PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2007-D64

PROVIDER -
Harbor Healthcare & Rehabilitation Center
Lewes, Delaware

Provider No: 08-5034

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Empire Medicare Services (n/k/a National Government Services-NY)

DATE OF HEARING -
January 10, 2007

Cost Reporting Periods Ended -
December 31, 1996 and December 31, 1997

CASE NOs: 04-0831 and 04-0833

INDEX

ISSUES**:**

1. Whether the Intermediary's notification of the reopening of the Provider's 1996 and 1997 final settled cost reports was timely pursuant to regulatory standards.

2. Whether the sampling methodology used by the Intermediary to disallow charges for the Provider's rehabilitation services was proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20(b) and 413.24(b).

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

Medicare regulations at 42 C.F.R. §405.1885(a) provide that an intermediary may reopen a previous determination with respect to findings on matters at issue in a cost report. Such a reopening must be made within three years of the date of notice of the intermediary determination. No intermediary reopening is permitted after three years unless it is established that such determination was procured by fraud or is directed by CMS. 42 C.F.R. §405.1885(d) and (e).

Additional rules concerning intermediary reopenings are addressed in CMS Pub. 15-1 §§2930, 2931 and 2932. CMS Pub. 15-1 §2932 states the following with regard to notices of reopening and correction:

> The provider or other party will be advised in the notice as to the circumstances surrounding the reopening, i.e., why it was necessary

> necessary
> to take such action, and the opportunity to comment, object,
> or submit evidence in rebuttal.

The Intermediary's adjustment reduced the Provider's allowable contract therapy costs based upon the results of a statistical sample of the documentation of another provider's therapy services – therapy services that had been furnished by the same therapy contractor. Therefore, Medicare program policy with respect to audit standards and the use of statistical sampling during the audit process is important to the resolution of this issue.

Medicare rules with respect to filed audit standards, CMS Pub. 13-4 §4112.4(B), provide the following direction to intermediaries:

> Ensure that evidence obtained during the course of the audit is sufficient to enable the auditor to support conclusions, adjustments, and recommendations. Make sure that there is enough factual and convincing evidence so that a prudent person can arrive at the same conclusion of fact as the auditor. In addition, evidence must be competent and relevant. That is, evidence must be valid and reliable and have a logical relationship to the issue/subject under review.

Medicare rules allow for the use of sampling as evidence in audits. CMS Pub. 13-4 §4112.4(B)(1)(e). It states in relevant part:

> Sampling is the application of an audit procedure to less than 100 percent of the items within an account balance or class of transactions to evaluate some characteristic of the balance or class. On the basis of facts known to the auditor, decide if all transactions or balances that make up a particular account are reviewed in order to obtain sufficient evidence. In most cases, however, the auditor will test at a level less than 100 percent.
>
> There are two general sampling approaches, nonstatistical and statistical. Either approach, when properly applied, can provide sufficient evidential data related to the design and size of an audit sample, among other factors. A nonstatistical sample may support acceptance of findings, but findings must be scientifically established to support adjustments.
>
> Some degree of uncertainty is inherent in applying audit procedures and is referred to as ultimate risk. Ultimate risk includes uncertainties due both to sampling and other factors. Sampling risk arises from the possibility that when a compliance or a substantive test is restricted to a sample, the auditor's conclusions may be

different had the test been applied in the same way to all items in the account balance or class of transactions.

The rules provide further guidance for planning samples, selecting a sample and sampling risk. Id.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Harbor Healthcare and Rehabilitation Center (the Provider) is a 179-bed acute care skilled nursing facility located in Lewes, Delaware. The Provider's fiscal years ended (FYE)12/31/96 and 12/31/97 cost reports were both final settled on September 28, 1999.

In a letter dated August 21, 2002, Empire Medicare Services (the Intermediary) notified the Provider that a reopening of the FY1996 and 1997 cost reports was necessary because the Department of Justice (DOJ)[1] had indicated that inflated therapy costs were reported for those years. Exhibit I-2. Following receipt of additional information from DOJ, the Intermediary notified the Provider in a letter dated March 18, 2003 of proposed supplemental adjustments reducing its Occupational Therapy (OT) and Speech Therapy (ST) costs.

