PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2002-D30

PROVIDER –
Mark Twain St. Joseph's Hospital
San Andreas, California

Provider No. 05-0366

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC--CA

DATE OF HEARING-
February 22-23, 2001

Cost Reporting Periods Ended -
December 31, 1992; December 31, 1993;
December 31, 1994 and December 31, 1995

CASE Nos.: 95-1515, 95-2428, 99-3520, 99-3125

INDEX

ISSUE:

Was the Intermediary's reopening in accordance with Medicare regulations, and did the Intermediary use the proper hospital-specific rate in determining the Provider's reimbursement?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Mark Twain St. Joseph's Hospital ("Provider") is a small, short-term general acute, rural district hospital located in San Andreas, California. On October 28, 1998 the Intermediary issued a Revised Notice of Program Reimbursement ("RNPR") for the fiscal years ("FYs")1985 through 1995.[1] The RNPR changed the allowable costs for the base year ended August 31, 1983 by eliminating, for purposes of computing the hospital-specific rate only, a termination expense (liability) incurred upon Provider's withdrawal from the California Public Employees Retirement System ("PERS"). The aggregate result of this recalculation was an amount owed to the Medicare program of $1,639,090.[2] On April 26, 1999, the Provider filed a timely appeal with the Provider Reimbursement Review Board ("Board")[3] and has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841.

The Provider was represented by Thomas J. Weiss, Esquire, of Seyfarth & Shaw. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

Relevant Regulatory Background:

The setting of the hospital-specific rate ("HSR") which is used for the computation of sole community hospital payments is governed by the regulations at 42 C.F.R. §§ 412.71 through 412.75. More specifically, 42 C.F.R. § 412.72 specifies when the rate per discharge calculation can be changed. The regulations applicable to the case at hand read in part:

> § 412.71 Determination of base-year inpatient operating costs.
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> . . .

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1 Provider Position Paper at P-1.

2 Id.

3 Provider Position Paper at P-2.

(b) Modifications to base-year costs.
Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, in accordance with § 413.53(a)(1)(i) of this chapter, and exclude the following:

(1) Medical education costs as described in § 413.85 of this chapter.
(2) Capital-related costs as described in § 413.130 of this chapter.
(3) Kidney acquisition costs incurred by hospitals approved as renal transplantation centers as described in § 412.100.
(4) Higher costs that were incurred for purposes of increasing base-year costs.
(5) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.
(6) Higher costs that result from changes in hospital accounting principles initiated in the base year.
(7) The costs of qualified nonphysician anesthetists' services, as described in § 412.113(c).

. . .

(d) Intermediary's determination

The intermediary uses the best data available at the time in estimating each hospital's base-year costs and the modifications to those costs authorized by paragraphs (b) and (c) of this section. The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in § 412.72.

§ 412.72 Modification of base-year costs.

(a) Bases for modification of base-year costs. Base-year costs as determined under § 412.71(d) may be modified under the following circumstances:

(1) Inadvertent omissions. (i) A hospital that becomes subject to the prospective payment system beginning on or after October 1, 1983 and before November 16, 1983 has until November 15, 1983 to request its intermediary to re-estimate its base-period costs to take into account inadvertent omissions in its previous submissions to the intermediary . . .

> (ii) The Intermediary may also initiate changes to the estimation -
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> (A) For any reason before the date the hospital becomes subject to prospective payment; and
> (B) Before November 16, 1983, for corrections to take into account inadvertent omissions in the hospital's previous submissions . . .

(2) Correction of mathematical errors of calculations. (i) The hospital must report mathematical errors of calculations to the intermediary within 90 days of the intermediary's notification to the hospital of the hospital's payment rates.

(ii) The intermediary may also identify such errors and initiate their correction during this period.

. . .

(3) Recognition of additional costs. (i) The intermediary may adjust base-period costs to take into account additional costs recognized as allowable costs for the hospital's base year as the result of any of the following:

> (A) A reopening and revision of the hospital's base-year notice of amount of program reimbursement . . .
> (B) A prehearing order or finding issued during the provider payment appeals process by the appropriate reviewing authority . . .
> (C) An affirmation, modification, or reversal of a Provider Reimbursement Review Board decision by the Administrator of HCFA . . .
> (D) An administrative or judicial review decision . . .

