PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D51

PROVIDER -
Athens-Limestone Hospital
Athens, Alabama

Provider No. 01-0079

vs.

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

DATE OF HEARING-
April 20, 1999

Cost Reporting Period Ended -
September 30, 1989
September 30, 1990

CASE NO. 94-0198

INDEX

ISSUE

Was the Intermediary's attempt to recover Disproportionate Share Hospital (DSH) payments from the Provider for FYs 89 and 90 proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Athens Limestone Hospital ("Provider") is a non-profit general acute care hospital located in Athens, Limestone County, Alabama. Blue Cross and Blue Shield of Alabama ("Intermediary") informed the Provider on November 25, 1991 that it did not qualify for a DSH payment. The Provider disagreed with the Intermediary's determination and filed an 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 in contention for the period ended 9/30/89 is $349,286, and for the period ended 9/30/90 the amount is $512,071.

The Provider was represented by Heather H. Crumpton, Esq. of Buff & Forman, LL.P. The Intermediary was represented by Bernard M.Talbert, Esq. of the Blue Cross and Blue Shield Association, Chicago.

PROVIDER'S CONTENTIONS:

The Provider points out that it made full disclosure of all reasonable facts by documenting the number of adult beds and the number of nursery beds in its cost reports for 1989 and 1990[1] and by designating 92 beds as adult and 12 beds as nursery beds. The Provider points out that on January 10, 1989, the Intermediary notified the Provider that it qualified for DSH payments.[2] This letter was received after the Provider filed its 89 FYE cost report, which indicated that the Provider had 104 beds, 12 of which were nursery beds.

The Provider did not make any prior request for DSH payments and the Provider independently attempted to verify the Intermediary's determination that it qualified for DSH payments.[3] On the following dates: 10/30/89, 11/7/89, 5/7/90, 12/11/90, 2/4/91, and 11/12/91, the Intermediary informed the Provider that it qualified for DSH payments.[4]

---

[1]Exhibit P-B

[2]Exhibit P-C

[3]Exhibit P-D

[4]Exhibit P- E,F,G,H,I,J,K

On November 25, 1991 the Intermediary reversed its determination concerning the Provider's qualification as a disproportionate share hospital, stating that:

> In our letter dated November 12, 1991, we indicated that your facility qualifies for a disproportionate share adjustment of 13.67%. Since our letter, it has come to our attention that your facility has less than 100 beds and for an urban hospital with less than 100 beds to qualify for DSH, the combined SSI ratio (.2374) and Medicaid ratio (.0796) must be at least 40%. As a result of your hospital not qualifying for DSH, your PPS payment rate for discharges on and after October 1, 1991 is $3,135.34.[5]

On July 13, 1992 the Provider was awarded a Certificate of Need ("CON") for ten additional hospital beds, increasing the bed count to 101 adult beds and 12 nursery beds. Thereafter, the Intermediary notified the Provider by letter dated October 5, 1992, that it qualified as a Disproportionate Share Hospital.[6]

On May 19, 1993 the Intermediary demanded repayment of the DSH payments. The Intermediary acknowledged that it was at fault and that the Provider received DSH payments as a result of the Intermediary's error.[7]

The Provider contends that the Intermediary may not recover overpayments from a Provider without fault. Section 1870 of the Social Security Act provides that neither the Secretary nor the Medicare Intermediary may recover overpayments from a Provider who is without fault. 42 U.S.C. § 1395gg, specifically states that:

> There shall be no adjustment as provided in subsection (b) of this section (nor shall there be a recovery) in any case where the incorrect payment has been made (including payments under section 1395f(e) of this title with respect to an individual who is without fault... if such adjustment would be against equity and good conscience.

42 U.S.C. §l395gg(c).

---

[5]Exhibit P-L

[6]Exhibit P-N

[7]Exhibit P-O

The Provider argues that it is without fault for at least two reasons. First, it did not know nor did it have reason to suspect, that the Intermediary was incorrectly providing DSH payments. The Provider was therefore without fault according to the plain meaning of the phrase. Second, administrative and judicial constructions of the phrase "without fault" in other provisions of the Social Security Act demonstrate that the Provider was "without fault."