During the audit of another provider's contracted OT and ST costs, the Department of Justice (DOJ) determined that Whitehorse Rehabilitation Services, Inc. (Whitehorse), the therapy contractor, had intentionally inflated invoices for its services. Whitehorse had also altered its therapy logs so that they supported the inflated invoices. Based on its findings, the DOJ concluded that the fraudulent scheme extended to all facilities served by Whitehorse and extrapolated the results of its review to all of the facilities, including the Provider. Exhibit I-7. In lieu of denying all therapy costs claimed for services furnished by Whitehorse, the Intermediary used the percentages calculated by the DOJ by which the invoices had been inflated for the other provider and made proposed adjustments reducing the Provider's allowable OT and ST costs accordingly.

Due to the unusual nature of the adjustments, all four providers that were impacted by the DOJ's findings were given the opportunity to provide documentation from their records that would demonstrate that their therapy costs were not inflated. Exhibit I-8. When the Intermediary did not receive the documentation it requested, the Provider's costs were reduced by the percentages developed by the DOJ.

The Provider appealed the Intermediary's adjustments to the Board and met the jurisdictional requirements of 42 C.F.R. §§405.1835-405.1841. The Provider was represented by Henry E. Schwartz, Esquire. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue

[1] Some of the documents in the record refer to the fraud allegations as "OIG findings" when in actuality, it was the U.S. Department of Justice, United States Attorney's Office for the District of Delaware that brought the matter to the Intermediary's attention and proposed the cost reduction percentages at issue.

Cross Blue Shield Association.

PARTIES' CONTENTIONS:

Issue 1 – Timely Notice of Reopening

The Provider notes that Medicare rules and regulations provide that the Intermediary has three years to reopen a cost report. In addition, CMS manual instructions also state that when a notice of reopening is sent, it must meet certain standards. CMS Pub. 15-1 §2932(A). The Provider points out that the correction notice must contain a "complete explanation" of the basis of the revision and offer the provider an opportunity to comment, object or submit evidence in rebuttal.

The Provider contends that the Intermediary's letter of August 21, 2002, issued within the three year reopening period, does not meet the regulatory and manual requirements. It does not contain a complete explanation of the proposed revision to the original settlement, nor does it afford the Provider an opportunity to comment, object or submit evidence in rebuttal. The Provider asserts that the letter itself indicates that it is not a notice of reopening. The Provider cites the following language from the August 21, 2002 letter: "Based on this letter, EMS [the Intermediary] reserves our right to reopen these cost reports when we have completed our review of the details of the OIG review." Exhibit P-3 (emphasis added).

The Provider notes that the Intermediary did send a subsequent letter on March 18, 2003 that arguably met the CMS requirements; it notified the Provider that its cost reports were in fact being reopened. However, the March 18, 2003 letter was issued beyond the three year time limit for reopenings.

The Provider also points out that the exception to the three-year reopening period for fraud does not apply in this case because there are no allegations that the cost report settlements at issue were procured through fraud perpetrated by the Provider. Whitehorse committed the fraud without any knowledge of the Provider.

The Intermediary argues that the August 21, 2002 letter notifies the Provider that the Intermediary intends to reopen its FYs 1996 and 1997 cost reports, and this letter was within the three-year time limit provided for in the rules and regulation.

Issue 2 - Sampling Methodology

While acknowledging that the sampling may be an appropriate basis for an intermediary's adjustment, the Provider notes that proper standards must be followed in the sampling process. The Provider indicates that the evidence must be reliable and have a logical relationship to the issue/subject under review. In this case, the "universe" was all the Provider's rehabilitation costs for the years under review. The sample, however, was not taken from any rehabilitation costs

reported by the Provider, and therefore, it is not valid for the Provider. The Provider points out that the sampling methodology has been found unacceptable when the data was not the best available (out-of-date) and has no justification. County of Los Angeles v. Shalala, U.S. Court of Appeals for the District of Columbia, No. 98-58-524 (10/1/99), Medicare & Medicaid Guide (CCH) ¶ 300,334, Exhibit P-12. Also, the Board has rejected the sampling methodology where the universe contained data not relevant to the provider. Hospital San Francisco, Inc. v. Cooperative de Seguros de Vida de Puerto Rico, PRRB Dec. No. 2003-D57, September 12, 2003, Medicare & Medicaid Guide (CCH) ¶81,043, rev'd, CMS Administrator, Medicare & Medicaid Guide (CCH) ¶81,089, November 10, 2003. Exhibit P-13.