(4) Successful appeal. The intermediary may modify base-year costs to take into account a successful appeal relating to modifications to base-year costs that were made under § 412.71(b)…
(5) Unlawfully claimed costs. The intermediary may modify base-year costs to exclude costs that were unlawfully claimed as determined as a result of criminal conviction, imposition of a civil judgement under the False Claims Act,(31 U.S.C. 3729-3731), or a proceeding for exclusion from the Medicare program.

Also at issue in this case is the timeliness of the Provider's reopening. The reopening regulation is at 42 C.F.R. § 405.1885 and states the following:

> § 405.1885 Reopening a determination or decision.
>
> (a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision . . . . Any such request to reopen 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 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.
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> . . .
>
> (d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision.
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> (e) Paragraphs (a) and (b) of this section apply to determinations on cost reporting periods ending on or after December 31, 1971.

PROVIDER'S CONTENTIONS:

The Provider contends that the October 28, 1998 RNPR is invalid for three reasons.

1. The Intermediary did not meet the criteria of 42 C.F.R. §§ 412.71 through 412.75 which governs when the rate per discharge calculation can be changed.

2. As of October, 1998, the 1992 and 1993 years were already past the 3-year limit of reopening discretion governed by the regulation at 42 C.F.R. § 405.1885.

3. The Intermediary failed to determine that the termination liability expense had a distorting effect on the Provider's base year costs.

Each of these contentions are explained as follows:

* The RNPR was not authorized by 42 C.F.R. § 412.71

The Provider points out that 42 C.F.R. § 412.71(d) is explicit in stating that:

> The intermediary's estimate of base-year costs and modifications thereto is final and may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided in section 412.72.

That section allows modifications under four circumstances:

1. Inadvertent omissions
2. Correction of mathematical errors of calculations
3. Recognition of additional costs, and
4. Successful appeal of base year costs

With respect to each kind of modification, the regulation explains under what conditions such modification is or is not allowed. The Provider contends that the Intermediary's RNPR does not meet the stated criteria. It points to uncontradicted testimony by its consultant, a former member of the Board, who stated that the RNPR was invalid under the regulation at issue. This testimony was supported by the Intermediary's own witness who agreed that this regulation governs and that the RNPR was improper.[4]

Based on the evidence cited above, the Provider concludes that the RPNR of October 1998 was ineffective to change the base-year rate to exclude the pension termination costs.

* The 1992 and 1993 years were beyond the three year limit for reopening governed by 42 C.F.R. § 405.1885

The Provider offered testimony at the hearing that the 1998 RNPR was untimely under 42 C.F.R. § 405.1885.[5] The Provider also contends that its August 26, 1997 letter to the Intermediary should not be considered as a request for reopening, as advocated by the Intermediary. Testimony at the hearing revealed that under program regulations, guidelines, and practices this letter cannot be considered a reopening as it does not meet the requirements of HCFA Pub. 15-1 § 2931 for a written request for a reopening.[6] The letter makes it clear that it was just one of a series of communications in 1997 in which

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4 Tr. at 506-507.

5 Tr. at 85-186.

6 Tr. at 187-188.

the Provider inquired and asked the Intermediary to verify the correctness of its determinations, and referring to the fact that sometime in 1997 the Intermediary had expressed an intent to modify the rate. Further, the Intermediary witness acknowledged it was the Intermediary's decision to make the modifications.

Specifically, in November, 1994, the Provider sent a letter to the Intermediary requesting verification of the Intermediary's calculations.[7] Since the pre-1992 years were paid at one rate and then at a lower rate, the Provider wanted to know what to expect for the 1992-1995 period. However, there was no substantive response from the Intermediary. Finally, in February, 1998, there was a meeting between the parties wherein the Intermediary indicated its intended decision. The Provider contends and testified that it was never asked nor ever consented to waiving any appeal rights relating to what the Intermediary ultimately proposed in the October, 1998, RNPR.[8]

- The termination liability did not have a distorting effect on the base year costs.

The Provider contends that the regulations at 42 C.F.R. § 412.71(b)(5) require the Intermediary to first make a determination of whether a given cost is nonrecurring and then, if so, whether its exclusion or inclusion has a distorting effect on the rate computation. The Provider points to testimony by the Intermediary that when the various rates were computed and issued it did not intend to exclude the termination costs.[9] Accordingly, this is not an instance of a mistake or typographical error which would lend itself to a mandated correction, as advocated by the Intermediary.

The Provider also contends that the Intermediary's assertion that a hospital does not routinely terminate its retirement plan and incur termination costs and therefore it would be improper to recognize these costs in the base year, is without merit. The Provider points to unchallenged testimony at the hearing that the pension costs were not extraordinary in the long run, were not subject to employer manipulation, and were not out of line with a normal year's pension expense.[10]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the unfunded PERS liability was appropriately excluded from the costs used to set the HSR, and the Provider never appealed the original exclusion. However, the unfunded liability was subsequently added back into the HSR by some Intermediary mistake or inadvertence. The Intermediary further contends that the Provider was clearly aware of the Intermediary's error. Thus, the Intermediary's subsequent action to remove the unfunded liability was procedurally correct.

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7 Tr. at 231-233, 235.

8 Tr. at 245.

9 Tr. at 489, 491.

10 Tr. at 310-313, 323-324.

The Intermediary first contends that its original exclusion of the PERS liability was appropriate under 42 C.F.R. § 412.71(b) which states:

> Modifications to base year costs. Prior to determining the hospital-specific rate, the intermediary will adjust the hospital's estimated base-year inpatient operating costs, as necessary, to include malpractice insurance costs in accordance with §413.53(a)(1)(i) of this chapter, and exclude the following:
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> . . .
>
> (5) One-time nonrecurring higher costs or revenue offsets that have the effect of distorting base-year costs as an appropriate basis for computing the hospital-specific rate.

The Intermediary points to the Provider's certified financial statements which state in part:

7. Extraordinary Items

> On November 15, 1982, the Hospital terminated its agreement with the Public Employees' Retirement System. The actuarial unfunded liability resulting from the termination of Plan amounted to $376,208, which has been classified as an extraordinary expense.

In addition, the Intermediary contends that the Provider's witness confirmed the non-recurring nature of the unfunded liability at the hearing.

> (Q) Intermediary: Okay, now but for the withdrawal from the PERS during this time frame, would the hospital have gotten hit with the $376,000 claim?
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> (A) Provider: This claim? No.[11]

The Intermediary also points out that the Provider's argument that the Intermediary failed to determine that the PERS liability had a distorting effect on the base year costs is without merit. In the year in question no normal pension expenses were incurred. Rather, the Provider is asking for a prospective rate based on a cost that the Provider chose not to incur. Accordingly, a full year's hypothetical pension payments should not be imputed into the cost base. With respect to the Provider's argument that the HSR

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[11] Tr. 373, lines 3-7.

calculation was frozen under the regulations at 42 C.F.R. §§ 412.71 and 412.72, the Intermediary does not concur based on the following. The Provider's first year under the prospective payment system ("PPS") was August 31, 1985, and that was the period to challenge any modifications under 42 C.F.R. § 412.71(b). A review of the FY 1985 appeal request and settlement revealed there was no reference made to the PERS modification.[12] Accordingly, the Provider's rate change in 1993, adding back the PERS adjustment, was not the result of a successful appeal decision (the criteria to change a rate after it was set). As such, the Intermediary's original modification was never correctly challenged and the Provider has no expectation to have those costs remain in the rate.

Similarly, the Intermediary argues that its October, 1998, reopening action was not improper even though that action was well past the three year reopening limit imposed by 42 C.F.R. § 405.1885. It asserts that the time passage should not be held as a bar to correcting the HSR. Specifically, it reaches that outcome by viewing the August 26, 1997 letter[13] from the Provider's Vice President of Finance to the Intermediary as a request for reopening. Portions of that letter addressing the 1983 Medicare cost report and the underfunded PERS withdrawal liability read as follows:

> Therefore, we agreed at the April 4, 1977 meeting that Blue Cross would correctly recompute the base year target rate by re-running the 1983 Medicare cost report including all appeals issues found in favor of the hospital.

. . . and excluding the one non-recurring expense item ($376,028 expense due to withdrawal from PERS).[14]

The Intermediary views those statements as recognition by the Provider that the mistake was clearly understood by the Provider and the Intermediary response correcting the rate to remove the unfunded liability was procedurally appropriate. The Intermediary also contends that its letter of December 30, 1997[15] to the Provider is an acknowledgement of every point raised by the Provider and should be viewed as an informal acceptance of the Provider's request for reopening. It further contends that formal Intermediary acceptance occurred upon issuance of the October 28, 1998 reopening notices followed by the RNPRs the next day. The Intermediary also argues that it does not agree with Provider testimony at the hearing wherein the Provider witness opined that the August 27, 1997 Provider letter could not be construed as a reopening request.[16] It is the Intermediary's

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12 Intermediary Exhibits 18 and 19.

13 Intermediary Exhibit 12.

14 Id.

15 Provider Exhibit 17.

16 Tr. at 193

contention that this is a situation where the substance, as noted above, should prevail over lack of a specific word (i.e. reopening).

Finally, the Intermediary contends that the facts in the instant case appear to fall under the regulation at 42 C.F.R. § 405.1885(d) which states:

> (d) Notwithstanding the provisions of paragraph (a) of this section, an intermediary determination or hearing decision, a decision of the Board, or a decision of the Secretary shall be reopened and revised at any time if it is established that such determination or decision was procured by fraud or similar fault of any party to the determination or decision.

The Intermediary acknowledges that "similar fault" is not a precisely defined term. However, it asserts that the record establishes that the Medicare share of the unfunded liability was initially excluded out of the HSR when it was established in 1984 and mistakenly added back. The Provider acknowledged this error, per the August 26, 1997 letter to the Intermediary. Given that background, the similar fault language should be sufficient to estop the Provider from raising the three-year limit to avoid correction.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Regulations – 42 C.F.R.:

§§ 405.1835-.1841	-	Board Jurisdiction
§ 405.1885 et seq.	-	Reopening a determination or decision
§ 412.71	-	Determination of base-year inpatient operating costs.
§ 412.71 (b)	-	Modifications to base-year costs.
§ 412.71 (d)	-	Intermediary's determination
§ 412.72	-	Modification of base-year costs
§ 412.75	-	Determination of the hospital-specific rate for inpatient operating costs based on a Federal fiscal year 1987 base period

2. Program Instructions-Provider Reimbursement Manual-Part 1 (HCFA Pub. 15-1):

§ 2931 - Time limits for reopening

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board majority, after consideration of the facts, parties contentions, evidence presented, testimony given at the hearing and the post-hearing briefs, finds and concludes as follows:

The Board majority finds that the unfunded PERS liability of $376,000 was initially excluded from the Target Amount Computation ("TAC") used to calculate the Provider's HSR. This impacted the years 1984 through 1989. Secondly, the Board majority finds that the record is unclear as to whether the Provider ever appealed the Intermediary's initial PERS exclusion. However, the Board majority notes that testimony indicates that an Intermediary mistake led to the erroneous reinstatement of a higher HSR,[17] which had the effect of negating the original PERS adjustment. This resulted in the Provider receiving excess reimbursement for fiscal years 1992 through 1995.

The Board majority also finds that the regulations at 42 C.F.R. §§ 412.71 and 412.72 require a finality in the setting of base-year rates. Under 42 C.F.R. § 412.71 "finality" regarding the Intermediary's estimate of base-year costs and modifications, may not be changed after the first day of the first cost reporting period beginning on or after October 1, 1983, except as provided by § 412.72. Section 412.72 allows for five exceptions, three of which could have applied to this appeal. The first exception involves inadvertent omissions and has a time limit of November 16, 1983. The second covers the correction of mathematical errors and these must be reported to the intermediary within 90 days of the intermediary's notification to a hospital of the hospital's payment rate. Intermediary errors must also be identified during this same period. The third is for the recognition of additional costs which were the result of a reopening and revision of the hospital's base-year notice of program reimbursement under §§ 405.185 through 405.1889 of this chapter. Adjustments to base-year costs to take into account these additional costs will be effective as of the first day of the hospital's first cost reporting period beginning on or after the date of the revision.

Applying these regulations, the Board majority finds there had to be finality in the Provider's base-rate by 1987. Accordingly, these regulations can not be used as a basis for reopening in 1998.

In examining the nature of the 1992 RNPR which was issued in October, 1994, the Board majority finds that the Intermediary committed an error when it inadvertently applied an incorrect HSR which inappropriately served to enrich the Provider. The record supports

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[17] In 1993 the Intermediary recalculated the HSR and erroneously included the $376,000 at issue.

the Intermediary's contention that the Provider, in fact, acknowledged that the PERS liability should be excluded.[18] The Board majority distinguishes the Intermediary's action from one in which the intent would be to reestablish or reset the Provider's HSR. Instead, the Board majority concludes that the Intermediary is merely correcting an administrative error, which is covered by the reopening regulation at 42 C.F.R. § 405.1885. Additionally, the Board majority finds that the Provider did not supply sufficient detail, nor was the Provider's testimony compelling enough to support its contention that the PERS liability was a recurring type of cost which would not distort the base-year computation.

Applying the reopening criteria at 42 C.F.R. § 405.1885, the Board majority finds that the Intermediary's attempt to reopen the 1992 and 1993 Medicare cost reports in 1998 was beyond the allowable time period for reopening. However, the 1993 and 1994 years are within the scope of the reopening regulation.

DECISION AND ORDER:

The Intermediary's attempt to reopen the 1992 and 1993 Medicare cost reports was not timely within the governing regulation at 42 C.F.R. §405.1885. Intermediary adjustments to the 1992 and 1993 years should be reversed. The Intermediary reopening of the 1994 and 1995 years was proper within the regulation at 42 C.F.R. § 405.1885. Intermediary adjustments to the 1994 and 1995 years are sustained.

Board Members Participating:

Irvin W. Kues
Henry C. Wessman, Esquire, (Dissenting Opinion)
Stanley J. Sokolove
Gary B. Blodgett, D.D.S.
Suzanne Cochran, Esquire (Dissenting in Part, Concurring in Part)

Date of Decision: August 02, 2002

FOR THE BOARD

Irvin W. Kues
Chairman

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[18] Intermediary Post Hearing Brief at 9 and 10.

Mark Twain St. Joseph's Hospital

Board Member Suzanne Cochran, Dissenting in Part, Concurring in Part

I dissent with that part of the majority's decision that holds the reopening regulation applies in the circumstances of this dispute and that fiscal years 1994 and 1995 can be reopened to change the base rate. I concur in the majority's result that fiscal years 1992 and 1993 are not subject to reopening but I concur for different reasons than those relied on by the majority.

My dissent is based on the principle of regulatory construction that a specific provision prevails over a more general one.[19]

For reasons discussed below[20], I am not at all convinced that the rate amount in issue was calculated in error or that the pension plan costs in issue should have been adjusted out of the base rate calculation as a distorting factor. Since the majority's decision is based on contrary findings, however, I will assume those facts to be established in my discussion of the applicable regulations.

It is undisputed that the regulations at 42 C.F.R. 412.71 and 412.72 govern how the hospital's base year rate is to be calculated. Section 412.71 directs that the intermediary's estimate [using the "best data available at the time"] " is final and may not be changed *except as provided in 412.72*." (emphasis added) Section 412.72 is explicit in what can be used to modify the estimate and in its deadlines for the modifications.

The Intermediary does not seriously dispute that it flunked the finality deadlines of 412.72. But it argues that the deadlines should not apply to what it characterizes as an error, made in 1993, upon recalculation of the base rate to reflect informal resolution in 1990 of some adjustments that were appealed.[21] The majority sidesteps the section

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[19] See Crawford Fitting Co v. J.T. Gibbons, Inc., 482 U.S. 437, 445 (1987)

[20] See note 4, infra.

[21] Recalculation of the base rate based on resolution of issues appealed is specifically permitted under 412.72(a)(3) and (4). The DC Circuit struck down that part of the regulation that attempted to make implementation of a successful appeal of the base rate prospective only. Georgetown University Hospital v. Bowen, 862 F.2d 323 (D.C. Cir. 1988). What was appealed is in dispute and confusing as noted by the majority. However, it is uncontested that the hospital at least had asked for an informal consideration of the adjustments made pertaining to the pension plan termination. See Provider Exhibit 6. The Provider claimed that it was involved with ongoing discussions about these matters with an FI manager (deceased prior to the 1998 FI action but after the 1993 action in which the pension expense was added into the base rate recalculated to implement appeal resolution of some items. TR. 468:17-471:2) and that the first FI manager expressed the FI's indecision on the matter. TR. 120: 18-135:21. It is also undisputed that the pension expense in issue here was moved in and out of the base rate several times over the course of this dispute and that the new manager did not know what his predecessor's thinking was on the issue. (See e.g. TR. 481:7-495:9; 497:3-498:2;). As to why it took seven years, the new manager testified that "Different appeals coming through and then auditor—remember all the players in this whole thing is quite new. They were not involved in the original case, let's put it this way, on both the Provider side and our side. And then at different stages, we were really trying to do the right thing. Of course we made a mistake. And then the whole issue, which we learned, is complicated. No doubt about that. For me it's complicated. So we attempted to go back and forth, back and forth numerous times as has really I think been demonstrated in all

412.72 deadlines by "distinguish[ing] the Intermediary's action from one in which the intent would be to reestablish or reset the Provider's HSR," referring to the action instead as "merely correcting an administrative error" to which the reopening regulations may be applied instead of sections 412.71 and 72. While I agree that this is a desirable outcome if, indeed, a simple calculation error has occurred, I do not believe the plain language of the regulation at 412.72(a)(2) that specifically addresses how and when "mathematical errors of calculations" are to be corrected permits that approach. Moreover, the regulation at 412.72(3)(a) explicitly addresses limited circumstances when "reopening" may be used only to *increase* the base year rate.

The key then is whether the Intermediary's action in 1998 modified the base rate. The NPR on which the Intermediary's action is based states in bold, capital letters:

> **SUBJECT: NOTICE OF REOPENING TO REVISE THE HOSPITAL SPECIFIC PAYMENTS BASED ON THE REVISED BASE YEAR PPS TAC**

Then every fiscal year from 8/31/85 through 12/31/95 is listed. Intermediary Exhibit 13.. The Intermediary's manager responsible for the action testified that "Reopening is not really the best terminology to use because **this is a result of base year target rate changes**." (emphasis added) TR.507:7-12. That the 1998 action revised the base year calculation is, I believe, crystal clear. Nothing in the regulations at 412.72 permits such a tardy modification, aptly described by the provider as "endless tinkering" with the base rate.

I also find support for my position in the Administrator's reversal of the PRRB's decision in *Corpus Christi Osteopathic Hospital v. Blue Cross and Blue Shield*, PRRB No. 89-D14 (Jan 4, 1989), Medicare & Medicaid Guide (CCH) Transfer Binder ¶37599. *Corpus Christi* involved a mathematical error in that part of the base rate calculation established by the wage index factor, governed by the regulation at 412.73. The Board found that the time limits for correction in 412.72 applied to all steps in setting the base rate, including the wage index calculation provided in 412.73.

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the documentation that we were trying to fix it. That's what took that long." 513:16-514:9 Although the Intermediary's new manager tried to rely on the lack of appeal of the amount in issue here to bolster his position that he would not have intentionally added the pension expense, see e.g. TR.515:1-517:12, it is undisputed that another of the claimed non appealed issues for which the provider also requested informal consideration at the same time was finally adjusted in favor of the provider by the new manager. TR: 479:5-481:6; 487:22- 495:9. At the hearing, the FI manager testified that he had only learned shortly before the hearing that the amount he did allow did not represent a full year's costs and that the annualized expense would have been about $270,000. TR. 454:6-457:16; 463:16-22; 479:5-480:8; 503:7-505:8.

The Administrator's rationale for reversal is particularly applicable here. He acknowledged that 412.72 "specifies time limits for the correction of errors in certain steps in the HSP determination. The regulation also gives specific rules on the retroactive application of certain corrections." The Administrator pointed out, though, that, under the specific language of the regulation, those limits only applied to the hospital specific rate governed by 412.71 (that portion of the rate in issue here), not the wage index portion treated under 412.73. "As there is no specific rule in the PPS regulations regarding the treatment of the type of error that occurred here, the general rules concerning Medicare provider reimbursement determinations and appeals apply." *Corpus Christi*, therefore, establishes the Administrator's position that the specific limitations found in 412.72 on correction of errors in calculating the cost per discharge portion of the rate under 412.71 preclude resort to the more general reopening provisions of 42 C.F.R. 405.1885(b), relied on here by the majority.

Suzanne Cochran June 17, 2002

Dissent - Henry C. Wessman, Esq

I respectfully dissent.

I view the bottom line in the instant cases to be on-point with that of Charlotte Memorial Hospital and Medical Center (PRRB Dec. No. 99-D29, March 18, 1999; PRRB Remand Dec. No. 2000-D62, June 6, 2000) in which the Provider argued to retain ill-gotten gains

from the Medicare Trust Fund, gains provided by the error, incompetence, nonchalance of the fiscal intermediary. While the fact patterns are slightly different, the ultimate result sought by the Provider is identical, i.e., that they be allowed to keep overpayment of Medicare funds to which they are knowingly not entitled.

I note that my Dissent in the instant case is written in the same vein as my Concurring Opinion in Charlotte. (See: Wessman Concurring Opinion, PRRB Dec. No. 2000-D62). For the record, it is important to state that my concurrence-to-dissent shift does not signal a change of viewpoint on my part relevant to Federal law and Judeo-Christian teachings that require the return of mistakenly-appropriated property to the rightful owner. Rather, it signals a shift in the PRRB Majority's stance to a more liberal viewpoint since the 1999 and 2000 opinions in Charlotte.

In my opinion, the following "parallels" exist between the instant cases and Charlotte.

FISCAL INTERMEDIARY ERROR
Described as embarrassing, (Tr. At 535) ugly, (Tr. at 23) and regrettable, (Tr. at 531) the instant cases detail the inadvertent add-back of a $376,208 "one-time non-recurring higher cost" (42 C.F.R. § 412.71(b)(5)) that had originally been appropriately adjusted out of the Provider's costs that were used to set the hospital specific rate (HSR). The initial adjustment removing the one-time non-recurring higher cost was not appealed by the Provider. (Tr. at 36). The inadvertent, careless (Tr. at 38) add-back of the $376,208, which found its way into the Settlement Cost Report (Tr. at 38) in 1993, resulted in overpayment to the Provider for years 1992, 1993, 1994, and 1995 in the amount of $1,639,090 (Provider's Hearing Brief at 3). The Provider did receive credit for the actual costs of an employee retirement plan for the base year ($53,075, Tr. at 454), but to suggest payment of more, such as the conjectured "annualized" speculation of $270,000 in retirement costs would have clearly represented the filing of a claim for which there was no basis. In Charlotte, there was also a glaring Fiscal Intermediary error (Charlotte Tr. at 31-32) via a Revised NPR which resulted in a direct overpayment of $298,914. (PRRB Dec. No. 99-D29 at 3).

PROVIDER KNOWLEDGE OF ERROR
In the instant cases, the Provider was aware of the potential for erroneous overpayment due to the $376,208 add-back, and dutifully notified the Fiscal Intermediary. (See

forthright Letter of Wayne Silveria, Intermediary Exhibit I-12). In Charlotte, the Provider was also aware of the erroneous overpayment. (PRRB Dec. No. 99-D29 at 4).