The Provider points out that in its position paper dated June 29, 1998, the Intermediary admits in four separate places that it alone made incorrect and erroneous conclusions that the Provider qualified for DSH payments. The Intermediary readily concedes that their error is why this case is before the Board. The Intermediary does not state anywhere in its position paper that its error and erroneous conclusion was caused by any action or inaction by the Provider. Therefore, the Provider argues it was without fault within the meaning of § 1870 of the Social Security Act, 42 U.S.C. §l395gg(c). See, e.g.; Jefferson v. Bowen, 794 F. 2d. 631, 633 (11th Cir. 1986) (recipient who provided all material information to agency and relied on the agency's representations was without fault); Adams v. Secretary of Health and Human Services, 653 F. Supp. 249 (C.D. Ill. 1986) (documents disclosing possibility of overpayment in possession of recipient not sufficient to create fault).

The Provider argues that the fault in this case belongs at the agency's doorstep. Rini v. Harris, 615 F.2d 625,627 (5th Cir. 1980) The Intermediary has expressly admitted its fault throughout its position paper. The Intermediary has also admitted that it did not find its errors during its own final eligibility determination, despite all of its expertise. The Intermediary has not provided any sound reasons in support of its position that the Provider should have discovered the Intermediary's error when the Intermediary itself did not find it while conducting its own final determination. The Intermediary's admitted mishandling of this key element simply cannot be shifted to the Provider. Id.

The Provider argues that it did not know, nor did it have reason to suspect, that following the Intermediary's repeated written instructions might result in an overpayment. It contends that the phrase "without fault" in § 1870 of the Social Security Act means that a provider may not be held liable for recoupment where it did not know and had no reason to know that it was overpaid. The Provider points out that it had no actual knowledge that the DSH payments it received from its Intermediary might result in an overpayment. Its cost reports were submitted to its Intermediary in accordance with their instructions to file for DSH payments. Unbeknownst to the Provider, its Intermediary was either refusing to follow or misinterpreting HCFA's policy of excluding nursery beds in order to determine whether a hospital qualified for DSH payments. The Provider was never informed of the HCFA policy until November 25, 1991, and all that while, the Intermediary provided repeated yet erroneous reassurances that the Provider qualified for DSH payments.

The Provider contends that it was never informed of HCFA's policy excluding nursery beds in determining a hospital's qualification for DSH payments. The Intermediary never provided or referenced anything from HCFA that would have put the Provider on notice of the policy, The

Intermediary directed the Provider to file for DSH payments and thereafter provided repeated written assurances to the Provider to continue filing for DSH payments until November 25, 1991. The Provider argues that it attempted to verify its qualifications for DSH payments by researching the Commerce Clearing House publications concerning DSH hospitals and also the Federal Register. The Provider found no information, publication or documentation that in any manner contradicted the Intermediary's January 10, 1989 letter stating that the Provider qualified for DSH hospital payments.

The Provider contends that a reasonable provider could not be expected to have known that its Intermediary was incorrectly making payments. It was reasonable for the Provider to believe that it qualified for DSH payments since the Provider:

> 1-made disclosure of all reasonable facts and documented the number of beds at the facility in its 1988 and 89 cost reports;
> 2-independently attempted to confirm its right to DSH payments;
> 3-received no less than 8 letters from its Intermediary explicitly directing it to file for DSH payments.

The Provider contends that far from blindly accepting a windfall of additional payments it had never before received, it took reasonable measures to verify whether it, in fact qualified for the DSH payments.

The Provider argues that it is within the immunity from repayment described in Mount Sinai Hospital v. Weinberger, 517 F.2d 329 (5th Cir. 1975), where the court found that 42 U.S.C. §l395gg does not permit an intermediary to demand repayment caused by its own administrative error which the provider had no basis for questioning. Id. at 340-341. Like the provider in Mount Sinai, the Provider argues it played no role in its Intermediary's determination that it qualified for DSH payments. Without any inquiry or solicitation on the Provider's part the Intermediary notified the Provider that it qualified for DSH payments and continued to reassure the Provider that it qualified for DSH payments.

The Provider argues that administrative and judicial construction of the phrase "without fault" in other provisions of the Social Security Act further establishes that the Intermediary may not recover the DSH payments. The Provider points out that 42 U.S.C. §404(b), governing overpayment of old-age benefits, provides that:

> [i]n any case in which more than the correct amount of payment has been made, there shall be no adjustment of payments to, or recovery by the United States from, any person who is without fault if such adjustment or recovery would defeat the purpose of this subchapter or would be against equity and good conscience.