The Provider also asserts that the sample utilized by the Intermediary in this case does not conform to the requirements in CMS Pub. 13-4 §4112, et seq. that provides the "Standards for Audit Under Medicare." Exhibit P-7. This manual provision recognizes the authority of the Government Accounting Standards (GAS) issued by the Comptroller General of the United States as applicable to all audits performed by or for any Federal agency. The standards require that the auditor obtain evidence that is sufficient to support his/her conclusions, adjustments and recommendations and that there is enough factual and convincing evidence that a prudent person can arrive at the same conclusion of fact as the auditor. As testified to by the Provider's expert witness, the Intermediary did not provide the necessary documentation of the factual basis and methodology used for sample to determine if it meets any professional statistical standard. Tr. at 106-112 and 125-126.

The Provider notes that the Board has reversed an intermediary's adjustments where there was no documentation to indicate how the intermediary selected the sample. Providence Medical Center v. Blue Cross Blue Shield Association/Blue Cross of Washington and Alaska, PRRB Dec. No. 99-D20, January 22, 1999, Medicare & Medicaid Guide (CCH) ¶80,157, rev'd, CMS Administrator, Medicare & Medicaid Guide (CCH) ¶80,175, March 13, 1999. Exhibit P-9. Since the Intermediary cannot demonstrate that it met the standards for a proper statistical sample, the Provider argues that the adjustments cannot be affirmed.

The Intermediary explains its rationale as follows: Whitehorse served at least four providers, including Harbor. DOJ investigators obtained from another provider serviced by Whitehorse, Harrison House of Georgetown, the January 1996 original log of actual therapy services. It was through a comparison of the original log to another log furnished by Whitehorse in support of its invoice that the fraud was detected. According to DOJ, all original logs were unavailable. Intermediary's post-hearing brief at 6. The Intermediary maintains that it used "the best---and only---evidence available" to it in making its adjustments, and since the January 1996 documentation was the only available source by which the percentage of overpayment could be determined, its use is fully consistent with generally accepted professional standards and also mandated as a reasonable means to recoup overpayments that represent the fruits of fraudulent activity. Id.

The Intermediary further contends that the Provider's witness testified that it is a generally

accepted practice to use the best data available, and if similar billings in the context of fraudulent activity was perpetrated on all of the providers, it would be reasonable to extrapolate the results of the sample. Tr. at 113-119. However, the Intermediary acknowledges that the expert witness also testified that she had insufficient evidence available to give an opinion regarding the validity of the extrapolation. Tr. at 121.

Finally, the Intermediary notes that the Provider did not furnish any documentation to dispute the adjustment, and since the Provider did not have documentation to justify its cost as required by the regulations at 42 C.F.R. §413.20 and §413.24, the Intermediary's actions were proper. Tr. at 48-49.

The Intermediary also notes that the Provider objected to the Intermediary's late submission of new exhibits the day before the commencement of the hearing and its failure to provide these documents in response to its earlier discovery request. The Intermediary claims that instead of some form of appropriate relief to the Provider, namely, a postponement of the hearing, the Board made a peremptory ruling in favor of the Provider to sanction the Intermediary for a perceived discovery abuse. The Board's action is an abuse of discretion and a reversible error. Intermediary's post-hearing brief at page 10.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After consideration of the Medicare law and guidelines, the parties' contentions, and evidence presented, the Board finds and concludes as follows:

Issue 1 – Timely Notice of Reopening

The Medicare regulation at 42 C.F.R. §405.1885 states that a request to reopen must be made within 3 years of the date of the intermediary's final determination. The Medicare manual, CMS Pub. 15-1 §2932(A), provides that a notice of reopening must provide a reason for the reopening.

The NPRs for both cost reports were issued on September 28, 1999; therefore, the Board majority finds that the August 21, 2002 letter is adequate notification of a reopening - the letter is within the three year time limit established in the regulation.