INTERMEDIARY NONCHALANCE
Sloppy, (Intermediary Position Paper, Jan 25, 2001 at 11) careless, (Tr. at 38) embarrassing, (Tr. at 535) ugly, (Tr. at 23) serious, (Tr. at 22) inadvertent, (Tr. at 38) and fluky (Tr. at 36) were some of the pejoratives used to describe the Intermediary error in

the instant cases. Charlotte only inferred incompetence and nonchalance (Charlotte PRRB Dec. No. 99-D29, Tr. at 31-32). The same descriptors could be used to portray the serious nonchalance and extreme length of time (3 to 5 year wait in instant cases; 6 year wait in Charlotte) taken by the fiscal intermediary before getting around to finally seek recoupment of the acknowledged overpayment from each of the Providers. This, despite the knowledge on the part of the Providers in question that there was overpayment (or potential for overpayment, as in the instant case), that there was an error that needed to be corrected, that money needed to be repaid to Medicare, and that ultimately the hammer would fall.

RECOUPMENT

By the time the fiscal intermediary finally got around to seeking recoupment, both the Provider in the instant cases (Provider's Supp. Position Paper, September 15, 2000, at 1-2) and in Charlotte (PRRB Dec. No. 99-D29, at 4) alleged that Medicare was estopped by SOL (42 U.S.C. § 1395gg(b)(1)(B); 42 C.F.R. § 405.1885 et seq).

It is at this point in the instant cases where I part company with the PRRB Majority, and where the instant PRRB Majority parts company with the unanimous decision of the previous Charlotte Majority. In Charlotte, a more conservative PRRB Majority firmly maintained, even in the face of a HCFA Administrator's remand, that they did not have jurisdiction over the issue of "recoupment"; that recoupment of Medicare overpayment is not an appealable issue, or that there is not an SOL. One reaches this conclusion either via the 42 C.F.R. § 405.1885(d) route of the instant case (Intermediary Position Paper, January 26,2001 at 17), or via the 42 C.F.R. § 405.1801(a)(4), § 405.374(j), and § 401.625 route used by the Majority in Charlotte. (PRRB Dec. No. 99-D29 at 19).

Further, it is my humble opinion that because the recoupment involves overpayment of hard-earned federal tax dollars, and because all parties were aware of the fact that there was an overpayment (or at least aware that an error was about to result in ongoing known overpayments, as in the instant case), there is also no SOL estopping recoupment, using either the routes discussed above, the fraud and false claims statutes of 42 U.S.C. § 1320a-7b(B) (false claims); 31 U.S.C. § 3729(A) (civil false claims); 42 U.S.C. § 1320a-7b(A) (false statements in connection with federal health care programs), or 42 U.S.C. § 1320a-7b(A)(3) (failure to return overpayments to which recipient is not entitled), or plain old Judeo-Christian ethics. Somehow, under the more liberal view of the current PRRB Majority in the instant cases, the mechanism of a "reopening" negates or modifies the act of recoupment (But cf. PRRB Dec. No. 99-D29 at 19, para. 2 where the Charlotte majority stated that a "reopening" was merely one of many vehicles that Medicare can use as a collection procedure to recoup overpayment without concern for SOL).

Using the instant Majority's analysis, either the SOL " 3 year rule" (42 C.F.R. § 405.1885(a) allows only two (2) years (1994 and 1995) of the four (4) to be recouped (Majority Decision), or the Provider should be allowed to keep the entire erroneous Medicare windfall (Cochran Dissent). Again, in my humble opinion, neither position withstands the plain fact that the Provider in the instant cases, as the Provider in Charlotte, was knowingly in possession of something of value that belonged to another, and that something needed to be returned, post-haste, to the rightful owner. In both

cases, that "something" is/was a federal tax dollar-funded Medicare overpayment, and the rightful owner is the U.S. Taxpayer via the Medicare Trust Fund.

The Intermediary adjustment in each of the instant cases is correct, and should stand.

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Henry C. Wessman, Esquire
Senior Board Member