42 U.S.C. §404(b).

The Provider points out that the construction given to the term "without fault" in §404(b) both by HHS and the courts demonstrates that recoupment by the Intermediary under the circumstances of this case would be inappropriate.

The Provider points out that the regulation implementing § 404(b) indicates that a person who provides all required and material information to the Social Security Administration and who has no reason to believe the payments are incorrect is without fault. Cases and rulings construing these provisions have uniformly held that individuals are without fault when they acted in good faith, provided the agency with all pertinent information, and had no reason to know that the payments were incorrect. These cases, in essence, hold that recoupment is only appropriate"from claimants with access to some clear indication that they were not presently entitled to the benefits they accepted," Myers v. Bowen, 704 F. Supp,45,48 (S.D.N.Y.1989).

The Provider argues that the Intermediary misstated or misinterpreted HCFA policy and as a result misinformed the Provider concerning its qualification for DSH payments. At some point between November 12 and November 24, 1991, the Intermediary was informed by HCFA that it had been incorrectly interpreting and/or applying HCFA's rules. The Intermediary had been giving providers wrong information for years and those providers had in good faith, been relying on it.

The Provider contends that the Intermediary's failure to follow the Secretary's binding regulations renders its action illegal and void. Administrative regulations are binding upon the federal agency promulgating the regulations. The principle that an administrative agency and its agents are bound by the agency's regulations is true "even when the administrative action is discretionary in Nature Service v. Dulles," 354 U.S. 363, 372 (1957), and "the administrative agency in question was not required to adopt the regulation in the first instance." Vitarelli v. Seaton 359 U.S. at 539-40. The Provider argues that Blue Cross is an agent of the Secretary. As a result, the Intermediary is bound by the regulations promulgated by the Secretary and/or HCFA.

The Provider points out that the Intermediary admitted that it did not find during its final determination that the Provider was ineligible to receive DSH payments. Form HCFA-2552, Worksheet S-3, speaks of Nursery beds. The regulation upon which the Intermediary relies, on the other hand, speaks in terms of "beds assigned to newborns", 42 C. F.R. § 4l2.118(b). The two terms do not mean the same thing. Nursery is commonly defined as "a place designed for the care or training of children; a room or place in a public building (as a church) where children are temporarily cared for in their parents' absence by trained attendants." Webster's Third New Int'l Dictionary, 1551 (1971). A newborn on the other hand, is commonly defined as "a newborn individual", "neonate", "recently born," Webster's Third New Int'l Dictionary, 1553 (1971).

The Provider argues that where a regulation does not contain a specific definition of a term or phrase, "we must look at its plain language and consider the terms in accordance with their

common meaning", Ingalls Shipbuilding Inc. v. Dalton, 119F.3d 972, 976 (Fed.Cir. 1997). The Form HCFA-2552 was insufficient to place the Provider on notice of the Intermediary's error because the term "nursery" does not mean the same thing as Newborn."

INTERMEDIARY'S CONTENTIONS:

The Intermediary points out that there is no dispute that the Provider did not qualify for DSH payments during its fiscal years ended 9/30/89 and 9/30/90, because in both years the Provider's bed count was less than 100. There is no dispute that the Intermediary made DSH payments to the Provider based on its erroneous conclusions that the Provider had 100 or more beds.
The Intermediary argues that the regulations governing reopening and correction of intermediary determinations in 42 C.F.R.§ 405.1885, § 405.1887 and §405.1889 are applicable to the issue. These regulations permit the reopening and correction of an initial determination within three years of the date of that determination. The regulations require correction where such determination is inconsistent with the applicable law, regulations, or general instructions. Section 415.1885 states in part:

> (b) A determination or a hearing decision rendered by the intermediary shall be reopened and revised by the intermediary if, within the aforementioned 3-year period, the Health Care Financing Administration notifies the intermediary that such determination or decision is inconsistent with the applicable law, regulations, or general instructions issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the intermediary.

Id.

The Intermediary points out that in January, 1989, it notified the Provider it was eligible for DSH payments, erroneously concluding the Provider's bed count was 100 or more. The error was not corrected in the original settlements of the cost reports. The only combination of available beds that total 100 or more includes nursery beds. This is not in accordance with the governing regulations.