The Board majority further notes that the Provider questions the adequacy of the August 21, 2002 letter because the letter contains the following language, "EMS [the Intermediary] reserves our right to reopen these costs reports when we have completed our review of the details of the OIG review." The Provider contends that this language suggests that the Intermediary may reopen the case at a later date but is not doing so at this time. The Board majority does not agree with characterizing this letter as an indication that the Intermediary may reopen at a later date, because the language in the letter clearly indicates that it is a notice of reopening.

First, the Board majority notes that the Intermediary used the following language in the subject line of the August 21 letter, "Re: Reopening of the 1996 and 1997 cost reports for Medicare

purposes." Second, the very first line of the letter states that:

> The Office of Inspector General (OIG) has informed Empire Medicare Services (EMS) – Audit and Reimbursement Department that a reopening of the 1996 and 1997 cost reports are (sic) necessary.

The Board majority finds that the subject line and first line clearly indicate that this is a reopening notice. And if this were not enough, the Board majority refers to the second paragraph where the Intermediary points out that the NPR was issued on September 28, 1999, and the three year window to reopen did not expire until September 28, 2002. Therefore, "it is still within the three year reopening limit." Id.

The Board majority finds that the sentence referred to by the Provider in the August 21, 2002 letter is unambiguous; it states: "EMS reserves our right to reopen these cost reports when we have completed our review of the details of the OIG review." This sentence clearly indicated that the Intermediary, by this letter, was notifying the Provider of its intention to reopen and/or correct the indicated cost reports, subject to the completion of its review of the OIG report.

The following language in the first paragraph of the August 21, 2002 provides a reasonably clear explanation of why the reopening is necessary:

> Our review of the correspondence we have received indicates that the Provider reported inflated therapy costs for those cost reports (sic) years.

The Intermediary stated that it had not completed its review of the details of the OIG review or determined whether additional information would be needed from the Provider. The Board majority finds that a notice of reopening may indicate that further analysis is needed to determine the extent of any corrections. CMS Pub. 15-1 §2932.A provides that after a notice of reopening is issued, it may be determined that no correction is warranted, and if so, the provider will be notified accordingly.

The Board majority finds that the August 21, 2002 letter was an adequate notice of reopening and that it was within the three-year limit for reopening. The reopening of the Provider's cost reports was proper.

Issue 2 – Sampling Methodology

The Board finds that the revisions made to the Provider's cost reports, removing a percentage of therapy costs, were not based upon a determination made with regard to any data obtained from the

Provider's records. Instead, the Intermediary sampled data from another provider and used the results from that analysis to deny costs on the Provider's cost reports. The Board recognizes that Medicare rules allow for the use of sampling to support adjustments, CMS Pub. 13-4 §4112 et

seq., when proper standards are followed. However, the Board finds that the sampling method used by the Intermediary in this case did not meet the relevant audit standards and cannot be upheld.

Medicare rules with respect to audit standards in CMS Pub. 13-4 §4112.4(B) provide that an auditor must "[e]nsure that evidence obtained during the course of the audit is sufficient to enable the auditor to support conclusions, adjustments, and recommendations" and "that there is enough factual and convincing evidence so that a prudent person can arrive at the same conclusion of fact as the auditor." The "evidence must be competent, and relevant . . . valid and reliable and have a logical relationship to the issue/subject under review." The manual describes four types of evidence that may be used: physical, documentary, analytical and testimonial and notes that testimonial evidence is the least reliable, and if utilized, should be corroborated with other forms of evidence. Id.

The manual describes "sampling" as the application of audit procedures to less than 100% of the items within an account balance or class of transaction to evaluate characteristics of the balance or class. The sampling approach may be statistical or non-statistical, but when a non-statistical sample is used, the findings "must be scientifically established to support adjustments." After obtaining and testing the various types of evidence considered, the auditor should retain documentation to support the conclusions, and where materiality is a factor, the auditor should define materiality within the scope and objective of the audit. In addition, the auditor is required to document the evidence obtained and the procedures applied to support the audit conclusions. Id.

Based upon the above rules, the Board finds that the Intermediary may utilize a sampling methodology to determine the propriety of costs claimed by the Provider but must use competent evidence to support its adjustments. The evidence must be relevant, reliable and logically related to the issue under review, and the evidence obtained, the procedures applied, and the tests performed to support the results of the audit must be documented.

