] and has the burden of timely proving other aspects of its claims under the regulations.

PROVIDER'S CONTENTIONS:

The Provider makes the following contentions:

1. That the Intermediary acted in an arbitrary and capricious manner in denying the valid request to reopen the FY 1982 cost report when there had been an assurance to reopen

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6 Rapides Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Louisiana, PRRB Dec. 94-D5, December 30, 1993, Medicare and Medicaid Guide (CCH) ¶ 42,054.
Eastwood Hospital v. BCBS Assn., PRRB Dec. 86-D118, September 30, 1986, Medicare and Medicaid Guide (CCH) ¶ 35,962.

7 HCFA Ruling 79-60c; Fairfax Hospital Association, Inc. v. Califano, 585 F. 2d 602 (4th Cir. 1978).

stated in the acknowledgment letter of March 16, 1987 which was later was rescinded.

2. That the Intermediary abused its discretion when denying the Provider's reopening requests for FY 1982 and 1983 cost reports to correct clear and obvious material errors because it was based on erroneous interpretations of the Medicare rules and regulations discussed below.

3. The Intermediary's denial is an abuse of discretion because it is based on the wrongful assertion that:

> [s]ufficient supporting documentation detailing the issues in question was not submitted to enable the intermediary to make a reopening decision within the 3 year statute of limitations.

Therefore, the Intermediary did not even attempt to evaluate the merits of the two requests.

4. That the requests were timely even if mailed on the last or next to last day of the regulatory 3-year period, <u>see</u> § 405.1885.

5. That there is no regulation or manual instruction that:

   a. requires or prescribes that all documentary evidence must be submitted with the reopening request; or

   b. requires the intermediary to make the necessary evaluation and adjustment within the 3-year period.

   (i) In fact, intermediaries are afforded prolonged time periods beyond the 3-year time limit to obtain relevant information when making a unilateral reopening of its own.

   (ii) The refusal to obtain or receive supplemental documentation was arbitrary and capricious resulting in a clear abuse of discretion.

   (iii) A letter from BCBSA regarding requests for reopenings specifically stated:

   > A Plan is required to review the issue to determine the validity of the request and, if necessary, request the documentation to make a determination and propose an adjustment.

   (iv) Fairness requires any timely filed reopening request must be treated equally including a “last minute” request.

I

The Provider asserts the Intermediary acted in an arbitrary and capricious manner when it ultimately denied the valid reopening request for the FY 1982 cost report because there had been an assurance to reopen stated in the March 16, 1987 acknowledgment letter:

> We will proceed with the reopening as time permits. When the reopening is completed, you will be notified by means of a revised Notice of Program Reimbursement of any changes resulting from this reopening.

Id.

The Provider relied on this statement that there would be a reopening based on the merits of its claim.

II & III

The Provider asserts that on February 5, 1993, the Intermediary abused its discretion when denying the Provider's requests to reopen the cost reports for FY 1982 and 1983 to correct clear and obvious material errors because of erroneous interpretations of the Medicare rules and regulations. The denial is clearly an abuse of discretion since it is based on the wrongful assertion that:

> Sufficient supporting documentation detailing the issues in question was not submitted to enable the intermediary to make a reopening decision within the 3 year statute of limitations.

Id.

The effect of this statement entails three misinterpretations which are discussed in detail in section V below:

1. that all documentation for a reopening must accompany the request;
2. that the intermediary can not request, seek, or obtain the necessary information; and
3. the reopening must be made within the 3-year statute of limitations period.

IV

The Provider asserts its reopening requests were timely even if mailed on the last or next to last day of the regulatory 3-year period under section 405.1885. The Provider states the regulations only require that a request for reopening be made within the 3-year period:

> any such request for reopening 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 the 3 years of the date of notice of the intermediary determination.

42 C.F.R. § 405.1885(a).

The Provider asserts the reopening requests were timely because the mailing date, rather than the date of receipt, is the controlling date under this section. The Provider also cites HCFA Pub.
15-1 § 2931.1G as further support because in computing the 3-year period the "dates of notice" of an NPR or decision is used rather than a date of receipt; and the 3-year period ends on the third anniversary of that date.

V

The Provider contends that there is no regulation or manual instruction that:

a. requires or prescribes that all documentary evidence must be submitted with the reopening request; or

b. precludes the Intermediary from seeking or accepting documentation after the reopening request and/or the expiration of the 3-year period, or

c. requires the intermediary to make the necessary evaluation and adjustment within the 3-year period.

a. Documentary Evidence:

The Provider asserts that there is no regulation or instruction that requires all documentary evidence must be submitted with the reopening request, or that the intermediary is restricted to the four corners of the reopening request.

The Provider declares its reopening requests were sufficient on their face and met all regulatory requirements.

The Provider argues that the Intermediary's denial for "sufficient documentation detailing the issues" far exceeds any requirements prescribed in the Medicare regulations and instructions, and is not supported by Board or court decisions. Contrary to the Intermediary's statement, the Provider asserts that both reopening requests were supported with documentation showing that there was a material obvious error on two issues. Namely, that both the "Cafeteria costs" and the "Medicare Settlement Data" were understated. With respect to the second issue, the Intermediary possessed the appropriate data to correct the understatement because it is based on claims paid subsequent to the Intermediary's cut-off date of the paid claims summary which is created by the Intermediary.

With respect to FY 1982, the Provider asserts additional data was submitted on September 3, 1987; and again on March 23, 1992[8] when the reopening request for FY 1982 was resubmitted with more documentation. For example, on the “Cafeteria” issue, auditable records, such as the Dietary Payroll for the fiscal years 1982 through 1987 and the “Payroll Labor Distribution” report for the fiscal year 1982 were submitted to support an adjustment of the Cafeteria costs, i.e., a reclassification from the dietary cost center to the cafeteria cost center of $224,549. (Note: same information was also submitted for FY 1983).

The FY 1983 reopening request made on January 30, 1987 included documentary evidence to correct “clear and obvious” material errors for the understatement of both the cafeteria costs and the Medicare settlement data.

> Auditable records, such as the Dietary Payroll for the fiscal years 1982 through 1986 and the “Payroll Labor Distribution” report for the fiscal year 1983 were submitted to support the reclassification of Dietary cost center personnel who also performed duties in the Cafeteria. The Intermediary was advised that $187,746 of salaries and employee benefits should be reclassified from Dietary to the Cafeteria cost center for the fiscal year 1983.
>
> With respect to the Medicare Settlement Data issue, the reopening request stated the Intermediary's determination was incorrect because of the:
>
> 1) exclusion of claims paid subsequent to the Intermediary's cut-off date of the paid claims summary; and
>
> 2) mismatching of revenues and expenses in several cost centers.

The Provider argues there was no additional documentation to submit on this issue because the Intermediary had the necessary information/data to support the adjustment, i.e., an updated PS&R report made by the Intermediary would have identified the claims paid after the cut-off date.

<u>b & c. Development of Documentation and Evaluation of the Reopening Request Under 42 C.F.R. § 405.1885</u>

The Provider argues that the Intermediary is not restricted to the four corners of the reopening request, nor is there any regulation or manual requirement to file all supporting documentary

[8] Provider Exhibit 3.

evidence with the reopening request nor is a requirement to complete the evaluation within the 3-year time period.

At the hearing, the Provider's representative testified[9] that four Board cases[10] essentially hold that the reopening requests must be submitted within the prescribed three year period; thereafter, the documentation could be requested and reviewed; and a final reopening can be processed by the intermediary, if appropriate.

The Provider claims that the regulation at 42 C.F.R. § 405.1885(a) affords the Intermediary a reasonable amount of time to evaluate and to request documentation, if necessary. This regulation section, cited above, only requires a reopening request to be made within the 3-year period and contemplates a reasonable time period for evaluation which may include securing of relevant information.

The Provider asserts that the refusal to obtain or receive supplemental documentation was arbitrary and capricious resulting in a clear abuse of discretion. The Provider also asserts an intermediary is required to evaluate a request on its merits. The Provider declares the Intermediary abused its discretion when it failed to evaluate the request on its merits because of two erroneous allegations that there was insufficient documentation and that the evaluation could not be performed within the 3-year period.

The Provider declares that intermediaries are afforded prolonged time periods beyond the 3-year time limit to obtain relevant information, make an evaluation, and to make a reopening of its NPR. The Provider cites the case of <u>Eastwood Hospital v. Blue Cross and Blue Shield Association</u>, PRRB Dec. 86-D118, September 30, 1996, Medicare and Medicaid Guide (CCH) ¶ 35,962, where the Board upheld an Intermediary's revised NPR issued nearly seven years after the notice of reopening which was made within the 3-year period. The decision also stated that the 3-year period was tolled by the Intermediary's notice of reopening. Since an intermediary is permitted to develop data beyond the 3-year period for its own NPR reopenings, then it was obligated to fully inquire into necessary information to enable a full evaluation of the Provider's reopening request on its merits.

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9 TR at p. 8.

10 <u>Rapides Regional Medical Center vs. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Louisiana</u>, PRRB Dec. 95-D5, December 30, 1993, Medicare and Medicaid Guide (CCH) ¶ 42,054.
<u>Providence Hospital vs. Blue Cross and Blue Shield Association/Blue Cross of California</u>, PRRB Dec. 95-D22, February 13, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,081, <u>Rev'd</u> HCFA Admr., CCH ¶ 43,252.
<u>Eastwood Hospital vs. Blue Cross and Blue Shield Association</u>, PRRB Dec. 86-D118, Medicare and Medicaid Guide (CCH) ¶ 35,962.

The Provider also maintains a letter[11] from Blue Cross and Blue Shield Association ("BCBSA") regarding requests for reopenings supports the above argument when it specifically stated:

> We have received clarification from the Office of General Counsel (OGC) that a timely request for reopening must be addressed. The three-year reopening period is held in abeyance until the Intermediary responds to the reopening request within the interpretation of 42 C.F.R. 405.1885. . . . Therefore, a Plan is required to review the issue to determine the validity of the request and, if necessary, request the documentation to make a determination and propose its adjustment.

Provider Exhibit 11.

Thus, pursuant to this letter, the 3-year period is tolled while the intermediary obtains necessary information to address and evaluate the merits of the reopening request.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its denial of the Provider's request to reopen the cost reports for FYs 1982 and 1983 was not an abuse of discretion because:

1) the denial was appropriate and supported by the Medicare regulations and HCFA instructions, such as the Provider Reimbursement Manual, Part 1, (HCFA Pub. 15-1);

2) the HCFA Administrator's decision in Providence, supra., requires the reopening request itself to be supported with significant and material evidence of a clear and obvious error, etc.; and

3) there must be a substantial clear and obvious error established by a provider before there is the possibility of tolling of 3-year statute of limitations period and imposing a burden on the intermediary's to obtain additional data to address the merits of an issue. The Provider has misinterpreted an internal letter from BCBSA administratively resolving another case with different facts.

I

The lntermediary asserts that the denial to reopen the cost reports was not an abuse of discretion because the decision was in accordance with relevant regulations and HCFA Instructions. The Intermediary has not addressed the merits of the issues raised by the Provider because the Intermediary's denial was caused by the Provider's failure to provide

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[11] Provider Exhibit 11.

new and material evidence to warrant a reopening of the cost reports pursuant to relevant regulations and general instructions.

The Intermediary states there are certain regulatory requirements that a Provider must meet for any reimbursement claims:

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

42 C.F.R. § 413.24.

In addition, the provision further states that the requirement of adequacy of data implies that data be accurate and in sufficient detail to accomplish the purpose for which it is intended.

The Intermediary also relies on two manual sections which state:

> Reopening an Intermediary determination - an Intermediary's initial determination of the amount of Program payment contained in a notice of amount of program reimbursement, which is otherwise final may be reopened by the Intermediary within the three years of the date of such notices.

HCFA Pub. 15-1 § 2931.lA.

> Whether or not the Intermediary will reopen a determination, otherwise final, will depend upon <u>whether new and material evidence has been submitted, or a clear and obvious error was made</u>, or the determination is found to be inconsistent with the law, regulations, and rulings, or general instructions.

HCFA Pub. 15-1 § 2931.2 (emphasis added).

The Intermediary asserts that in this particular case, the Provider failed to comply with § 2931.2 by not submitting any new and material evidence to the Intermediary sufficient to justify the reopening of the cost report within the three year period, i.e., from the date of the original NPR. In fact, the reopening requests only provided enough information about the issues to deny the reopening request.

The Intermediary claims its decision to refuse reopening was based on sound, reasonable, and legal discretion because the data submitted with the reopening requests was inadequate, i.e., it failed to detail the issues in question to enable the Intermediary to render a decision on the merits of the issues.

II

The Intermediary's representative believes the Provider's reliance on the Board's ruling in the Providence case was flawed as evidenced by an Intermediary letter, dated March 20, 1995,[12] and an analysis of that case. Further, the Intermediary's representative stated[13] that the HCFA Administrator reversed the Board's holding in Providence. The Board held that where there was a timely reopening request, then the burden of developing the provider's case fully was shifted to the Intermediary. The HCFA Administrator, however, held the provider has the burden of presenting in its reopening request significant evidence or an articulation of a clear and obvious error. Applying that test to this case, the Intermediary states the reopening requests fail to provide significant evidence or an articulation of a clear and obvious error. The Provider submitted no evidence with the FY 1982 request and insufficient data with the FY 1983 request.

At the hearing, the Intermediary's representative stated that the FY 1982 reopening request[14] contained no evidence at all and only gave an estimate of the total amount in dispute pertaining to eight issues; and that on its face, it did not articulate any clear and obvious errors of any kind. Moreover, the last full paragraph on page three stated:

> Additional data will be forthcoming upon completing a review of audited workpapers in your office.

Thus, the Intermediary representative concluded the Provider wanted to review Intermediary work papers to figure out what kind of case they had rather than submit evidence concerning the issues listed.

With regard to the FY 1983 reopening request,[15] the Intermediary representative cross examined a Provider witness[16] concerning the schedule attached to the reopening request in the Provider's exhibit relevant to the “Cafeteria” issue. The representative described the format of the schedule as four columns identified as FYs 82, 83, 84, and 85 with a listing of names and related earnings and benefits by each year. The representative asked:[17]

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[12] Intermediary Exhibit 3.

[13] TR. at pp. 15 - 21.

[14] Provider Exhibit 1.

[15] Provider Exhibit 3A.

[16] TR at p. 26 - 29.

[17] TR at pp. 27-28.

Q. Okay. Now, to your knowledge that schedule was not attached to the January 30, 1987 request.

A. No, the work was done subsequent to that.

Q. Okay. If you would look at point seven now, is cafeteria, is that a separate cost on the cost report, on the cost center?

A. Yes.

Q. Is Dietary a separate cost on the cost center?

A. Yes.

Q. Is there any way of just looking at numbers in the cost center as they are presented on a cost report and know whether they are right or wrong?

A. A good consultant can make a judgement whether the cafeteria costs are exceeding the low or high and that was the determination we made, they were exceeding the low.

Q. Is that judgement at all communicated in the description of issue seven? All it says is that the numbers are wrong.

A. It says understated and that is very obvious looking at the cost report.

Q. Okay. But that cost report is nowhere in the record of this case, is it?

A. It is not in the record of this case.

Q. . . . It is your position that anybody looked, a reasonable person looking at the numbers at a cost report, would see some type of distortion.

A. An obvious distortion, yes.

Q. Okay. But that position was not articulated or backed with any numbers in the narrative or with any exhibits attached to the January 30, 1987 reopening request...

A. We stated that it was understated.

The Intermediary representative concluded that the reopening request did not contain any material evidence nor was there an articulation of an obvious error. This requirement must be met before the Intermediary can even undertake the issue and address the merits thereof.

III

The Intermediary asserts that there must be a substantial clear and obvious error established by the Provider before there is the possibility of tolling the 3-year statute of limitations period and imposing a burden upon the intermediary to obtain more data to address and resolve the merits of an issue.

The Intermediary representative discussed at the hearing[18] that 42 C.F.R. § 405.1885(a) calls for the filing of a reopening request within the 3-year period, and it also closes with the requirement that no such determination or decision may be reopened after such 3-year period, except as provided in subparagraphs (d) and (e) of this section. The subparagraphs had no application to this case. If read literally, all necessary material had to be in well in advance of the 3-year deadline. Thus, the representative stated, if a request were made close to the end of the 3-year period with adequate evidence, then it would be possible to suspend making the decision. However, there must be a substantial clear and obvious error established before the decision can be suspended which was not done in this case.

The Intermediary representative maintained the Provider had misinterpreted an internal letter between BCBCA and a Plan which administratively resolved another case with a different factual situation. The Intermediary disagrees with the Provider's claim that pursuant to this letter, the 3-year period is tolled while the intermediary obtains necessary information to address and evaluate the merits of the reopening request. The representative asserted that in the case discussed in the letter, a clear and obvious error had been established. Namely, that the intermediary had made an adjustment removing some assets not related to patient care, but failed to remove the corresponding liability which meant the equity capital computation was obviously in error. Therefore, the Intermediary was required to correct this obvious error even beyond the 3-year period.

In the present case, the Intermediary states the Provider's requests only made assertions of an obvious error with no supporting evidence establishing such errors. The Provider's FY 1982 request affirmatively stated additional data would be provided only after a review of the Intermediary's work papers; and the FY 1983 request only contained a schedule listing earnings and benefit information of named employees for four years without any explanation of the relevance of the data.

The Intermediary concluded that the BCBSA letter had no application in this case; and that the mere filing of a timely reopening request does not impose an obligation on the

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18 TR at pp. 20 - 21.

Intermediary to develop the case which would include accepting more information beyond the 3-year period.

CITATION OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Regulations - 42 C.F.R.:

§ 405.1801 et seq.	-	Provider Reimbursement Determinations and Appeals
§ 405.1885 et seq.	-	Reopening a Determination or Decision
§ 405.1887	-	Notice of Reopening
§ 413.24	-	Adequate Cost Data and Cost Finding

2. Program lnstructions - Provider Reimbursement Manual, Part I, HCFA Pub. 15-1:

§ 2931.l et seq.	-	Reopening and Correction-Time Limits for Reopening
§ 2931.2	-	Reopening Final Determination on Cost Reports

3. Cases:

Eastwood Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. 86-D118, September 30, 1986, Medicare and Medicaid Guide (CCH) ¶ 35,962.

Fairfax Hospital Association, Inc. v. Califano, 585 F.2d 602 (4th Cir. 1978).

Providence Hospital v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. 95-D22, February 13, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,081, Rev'd HCFA Admr. Dec., April 6, 1995, CCH ¶ 43,262.

Rapides Regional Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Louisiana, PRRB Dec. 95-D5, December 30, 1993, Medicare and Medicaid Guide (CCH) ¶ 42,054.

State of Oregon - O.B.O. Oregon Health Services v. Bowen, 854 F.2d 346 (9th Cir. 1988).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, and documentary evidence presented, testimony elicited at the hearing, and posthearing briefs, finds and concludes that the Intermediary did not abuse its discretion when denying the reopening requests for FYs 1982 and 1983.

With regard to the basic issue of the Intermediary's abuse of discretion when denying the reopening requests for FYs 1982 and 1983, the Board takes judicial notice that: i) generally, an intermediary decision not to reopen a cost report is not reviewable under 42 C.F.R. § 405.1885(c) which grants exclusive jurisdiction for a “reopening” to the last administrative body that rendered the determination; but, ii) the Provider is located in the Ninth Circuit, where the U.S. Court of Appeals in Oregon, supra, held that the Board has limited jurisdiction to review for an abuse of discretion when an intermediary denies a reopening request.

Therefore, the limited issue for resolution in this case is whether the Intermediary abused its discretion in denying the Provider's reopening requests for FYs 1982 and 1983. The Board considered HCFA Pub. 15-1 § 2931.2 for guidance in this case as prescribed by Court of Appeals in the Oregon case, supra. This provision states:

> Whether or not the intermediary will reopen a determination, otherwise final, will depend upon whether, 1) new and material evidence exists, or 2) a clear and obvious error exists, or 3) the determination is found to be inconsistent with the law, regulations, and rulings or general constructions.

Id.

The Board recognizes the Provider has the burden of proof to establish any one of the above three elements. The Board also believes that the standard of review for this case is whether the intermediary exercised sound, reasonable, and legal discretion, or whether an intermediary's conclusions and judgement were clearly erroneous.

The Board finds the Provider filed two timely reopening requests, January 30, 1987 for FY 1982 and September 3, 1987 for FY 1983. Both requests were made on the last day or next to last day of the three (3) year reopening period as required by 42 C.F.R. § 405.1885(a). The Board finds that the Intermediary did not dispute the timeliness of these requests; and, that the Intermediary's acknowledgement of the FY 1982 reopening request did not create any obligation to, in fact, make a reopening as suggested by the Provider.

The Board finds that the Provider did not sustain its burden of proof because the two reopening requests did not contain an adequate or sufficient articulation of or documentation that:

1) new and material evidence existed, or 2) documentation that a clear and obvious error existed, or 3) documentation that the Intermediary's determination was inconsistent with the law, regulations, rulings, or instructions.

The Board finds that the Intermediary denied the FY 1983 reopening request initially on September 23, 1987 for insufficient documentation; and that this denial effectively placed the Provider on notice that the FY 1982 request was also insufficient. The Board finds that the Intermediary denied both of the Provider's reopening requests for FYs 1982 and 1983 on February 5, 1993, because:

> "Sufficient supporting documentation detailing the issues in question was not submitted to enable the Intermediary to make a reopening decision within the 3 year statute of limitations."

The Board, after reviewing all of the parties' documentation and relevant Medicare authorities, upholds the Intermediary's overall decision; but concludes the 3-year statute of limitations aspect requires clarification. The Board takes notice that the 3-year period is tolled where providers make appeals and when an intermediary issues a notice of reopening under 42 C.F.R. § 405.1887; and the Board believes a similar response is warranted in situations like this case.

The Board believes that an Intermediary has an obligation to promptly review and evaluate a timely made reopening request regardless of when it is made. As in this case, reopening requests were made on the next to last and the last day of the 3-year period, thereby making the 3-year time period critical. The Board concludes that within the scope of the provisions of 42 C.F.R. 405.1885, if a timely request is made close to the end of the 3-year period, then the three-year reopening period may be held in abeyance for a reasonable time to enable the Intermediary to properly evaluate, respond and take appropriate action concerning a reopening request. If the Intermediary were convinced by either the articulation of or documentary evidence that a significant or clear and obvious error existed, or that the NPR was not properly based upon Medicare authorities, then the Intermediary has a reasonable time to obtain and verify data, if necessary, to make its decision together with any reopening which could occur beyond the 3-year period.[19]

[19] The Intermediary initially responded and denied the FY 1983 reopening request on September 23, 1987 which was 19 days after the 3-year period. On February 5, 1993 both reopening requests were denied which was 6 years after the FY 1982 request.

