PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

98-D58

PROVIDER -
The Mary Imogene Bassett Hospital
Cooperstown, New York

Provider No. 33-0136

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Empire Blue Cross and Blue Shield

DATE OF HEARING-
April 22, 1997

Cost Reporting Periods Ended -
December 31, 1979;
December 31, 1980

CASE NO. 85-0058

INDEX

ISSUE:

Was the Intermediary's refusal to reopen the Provider's cost reports for the fiscal years ending December 31, 1979, and December 31, 1980, an abuse of discretion?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Mary Imogene Bassett Hospital (the "Provider") is a 180 bed voluntary not-for-profit teaching hospital located in Cooperstown, New York. The Provider elected to receive reimbursement for the costs of its salaried physicians under the Teaching Amendment, 42 U.S.C.
§ 1395x(b)(7), whereby direct costs of medical and surgical services rendered to Medicare patients in a teaching hospital are reimbursed as a provider of service on a reasonable cost basis. These costs are separately accumulated and apportioned using an average cost per diem, and require a Provider to accumulate data to count individually each outpatient visit day.

For Providers (electing reimbursement under the Teaching Amendment) unable to accumulate data to calculate their outpatient visit days, the Secretary promulgated two additional methods to calculate outpatient visit days. These additional methods are set forth in the Provider Reimbursement Manual, (PRM) HCFA Pub. 15-1, at Sections 2218.C3.a. and b.

The " 3a formula" backs into a hypothetical Medicare outpatient visit day figure by using a mix of provider data: inpatient days, inpatient charges, physician service costs etc. The "3b formula" calculates the outpatient visit days by using a statistical sample from a provider's outpatient records.

Rather than apply any of the three methodologies prescribed by the Secretary, (as described above) the Intermediary computed the physician reimbursement by using the total number of outpatient physician visits. The formula used by the Intermediary resulted in an under-reimbursement to the Provider for physician services rendered to Medicare beneficiaries. Notices of Program Reimbursement (NPRs) were issued for the 1979 and 1980 years on October 31, 1981, and September 30, 1982, respectively.[1]

By letter dated November 11, 1983, the Provider requested that the Intermediary reopen its cost reports to redetermine the physician reimbursement for several years, including 1979 and 1980. This was followed by other written and oral communications between the Provider and Intermediary.

On January 25, 1984, the Intermediary wrote to the New York Regional Office of the Health Care Financing Administration (HCFA) seeking advice with respect to the Provider's request

---

[1] Provider Exhibit 6, Tab B.

to reopen. On June 20, 1984, the Regional Office indicated that reopening was not available since the Provider always had the option in its original cost report to use the method of reimbursement sought in the request to reopen.

On October 22, 1984 the Provider requested that the Provider Reimbursement Review Board (Board) review the Intermediary's refusal to reopen.[2] However, the Board dismissed the Provider's case citing lack of jurisdiction over an intermediary's refusal to reopen.

In November 1986, the Provider filed a lawsuit in the United States District Court for the Northern District of New York, seeking judicial review of the Board's decision that it lacked jurisdiction over the Provider's appeal. Subsequently, the Court granted final judgement in favor of the Provider and ordered the Board to assume jurisdiction over the Provider's appeal.[3]

PROVIDER'S CONTENTIONS:

The Provider contends that HCFA Pub. 15-1 § 2931.2 states that the reopening of an otherwise final reimbursement determination depends on whether any of the following criteria have been met: 1) new and material evidence has been submitted; 2) a clear and obvious error has been made; or 3) the determination is inconsistent with the law, regulations and rulings, or general instructions.

The Provider contends that the Intermediary's use of an unauthorized reimbursement methodology is inconsistent with the law and regulations. Specifically, the Provider points out that there are three permissible methodologies which may be employed in calculating the total number of outpatient visit days under the Teaching Amendment. The first method, as set forth in 42 C.F.R. § 405.465(h)(3), counts one visit day for each calendar day that a patient visits the outpatient department. Two alternative methods are provided; the "3a formula" (HCFA Pub.
15-1 § 2218.C.3.a.), and the "3b formula" (HCFA Pub. 15-1 § 2218. C.3.b.).

The Provider contends that for 1979 and 1980 the Intermediary used the total number of outpatient visits, rather than outpatient visit days, as required under the rules referenced above. The Provider's request to reopen sought application of the alternative method for determination of outpatient visit days using the "3a formula". Consequently, the Intermediary's determination is argued to be inconsistent with the applicable regulation and thus subject to reopening. The Provider also contends that the use of outpatient visits rather than visit days constitutes a clear and obvious error, which is another ground for reopening.

---

[2] Provider Exhibit 8.

[3] Provider Exhibit 9.

The Provider asserts that it presented the Intermediary with all requested information and documentation, and that the original determination not to reopen was based on advice from the HCFA Regional Office, not the inadequacy of records. At the hearing, no evidence was introduced to show that the documentation was inadequate by 1983 standards.[4] Therefore, the Intermediary should not be permitted to perform a de novo review wherein it now asserts new grounds for its decision.[5]

The Provider contends that the Intermediary, in denying the reopening, ignored the central issue of the use of an improper methodology and characterized the Provider's request as one for a change in a cost reporting option not originally elected. The Provider contends that this action is not sound, reasonable or logical (the PRRB standard of review in abuse of discretion cases).[6] It is an abuse of discretion for the Intermediary to ignore the options approved by Congress and enacted as regulations and Medicare program instructions, than to use an option it prefers as more convenient.

The Provider asserts that on February 17, 1995 the United States District Court for the Northern District of New York issued a final judgement with respect to the Provider's 1982 cost report year.[7] The court held that the Intermediary's failure to use an approved methodology in determining the Provider's outpatient visit days was improper. The court then ordered the case remanded to the Secretary for recalculation of the reimbursement amount based on either appropriate application of the "3b formula", or a manner of reimbursement which most closely corresponds to the Provider's circumstances and accommodates the Provider's accounting capability. Based on this decision, the Provider contends that a reopening should be approved in accordance with HCFA Pub. 15-1, § 2931.2, in that the Intermediary's similar calculation of physician costs with respect to 1979 and 1980 was also inconsistent with existing law, regulations, and instructions.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that 42 C.F.R. 405.1885(c) states that jurisdiction for reopening a

---

4 Tr. at 142, 146-147.

5 Western States Labor/Delivery Room Day Group Appeal, PRRB Dec. No. 90-D4, November 9, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,277, rev'd HCFA Administrator January 4, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,325.

6 Provider's Post Hearing Brief at 18. Also see Healthlink Group Appeal v. Blue Cross and Blue Shield Association, PRRB Hearing Dec. No. 94-D59, July 22, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,611, declined rev. HCFA Administrator, September 2, 1994.

7 Id at 16-17.

determination rests exclusively with that administrative body that rendered the last determination or decision.[8] In making its decision not to reopen, the Intermediary did not abuse its discretion, but properly applied the criteria of HCFA Pub. 15-1, § 2931.2 for reopening a final determination.[9]

The Intermediary points out that one criteria for reopening a cost report is that a provider must submit information that is " new and material". The Intermediary has consistently defined "new" to mean that the documentation being presented could not have been expected to be available at the time of the audit. In the instant case, the Provider did not submit its requested methodology (to report outpatient visit days) with the cost report or at the time of audit. That would have enabled the Intermediary to determine if the Provider's requested calculation rendered a more accurate identification of Medicare reimbursable costs.

The Intermediary contends that the Provider's request for reopening did not meet the criteria in HCFA Pub. 15-1 § 2931.2. That section makes reference to a "clear and obvious error" or an intermediary determination that is found to be inconsistent with the law, regulations, or general instructions. The Intermediary states there is no evidence that its calculations were in error or contrary to law, regulations, or general instructions.[10] In this case, the Intermediary contends that the Provider's position is more in the nature of a change in election, rather than one which requires the curing of an error.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(b)(7)	-	Teaching Amendment

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

§ 405.465 et seq. (Subpart D) Removed	-	Determining Reimbursement for Certain Physician Services
§ 405.1885 et seq.	-	Reopening a Determination or Decision

---

8 Exhibit I-3.

9 Id at 4.

10 Id at 9-10.

3. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2218.C.3 et seq.	-	Aggregate Per Diem Methods For Physicians Direct Medical and Surgical Services
§ 2931 et seq.	-	Reopening and Correction

4. Cases:

Healthlink Group Appeal v. Blue Cross and Blue Shield Association, PRRB Hearing Dec. No. 94-D59, July 22, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,611, declined rev. HCFA Administrator, September 2, 1994.

Western States Labor/Delivery Room Day Group Appeal, PRRB Hearing Dec. No. 90-D4, November 9, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,277, rev'd HCFA Administrator, January 4, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,325.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the regulations, manual instructions, facts, parties' contentions, and evidence in the record, finds and concludes that the Intermediary abused its discretion by not reopening the Provider's Medicare cost reports for the years ending December 31, 1979 and December 31, 1980.

The Board finds that the Provider elected to receive Medicare reimbursement for its physicians' costs pursuant to a provision of the Social Security Act known as the "Teaching Amendment", 42 U.S.C. § 1395x(b)(7). The Board also notes that the "Teaching Amendment" regulation at 42 C.F.R. § 405.465, and the related program instructions in the Provider Reimbursement Manual ("HCFA Pub. 15-1") § 2218.C.3.a and b are careful to define an outpatient visit day and to prescribe alternate means for determining a provider's amount of outpatient visit days.

The Board finds that the Intermediary calculated the Provider's Medicare reimbursement for the 1979-1980 period by treating each occasion of outpatient physician service as an outpatient visit day, a methodology not authorized by the statute, regulations, or by the manual. The Board also notes that with respect to this same issue, the United States District Court for the Northern District of New York held that the Intermediary's failure to use an approved methodology in determining the Provider's outpatient visit days for the year 1982 was improper. The court ordered the case remanded to the Secretary for recalculation of reimbursement in accordance with the " 3b formula" or a manner of reimbursement which most closely corresponds to the Provider's accounting capability.

The Board finds that HCFA Pub. 15-1 § 2931.2 states that a reopening determination will depend upon whether new and material evidence has been submitted, or a clear and obvious error has been made, or the original determination is found to be inconsistent with the law, regulations, or general instructions. In that the Intermediary employed an unapproved method to calculate Medicare reimbursement, the Board finds that the Intermediary's actions were not in accordance with existing laws and regulations, and also constituted a clear and obvious error. Based on the above findings, the Board concludes that the Provider is entitled to the requested reopening.

DECISION AND ORDER:

The Intermediary abused its discretion in refusing to reopen the Medicare cost reports for the years ending December 31, 1779 and December 31, 1980. The Intermediary is directed to reopen the Medicare cost reports for those years, and reimburse the Provider for the costs of physicians' services in accordance with whatever method is ultimately determined to be correct with respect to the December 31, 1982 cost report year.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esquire

Date of Decision: June 02, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman