PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D15

PROVIDER -Sterling Physical Therapy and Rehabilitation, P.C.
Warren, Michigan

Provider No. 23-6563

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross and Blue Shield of Michigan

DATE OF HEARING-
September 29, 1998

Cost Reporting Period Ended -
December 31, 1990

CASE NO. 94-0030

INDEX

ISSUES:

1. Was the Intermediary's adjustment to Medicare charges relating to settlement data based on information contained in the PS&R report proper?

2. Was the Intermediary's adjustment to Medicare payments proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sterling Physical Therapy and Rehabilitation P.C. ("Provider") is located in Warren, Michigan. The Provider filed its cost report for the period ended December 31, 1990. On April 16, 1993, Blue Cross and Blue Shield of Michigan ("Intermediary") issued a revised Notice of Program Reimbursement ("NPR") for the cost reporting period ended December 31, 1990. On October 8, 1993, the Provider appealed the NPR. The Provider disagreed with the Intermediary's adjustments and filed a timely appeal with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement amount is approximately $57,340.

The Provider was represented by Roy Luttmann, Esquire, of Cox, Hodgman & Giarmarco. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

JURISDICTION:

PROVIDER'S CONTENTIONS:

The Provider contends that the issue in dispute involves claims which are a proper issue for appeal to the Board. Since the Intermediary stipulated, by signing the list of issues, to the fact that there are no impediments to jurisdiction it cannot now contest the issue.

The Provider points out that the Board has jurisdiction to hear cost issues as per Curators of the University of Missouri Center v. Sullivan, 963 F.2d 220 (8th Cir. 1992) ("Curators"). The Intermediary's adjustment to the Provider's calculation of the program charges is a cost issue as it relates to an item on the cost report. This does not involve a coverage issue as it does not involve a claim for reimbursement for denied claims. The Intermediary never denied or rejected these claims and thus they are properly payable.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that the issue in dispute involves claims review, and is therefore not a proper issue for appeal to the Board. The Board does not have jurisdiction to hear coverage issues, pursuant to 42 C.F.R. § 405.1873 and the HCFA Pub. 15-1 Chapter 29,

Appendix A, Section A. In addition the Intermediary cites Curators. The Intermediary points out that the United States Supreme Court declined to review the decision of the United States Court of Appeals for the Eighth Circuit, which upheld the Board's decision that it lacked jurisdiction over a hospital's challenge for reimbursement denial. The Eighth Circuit found that the Intermediary's decision involved a coverage issue rather than a cost.

Issue No. 1 -- Charges:

Facts:

The Intermediary adjusted the Provider's as-filed settlement data based on the information contained in the Provider's Statistical and Reimbursement Report ("PS&R"). The Providers' figure was $654,450 while the Intermediary's figure was $631,680, a difference of $22,770.

PROVIDER'S CONTENTIONS:

The Provider contends that the difference between the Intermediary's figures and its figures represents claims that were submitted to the Intermediary but were neither paid nor rejected by the Intermediary. The amount of total "Program Charges" for the cost year ended December 31, 1990 was $654,450. This amount represents the number of program charges as they appeared on the Intermediary's PS&R plus the costs relating to claims that the Intermediary never rejected and never paid.

The Provider asserts that it has met its burden of proof regarding the adequacy of the cost information. The Provider contends that its list[1] contains an itemized statement of claims that the Intermediary did not include in its PS&R or final settlement. The first column on the first page of Exhibit E lists "Program Charges" on which the Provider and the Intermediary disagree. The second column lists the monthly total of additional properly filed claims that the Intermediary failed to deny or pay. Each individual claim is discussed separately in the monthly reconciliation statement included in Exhibit E. The Provider points out that the data is current, accurate, and in sufficient detail to meet the requirements of HCFA Pub. 15-1 § 2304.

The Provider further argues that the Intermediary failed to rebut the Provider's proof that the claims at issue were properly filed and never denied, and that the PS&R is wrong. The Intermediary has not produced a list of denied claims or any other proof supporting the accuracy of its figures contained in the PS&R.