The Board notes that the record created by the parties in this case is limited. Information concerning the DOJ investigation is limited to the material provided by the Intermediary in its exhibits, and the Intermediary presented no testimony with regard to the nature of the fraud, its scope, or what procedures were utilized to select the sample that formed the basis of the disallowance of the Provider's therapy costs.

The following facts are documented in the record. The DOJ conducted an investigation of the therapy services provided by Whitehorse. In January 2001 that investigation resulted in the indictment of two Whitehorse employees. Exhibit I-11. The indictment alleges that employees

of Whitehorse recorded the units of time they spent providing services at nursing homes in monthly logs, and that the two employees who created and ran the company caused these logs to be altered to increase the number of units listed. Id. at 3. Using these altered, inflated logs, the two employees submitted invoices to the nursing homes they served requesting payment in excess

excess of the amount actually due. Id. at 4. The record indicates that both of these employees plead guilty to one count of conspiracy to commit wire fraud. Exhibit I-12. However, the record does not contain any evidence from the DOJ investigation. The only information in the record that states the basis for the adjustments to the Provider's costs is contained in a letter from an auditor in the U.S. Attorney's Office for the District of Delaware. Exhibit I-7. It states in relevant part:

> Enclosed are the spreadsheets which represent the process for estimating the amount of unearned therapy costs billed by Whitehorse/Whiteoak to four nursing homes in Delaware. The percentage of the therapy estimated to be bad was developed from altered logs at one location for the month of January 1996. Witness interviews indicated that the same thing occurred at all four facilities during the entire time the company served those locations. The percentage bad [sic] from the one month at the one facility was then applied to all speech and occupational therapy invoices to all four facilities.

Id.

The facility used for the calculation was Harrison House of Georgetown, not the Provider. Id. at 2. The Intermediary subsequently sent a letter to the Provider on March 18, 2003 indicating that it was proposing adjustment to the Provider's cost reports based upon the information provided by the U.S. Attorney's office. Exhibit I-3. The Intermediary allowed the Provider 30 days to respond to the proposed adjustment. Id. An Intermediary internal memo dated July 11, 2003 indicates that the Provider responded to the March 18, 2003 letter but did not supply any documentation. Exhibit I-8. The memo refers to another letter dated June 9, 2003 from the Intermediary to the Provider that gave the Provider until June 25, 2003 to respond and notes that no response was received. Id. However, the reference letter of June 9, 2003 was not in the record. The record also contains e-mail correspondence between the Intermediary and the Provider from December 7, 2006 through January 5, 2007. Exhibit I-10. An email on December 19, 2006 from the Intermediary specifies the type of information the Provider should present to resolve the case. Exhibit I-10. It also suggests that the information be provided as soon as possible, because the hearing for the case was scheduled for January 10, 2007. Id.

The Board's concerns with the sampling method relied upon by the Intermediary is based on a number of factors. While the Board accepts that Whitehorse inflated some of its therapy service claims, there is no direct evidence of the extent of the problem at the Provider's facility. The record indicates that the only sample taken was from another facility. Although the auditor wrote

that witness interviews indicate that the same practice occurred at all four facilities, there is no evidence of this in the record in the form of witness testimony, affidavits or other documents. The validity of using data from another facility is, in itself, questionable. In addition, the sample only encompasses data from one month during the two year period. The Board finds that a

sample that includes only one of four providers and only one month out of a possible 96 months of data is both too small to yield meaningful results and not representative of the total population. The record also provides very little information about how the audit analysis was actually conducted. The process for eliminating the amount of the "unearned therapy costs" billed by Whitehorse was developed from altered logs at one facility for the month of January 1996. The Board finds no evidence in the record to support the sample as a competent and valid basis for determining that the costs claimed by the Provider were not proper.

The Provider presented an expert witness to testify about whether the Intermediary had applied standards commonly used by professional statisticians or the standards set out in the manual. Tr. at 106-112, 125-126. The Provider's witness indicated that based on the record in this case, she was unable to determine whether the Intermediary's actions met either standard, because the necessary documentation of the methodology used was not presented by the Intermediary. The Board agrees with this assessment and finds that the Intermediary failed to document and identify the rationale for the method it utilized to make its adjustments.

The Board notes that the Provider was given an opportunity to submit any documentation or information it wanted to be considered to modify the Intermediary's proposed adjustments. Exhibits I-3. However, the Provider was not given any guidance on what documentation it was being asked to submit until the email dated December 19, 2006. Exhibit I-10. In addition, the Provider was not furnished with any information concerning the basis for the Intermediary's disallowance until January 9, 2007, the day prior to the Board hearing, when Intermediary Exhibits I-7 and I-8 were submitted. Tr. at 8. The Provider indicated that it had submitted discovery requests in order to determine the basis for the Intermediary's disallowance, but no information was provided. Tr. at 10.

The Board also notes that the defendants in the fraud case were ordered to pay restitution of just under $500,000. Exhibit I-12. If these funds were recovered to repay Medicare for the amount it was overcharged, the Board questions whether the funds should also be recovered from the Provider.

Finally, the Board notes that the Intermediary claims that the Board made a peremptory ruling in favor of the Provider as a sanction for its failure to provide timely discovery. The Intermediary has overstated the actions taken by the Board in this case. First, the Board did not exclude the Intermediary's additional exhibits. While noting that the materials were submitted very late and that they should have been made available to the Provider in response to its earlier discovery requests, the Board admitted the exhibits because they were relevant and essential to the creation of a complete record for the case. Second, the Provider had requested a postponement of the

hearing to further consider the new exhibits and potentially prepare additional rebuttal evidence.

In ruling on the Provider's request, the Board indicated to the Provider that, based on the record currently before it, even with the additional exhibits, it did not find substantial support for the

Intermediary's sampling methodology. The Provider was also told that even though the Board was prepared to grant its request for a continuance, it might wish to proceed with the case rather than waste additional time and expense. The Provider decided to proceed with the hearing.

The Board does not believe it has abused its discretion or otherwise affected the Intermediary's rights to fully present its case.

DECISION AND ORDER:

Issue 1 –Timely Notice of Reopening

The Board majority finds that the August 21, 2002 letter was an adequate notice of reopening and that it was within the three-year limit for reopening. The reopening of the Provider's cost report was proper.

Issue 2 – Sampling Methodology

The Board finds that the Intermediary's failure to use any of the Provider's records in the sample that was used to reduce the Provider's therapy costs or to justify the rationale for the application of the sample that actually was used in making the reduction was improper. The Intermediary's adjustments are reversed.

Board Members Participating:

Suzanne Cochran, Esquire (Dissenting as to Timeliness of Notice)
Gary Blodgett, D.D.S.
Elaine Crews Powell, C.P.A. (Dissenting as to Timeliness of Notice)
Anjali Mulchandani-West
Yvette C. Hayes

DATE: August 24, 2007

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman

Dissenting Opinion of Suzanne Cochran and Elaine Crews Powell

The Board majority concluded that the Intermediary's letter to the Provider dated August 21, 2002 constituted a valid notice of reopening. We respectfully dissent. While there is no question that 42 C.F.R. §405.1885 provides that a determination of an intermediary may be reopened within three years of the date of the notice of the determination, we find that the referenced letter was notice to the Provider that the Intermediary reserved its right to reopen the 1996 and 1997 cost reports when it had completed its review of the details of DOJ's review. As such, that letter did not constitute a notice of reopening as envisioned by CMS Pub. 15-1 Section 2931 entitled: Reopening and Correction. The section states in relevant part:

> . . . the term "reopening" mean an affirmative action taken by an intermediary . . . to re-examine or question the correctness of a determination or decision otherwise final.

We find further support for our conclusion in the Intermediary's own letter dated March 18, 2003, which reads in part as follows:

> This letter is a follow-up to my letter dated August 21, 2002 in reference to the potential reopening of your 1996 and 1997 cost reports. Please be advised that a reopening of those cost reports are (sic) necessary per HCFA Pub. 15-1 section 2931. The cost report is being reopened . . . . (emphasis added.)

In our opinion, the actual notice of reopening occurred on March 18, 2003, and since that notice was more than three years after the issuance of the NPRs for 1996 and 1997, the reopening was not within the three-year reopening period set forth in 42 C.F.R. §405.1885.

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Suzanne Cochran Elaine Crews Powell