The Board agrees with the Intermediary's representative's observation at the hearing[20] that, where a reopening request is made close to the end of the 3-year period [as in this case], it is impossible to review the reopening request, make a decision, respond, and make the reopening, if appropriate, within the 3-year period. Thus, intermediaries must review, evaluate, decide, and make reopenings promptly where the 3-year period is a critical factor.

In this case, the Board reiterates that the Provider's reopening requests had insufficient documentation for the Intermediary to make a decision to reopen either cost year. Contrary to the Provider's allegations of a clear and obvious error, the Board finds the Provider did not establish that a clear and obvious error existed.

The Board finds that the FY 1982 request was completely devoid of any documentation or definitive information of an error regarding either issue. The Board notes the request initially cited eight issues of which six were later withdrawn, and there was no documentation regarding these issues. More definitive information was not submitted until March 22, 1992, which was not sought by the Intermediary, and under any circumstances was too late, i.e, more than 5 years after the reopening request. The Board notes the Provider characterized this transmission as a resubmission of the FY 1982 reopening request which by any standard was too late.

The Board took special note of the Intermediary's September 23, 1987 denial of the FY 1983 reopening request because of the Provider's lack of detailed explanations and documentation to support the allegations of clear and obvious errors. This letter explained the problems with the request and specified the type of additional information/documentation needed to complete the review and evaluation. The Board concluded that the one schedule submitted with the FY 1983 request did not sufficiently identify the specific relevance to the stated cafeteria issue. The Board found the Intermediary's comments to be fair and reasonable.

The Board also noted the Intermediary’s initial FY 1983 response was only 20 days after the request. Although the February 5, 1993 denial of both FY 1982 and FY 1983 was nearly six years after the FY 1982 request, the Provider should have known the FY 1982 request was deficient by the substance of the Intermediary's comments made on September 23, 1987. That is, if the FY 1983 request contained only one document deemed insufficient, then the FY 1982 request with no documentation had to be insufficient.

The Board finds that the Provider erroneously attempted to shift the burden to the Intermediary regarding the Medicare settlement data issue, i.e, that an updated PS&R report was needed which was beyond the control of the Provider. Since both requests were being

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20 TR pp. 20-21: You had kind of an impossibility of responding to a reopening request that came close to the end. So, under those circumstances, you would suspend your decision until you had time to make your decision.

submitted virtually 3 years from the NPR, the Provider had possession of -or- access to -or- should have obtained such reports that were generated a few months after the NPR.

The Board also notes the Intermediary letter of March 20, 1995[21] explained in more detail that it reviewed all the documents submitted, discussed its findings, had specified the type of additional information/documentation needed, and had reviewed the merits of the requests.

The Board concludes that the Intermediary considered the merits of the Provider's reopening requests and properly set forth the reasons for denial including the lack of documentation in its denial letters of September 23, 1987 and February 5, 1993. Therefore, the Board finds that the Intermediary exercised sound and reasonable judgement in denying the Provider's reopening request, and there was no abuse of discretion when refusing to reopen the Provider's FYs 1982 and 1983 cost reports.

DECISION AND ORDER:

The Board concludes that the Intermediary did not abuse its discretion when refusing to reopen the Provider's cost reports for FYs 1982 and 1983. The Intermediary's determination is affirmed.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire
Martin W. Hoover, Jr. Esquire
Charles R. Barker

FOR THE BOARD:

Irvin W. Kues
Chairman

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[21] Intermediary Exhibit 3.