The Intermediary argues that its error in counting the Provider’s number of beds for purposes of making DSH payments does not alter the fact that the published regulations on the matter clearly require the exclusion of beds assigned to newborns.. The Provider's knowledge of the rules governing DSH payments were not limited solely to correspondence issued by the Intermediary. The Code of Federal Regulations is published and available to all interested parties. The governing regulations in 42 C.F.R.§ 412.106(a)(3) and §412.106(a)(1)(1) state:

"[t]he number of beds in a hospital is determined in accordance with 412.118(b)." The determination of number of beds as presented in 42 C.F.R. 412.118(b) states:

> The number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number of days in the cost reporting period.

The Intermediary points out that § 412.118(b) was modified effective October 1, 1985 as per the Federal Register of September 3, 1985, § 35,690, to include the new bed count criteria in the text of the regulations, using bed days available as the basis for making the count. The published regulations make clear the method of counting beds for purposes of determining eligibility to, and the amount of, DSH payments to be made to hospitals. The Intermediary's determination properly recognizes bed days available, not including beds assigned to newborns, in accordance with the text of the published regulations.

The Intermediary argues that the Provider's equity argument is beyond the authority of the Board. The rules governing administrative finality**,** reopening and correction of intermediary determinations, and DSH payments, require the corrections at issue.

CITATIONS OF LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS:

1. Law:

   Social Security Act:

§1870	-	Overpayment on behalf of individuals and settlement of claims for benefits on behalf of deceased individuals.

   42 U.S.C.:

§404(b)	-	Overpayments and Underpayments.
§1395gg(c)	-	Overpayment on behalf of individuals and settlement of claims for benefits on behalf of deceased individuals.

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

§412.106 et seq	-	Special Treatment: Hospitals that serve a disproportionate share of low income patients.

§412.118(b)	-	Determination of number of beds.
§405.1835	-	Right to Board hearing.
§405. 1841	-	Time, place, form, and content of request for Board hearing.
§405.1885	-	Reopening a determination or decision.
§405.1887	-	Notice of reopening.
§405.1889	-	Effect of revision.

3. Cases:

Adams v. Secretary of Health and Human Services, 653 F. Supp. 249 (CD Ill.1986).

Rini v. Harris, 615 F. 2d. 625 (5th Cir. 1980).

Mount Sinai Hospital v. Weinberger, 517 F. 2d. 329 (5th Cir 1975).

Myers v. Bowen, 704 F. Supp 45 (SDNY 1989).

Nature Services v. Dulles, 354 U.S. 363 (1957).

Vitarelli v. Seaton, 359 U.S. at 535 (1959).

Jefferson v. Bowen, 794 F. 2d. 631 (11th Cir. 1986).

Ingalls Shipbuilding Inc. V. Dalton, 119 F. 3d. 972 (Fed Cir. 1997).

4. Other:

Websters Third New Int'l Dictionary 1551,1553 (1971).
Federal Register, §35,690 September 3, 1985.

FINDINGS AND CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after reviewing the contentions and evidence presented by both parties, and the applicable law and regulations, find and conclude that the Intermediary properly adjusted the Providers Disproportionate Share Payments.

The Board finds that the Provider was not entitled to DSH payments because in both years the Provider's bed count was less than 100. The Intermediary erred in counting the Provider's nursery beds to determine that there was more than 100 beds in the facility.

The Board finds that an error was made by the Intermediary in paying the Provider for DSH. However, the Board finds that the Provider should have known that its Intermediary was incorrectly making DSH payments.

The Board finds that the Intermediary reopened the Provider's cost reports within the three year period from the dates of the NPRs. Therefore, the Intermediary acted within the regulations in denying the Provider payment for the DSH.

The Board is not persuaded by the Provider's arguments that it should be held without fault because the Intermediary informed the Provider on numerous occasions that it was entitled to the DSH payments. There was sufficient information in the Federal Register § 35,690 September 3,1985 for the Provider to know that they were not qualified to receive DSH payments.

The Board finds that although the Intermediary caused the overpayment when it consistently informed the Provider that it was qualified to receive and then actually paid the Provider the DSH payments, the Provider should not profit from the Intermediary's error. The Board does note that the Provider was required to pay interest on the overpayment. The Board finds that since the error was caused by the Intermediary, the Provider should not be required to pay interest on the overpayment.

DECISION AND ORDER:

The Intermediary's attempt to recover Disproportionate Share Hospital (DSH) payments from the Provider for FYE 89 and 90 was proper. The Provider should not be required to pay interest on the overpayment. The Intermediary's adjustment is modified.

Board Members Participating:

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

Date of Decision: June 16, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman