PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D18

PROVIDER -
Valley Presbyterian Hospital

Provider No.: 05-0126

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
First Coast Service Options-CA

Cost Reporting Periods Ended -
October 31, 1987 through
October 31, 1997

CASE NOs.: 09-0801, 09-0802, 09-0803, 09-0804, 09-0805, 09-0806, 09-0807, 09-0809, 09-0810, 09-0815 and 09-0816

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ISSUE:

Whether the Board has jurisdiction over the Intermediary's refusal to reopen cost reports to adjust the Supplemental Security Income percentage where the requests for reopening were filed more than three years after the issuance of the Notices of Program Reimbursement (NPR).

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This dispute arises under the Medicare program, a Federal health insurance program for the aged and disabled 42 U.S.C. §§ 1395-1395cc. The Medicare program is administered by the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, a component of the Department of Health & Human Services. 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 providers under the Medicare law and interpretative guidelines published by CMS. See, 42 U.S.C. § 1395(h), 42 C.F.R. §§ 413.20 and 413.24. Providers have 180 days after the intermediary issues an NPR to file an appeal with the Provider Reimbursement Review Board (Board). See, 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§405.1835- 405.1840 (2008).[1] The regulation at section 405.1836 permits late filing upon a showing of good cause provided the request for extension of the time limit is received within three years of the date of the NPR from which the appeal is filed.

Hospitals are paid for services to Medicare patients under a prospective payment system (PPS). Under PPS, the inpatient operating costs are reimbursed based on a prospectively determined formula taking into account national and regional operating costs. The PPS legislation contains a number of provisions that adjust reimbursement based on hospital-specific factors. See, 42 U.S.C. § 1395ww(d)(5). These cases involve one of the hospital-specific adjustments, the disproportionate share adjustment.

The "disproportionate share" or "DSH" adjustment, effective in 1986, requires the Secretary to provide increased PPS reimbursement to hospitals that serve a "significantly disproportionate number of low-income patients." 42 U.S.C. § 1395ww(d)(5)(F)(i)(I). Whether a hospital qualifies for the DSH adjustment, and the amount of adjustment it receives, depends on the hospital's "disproportionate patient percentage." See, 42 U.S.C. § 1395ww(d)(5)(F)(v).

The "disproportionate patient percentage" is the sum of two fractions (expressed as percentages), the "Medicare and Medicaid fractions," for a hospital's cost reporting period. 42 U.S.C. §1395ww(d)(5)(F)(vi). This dispute involves the Medicare fraction, also often referred to as the Supplemental Security Income (SSI) fraction because it captures the number of Medicare patients who are also eligible for SSI. The statute at section 1395ww(d)(5)(F)(vi) establishes that the numerator of the Medicare fraction is the number of days that an individual was both, entitled to benefits under Part A, and entitled to SSI benefits. The denominator is the total

[1] See, revisions to subpart R of Title 42, 73 Fed. Reg. 30190 (May 23, 2008), effective August 21, 2008.

number of days of hospital inpatient care furnished to Medicare Part A beneficiaries.[2]

The SSI program is administered by the Social Security Administration (SSA); therefore, identifying patients who were entitled to SSI during their hospitalization requires access to SSA's SSI data. Regulations provide that the number of patient days for those patients entitled to both Medicare Part A and SSI will be determined by matching data from the Medicare Provider Analysis and Review (MEDPAR) file,[3] which is Medicare's database of hospital inpatients, with a file created for CMS by SSA (SSA file) to identify SSI individuals. CMS calculates the Medicare fraction and notifies the provider and the intermediary.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY

The Provider requested that the Intermediary reopen its cost reports to correct the SSI fraction and the Intermediary denied the request through correspondence dated August 8, 2008, citing the three year limitation on reopening 42 C.F.R. §405.1885(b)(2). The Provider appealed the Intermediary's denial and the Board received the Provider's request for hearing on February 5, 2009 for the fiscal years ended October 31, 1987 through October 31, 1997.

It is undisputed that the Intermediary's final determinations for these cost report periods were issued more than three years prior to the request for reopening or to the filing of this appeal. The Provider contends the three year time limit is inapplicable because CMS was aware of significant fundamental errors when it computed the published Supplemental Security Income (SSI) percentage for this Provider, but failed to disclose or correct those errors when it gave the SSI percentage to the Intermediary. This SSI percentage was used to compute the Provider's disproportionate share adjustment. The Provider claims that CMS most recently admitted the existence of numerous errors in the SSI data in Baystate Medical Center v. Leavitt.[4] Consequently, the Provider contends that the Board should take jurisdiction under 42 C.F.R. §405.1885(b)(3) which provides that a decision by the Secretary or Intermediary may be reopened at any time if it is established that the determination was procured by fraud or similar fault of any party to the decision.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

For the reasons discussed below, the Board finds and concludes that it does not have jurisdiction

[2] 42 U.S.C. § 1395ww(d)(5)(F)(vi)

[3] 52 Fed. Reg. 33143, 33144 (September 1, 1987) CMS uses the term PATBILL (Part A Tape Bill] and MEDPAR [Medicare Provider Analysis and Review] file interchangeably. The Agency states that the MEDPAR file contains the same data as the PATBILL file but it is in a simplified reformatted record layout.

[4] 545 F. Supp. 2d 20 (D.D.C. 2008), amended in part 2008 WL 483216 (D.D.C. November 8, 2008) and 2008 WL 5120771 (D.D.C. December 8, 2008) on appeal from Bay State Medical Center v. Mutual of Omaha, PRRB Dec. 2006-D20 (March 17, 2006) Medicare & Medicaid Guide (CCH) ¶ 81,468, rev'd in part CMS Administrator Dec. CCH ¶ 81,506 (May 11, 2006).

of this appeal.

Authority to reopen an intermediary determination rests exclusively with the intermediary. 42 C.F.R. §405.1885(c). Subsection (a)(6) also provides that a determination of whether or not to reopen is not a final determination within the meaning of Subpart R of Title 42, (PRRB appeals) and is not subject to further administrative or judicial review. The Supreme Court has likewise held that an intermediary's denial of a reopening request is not reviewable by the Board. Your Home Visiting Nurse Service, Inc. v. Shalala, 525 U.S. 449 (1999). The Intermediary's denial of the reopening request is therefore not reviewable by the Board.

With regard to the Provider's claim that CMS's conduct justifies a late request for reopening or for appeal, 42 U.S.C. § 1395oo(a)(1)(A)(i) limits the Board's jurisdiction to matters "covered by the cost report." The Board's authority is to adjudicate reimbursement controversies, not to decide whether an entity acted fraudulently or unethically. The Board concludes that it lacks jurisdiction over Provider's claim that CMS defrauded or mislead regarding the accuracy of the SSI percentage calculation. See Morehouse General Hospital v. Louisiana Health Service and Indemnity Company.[5]

The Provider asserts in its appeal request that because of CMS' actions, the "appeal timeline was tolled." To the extent the Provider invokes equitable tolling principles to permit filing an appeal from the Intermediary's final determinations more than three years from the date of issuance, the Board finds and concludes that it has no authority to extend the timeline for an appeal beyond the limits expressed in the statute and regulations.

A firmly established principle of administrative law is that an agency is but a creature of statute. An agency's power is no greater than that delegated to it by Congress. Lyng v. Payne, 476 U.S. 926, 937, (1986); see also Gibas v. Saginaw Mining Co., 748 F.2d 1112, 1117 (6th Cir.1984) (administrative agencies are vested only with the authority given to them by Congress), cert. denied, 471 U.S. 1116 (1985); Atchison, Topeka & Santa Fe Ry. Co. v. Interstate Commerce Comm'n, 607 F.2d 1199, 1203 (7th Cir.1979) (same). Though an agency may promulgate rules or regulations pursuant to authority granted by Congress, no such rule or regulation can confer on the agency any greater authority than that conferred under the governing statute. Bowen v. Georgetown Univ. Hosp., 488 U.S. 204**,** 208, (1988); Ernst & Ernst v. Hochfelder, 425 U.S. 185, 213-14, (1976).

42 U.S.C. § 1395oo(a) establishes that a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report "if it . . . files a request for a hearing within 180 days after notice of the intermediary's final determination . . ." The time limit for filing is embedded in the legislation establishing the very right to a hearing and clearly indicates Congress' intent that filing within the time specified is a condition precedent to the right to a hearing.

[5] PRRB Dec. 81-D58 (March 19, 1981), Medicare and Medicaid Guide (CCH) ¶ 31,405.

Likewise, the Secretary's grant of authority to the Board in 42 C.F.R. §405.1836(b) (2008) allowing it to consider good cause for late filing is strictly limited. The Board must receive the request within 3 years after the date of the intermediary determination the provider seeks to appeal. The Board is not at liberty to enlarge the regulatory terms.

In St Joseph's Hospital v. Heckler, 786 F.2d 848 (8th Cir. 1986), the Court explained the jurisdictional nature of the timely filing requirement as follows:

> The Hospitals admit they have not complied with the clear requirements of section 1395oo(a). Specifically, they have not complied with the mandatory requirement of section 1395oo(a) which unambiguously specifies that a provider "may obtain a hearing" on its claim "if . . . a request for a hearing [is filed] within 180 days . . . of the intermediary's final determination." 42 U.S.C. Sec. 1395oo(a)(3). The imperative nature of this provision is underscored by the legislative history of the Medicare Act which states:
>
> > Any provider of services which has filed a timely cost report may appeal an adverse final decision of the fiscal intermediary with respect to the period covered by such a report to the Board where the amount in controversy is $10,000 or more. The appeal *must* be filed within 180 days after notice of the fiscal intermediary's final determination.
>
> H.R. Rep. No. 231, 92d Cong., 2d Sess, reprinted in 1972 U.S. Code Cong. & Ad. News 4989, 5094 (1972) (emphasis added). Clearly, had Congress intended the 180 day limitation of section 1395oo(a)(3) to be less than mandatory, it could have easily provided that a request for a hearing be filed "within days . . . or within such further time as the Secretary may allow" as it did when defining this court's jurisdiction to review social security disability claims. See 42 U.S.C. Sec. 405(g).
>
> Because section 1395oo(a) specifically defines those situations in which a provider may seek review, it also necessarily defines those situations in which the Board will have jurisdiction to review a claim. See Highland, 676 F.2d 230, 235 (6th Cir. 1982). Thus, in this case, because the Hospital has not complied with and cannot comply with the jurisdictional requirements of section 1395oo(a) and has no right to seek Board review, the Board itself is without jurisdiction to address the Hospital's claims.

Id. at 851-852. See also Alacare Home Health Serv. V. Sullivan, 891 F.2d 850, 852-8536 (11th Cir. 1990).[6]

DECISION AND ORDER:

The Board has no jurisdiction to review either Intermediary denials of reopening or Intermediary final determinations issued more than three years before filing. Because the Board lacks jurisdiction over the appeal, these cases are dismissed.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Chairman

Date: April 9, 2009

[6] This case also held the regulation permitting late filing up to three years from the NPR upon a showing of good cause invalid as beyond the statutory authority granted to the agency. Alacare at 856; St. Joseph's at 852-853. But see Western Medical v. Heckler, 783 F. 2d 1376 (9th Cir. 1986) (contra).