The Provider therefore concludes that its records are more accurate than the PS&R and should be relied upon to decide this issue.

---

[1] Provider Exhibit E.

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that the PS&R is a computerized system utilized by all fiscal intermediaries in order to capture the Medicare data required for preparation and settlement of the Medicare cost report. Since the Provider's as-filed data did not agree with the PS&R, the Intermediary made adjustments to reconcile the Provider's data to the PS&R.

The Intermediary contends that these adjustments are in accordance with Medicare laws, regulations and instructions. Section 1861(v)(1)(A) of the Social Security Act provides for the reimbursement of reasonable and necessary costs incurred in the delivery of Medicare services. This section also authorizes the Secretary to promulgate regulations to provide for the determination of costs of services on a per diem, per unit, or other basis and generally gives the Secretary latitude in providing for the methods of determining costs of services.

The Intermediary cites 42 C.F.R. § 413.20 which states: "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program." In addition, 42 C.F.R. § 413.24 states: "Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors." Id.

The Intermediary also cites 42 C.F.R. § 413.24(c)et seq, adequacy of cost information, which states in part: "[a]dequate cost information must be obtained from the providers records to support payments made for services furnished to beneficiaries." Id.

These regulations are reiterated in the program instructions published by HCFA. The Intermediary cites HCFA Pub. 15-1 § 2304 which states in part:

> Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records and original evidences of cost. . . which pertain to the determination of reasonable cost, capable of being audited.

Id.

In addition the Intermediary cites § 2242 of the Medicare Intermediary Manual which provides that the PS&R is to be used to settle Medicare claims unless there is proof that the PS&R is inaccurate. The Intermediary contends that the above cited regulations and instructions justify the audit adjustment, as the Provider did not furnish any documentation indicating that its data is more accurate or adequate than the PS&R.

The Intermediary points out that the policy that requires an intermediary to use the PS&R, unless the Provider is able to show that the data in the PS&R is wrong, has been upheld by the Board and the HCFA Administrator. In Remedial Care Inc. v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Mississippi, Inc, PRRB Dec. No. 92-D25, March 18,1992, Medicare and Medicaid Guide (CCH) § 40,170, affirmed HCFA Adm. May 29, 1992, it was held that the intermediary cannot use the provider's data unless the provider demonstrates that the data in the PS&R is inaccurate and the provider's data is correct. The Intermediary also points out that in Carepoint Home Health Agency-South Walnut Creek CA v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 94-D13, March 11, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,173, the Board ruled that the Intermediary must use the PS&R.
The Intermediary contends that based on the above cited cases it properly adjusted the Provider's cost report since the Provider did not furnish documentation to support that its data is more accurate or adequate than the PS&R.

Issue No. 2 -- Payments:

Facts:

The Intermediary adjusted the Provider's "Payments" in the amount of $69,204 to reconcile the payments to the PS&R data (cut-off date of 12/31/91) dated March 25, 1992 and August 12, 1992, and to the Intermediary's payment data of January 15, 1993.

PROVIDER'S CONTENTIONS:

The Provider contends that the Intermediary's adjustment to it's payments figure was improper. The Intermediary's final settlement showed total payments received by the Provider as $377,264. In amending its cost report, the Provider relied on the Intermediary's PS&R for interim payments made to the Provider from January 1, 1990 through December 31, 1991, as well as the lump sum payment of $16,700 it claims was made to the Provider for adjustments in 1990 which amount to total payments of $327,338. The difference between the Intermediary's figure for total payments and the Provider's figure is $49,926.

The Provider does not contest that the Intermediary has the authority to make retroactive adjustments in proper circumstances pursuant to HCFA Pub. 15-1 § 2408 or 42 C.F.R. § 413.64. However, the Provider argues that the adjustments were not proper in this case because the interim payments do not agree with the reimbursement amount payable to the Provider for the services furnished to program beneficiaries during the cost report period.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that its adjustment is proper and in accordance with Medicare laws, regulations and instructions. The Intermediary cites HCFA Pub. 15-1 § 2408 which

states:

> A retroactive adjustment will be made after the end of the provider's reporting year to bring the interim payment made during the period into agreement with the reimbursable amount payable to the provider. This adjustment will be determined from the respective settlement sheets applicable to the cost reporting form and apportionment method used by the provider.

Id.

The Intermediary asserts that its adjustment is based on verifiable data. The Provider has not supported its contentions that its data is more accurate.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

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

§ 1861(v)(1)(A)	-	Reasonable Cost

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

§ 405.1873	-	Board Jurisdiction
§ 413.20	-	Financial Data and Reports
§ 413.24	-	Adequate Cost Data and Cost Finding
§ 413.64	-	Payments to Providers: Specific Rules

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

Chapter 29, Appendix A Section A

§ 2304	-	Adequacy of Cost Information
§ 2408	-	Retroactive Adjustments

4. Medicare Part A Intermediary Part II Program Administrative Manual, HCFA Pub. 13-2:

§ 2242	-	Intermediary's Use of PS&R System Reports in Cost Settlement Process

5. Cases:

Remedial Care Inc. v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Mississippi, Inc., PRRB Dec. No 92-D25, March 18, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,170, affirmed HCFA Adm. May 29, 1992.

Carepoint Home Health Agency-South Walnut Creek CA v. Blue Cross and Blue Shield Association/Blue Cross of California PRRB Dec. No. 94-D13, March 11, 1994, Medicare and Medicaid Guide (CCH) ¶ 42,173.

Curators of the University of Missouri, d/b/a University of Missouri Medical Center v. Sullivan, U.S. District Court, Western District of Missouri, Central Division, No. 89-4415-CV-C-9, June 24, 1991, Medicare and Medicaid Guide (CCH) ¶ 39,497.

Curators, University of Missouri v. Sullivan, 963 F.2d 220 (8th Cir. 1992).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board after consideration of the controlling laws, regulations and program instructions, the facts of the case, parties' contentions and evidence presented in the record, finds and concludes as follows:

JURISDICTION:

The Board finds that it does have jurisdiction. The Intermediary's adjustment to the Provider's calculation of the program charges is a cost issue as it relates to an item on the cost report. The Board finds that this does not involve a coverage issue as it does not involve a claim for reimbursement for denied claims since the Intermediary never denied or rejected the claims.

Issue No. 1 -- Charges:

The Board finds that the Provider did not submit sufficient information to prove that the PS&R was incorrect. Since the Provider was unable to prove to the satisfaction of the Board that the PS&R was incorrect, the Board finds that the Intermediary properly used the PS&R in making final settlement. The Board finds that although the Provider submitted evidence which identified claims, there was not sufficient evidence that these claims were not paid.

There were no service dates nor copies of the billing form UB82 in evidence. Therefore, the Board finds that there was not sufficient evidence in the record to prove the Provider's contentions.

Issue No. 2 -- Payments:

The Board finds that the Provider did not submit sufficient evidence to prove to the satisfaction of the Board that the PS&R was incorrect. The Board finds that the HCFA manuals require an intermediary to use the PS&R to make all settlements unless it can be proven that the PS&R is incorrect. Since the Provider was unable to prove to the satisfaction of the Board that the PS&R was incorrect, the Board finds that the Intermediary's settlement was proper.

DECISION AND ORDER:

JURISDICTION:

The Board finds that the issue is a cost issue and not a coverage issue. Therefore it does have jurisdiction.

Issue No. 1 -- Charges:

The Board finds that there was not sufficient documentation to demonstrate that the PS&R was incorrect. The Intermediary's adjustment is affirmed.

Issue No. 2 -- Payments:

The Board finds that there was not sufficient documentation to demonstrate that the PS&R was incorrect. The Intermediary's adjustment is affirmed.

Board Members Participating:
Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq.
Charles R. Barker

Date of Decision: December 08, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman