PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2009-D21

PROVIDER -
Triad 2007 Liability for Periodic Interim Payments to Former Owner Group
Alpharetta, Georgia

Provider Nos.: Various

Cost Reporting Period Ended -
June 30, 2007

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
Blue Cross Blue Shield of Georgia

CASE NO.: 09-0380GC

INDEX

ISSUE:

Whether the Board has jurisdiction over a challenge to an overpayment recoupment action involving the Provider's liability for erroneous payments made to the former owners of the skilled nursing facilities (SNFs) after the change of ownership.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over whether the Board has jurisdiction over a challenge to an overpayment recoupment action.

The Medicare program is a Federal health insurance program for the aged and disabled. Part A of the Medicare program provides payments to "provider," including SNFs for services furnished to Medicare beneficiaries. 42 U.S.C. §1395g. To participate in the Medicare program and receive reimbursement for the services to Medicare beneficiaries, providers must enter into Provider Agreements with the Secretary of the Department of Health and Human Services (DHHS). 42 U.S.C. §1395cc(a). The Centers for Medicare & Medicaid Services (CMS) is the operating component of 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 interpretative guidelines published by CMS. See, 42 U.S.C. §§ 1395(g) and 1395(h).

SNFs are paid under a Prospective Payment System (PPS) in which per diem payment of a predetermined rate is made for inpatient services furnished to Medicare beneficiaries. 42 C.F.R. §413.335(a). Under PPS, SNFs receive either the prospectively determined per diem rate based on specific billing or a periodic interim payment (PIP) amount that is a biweekly payment based on historical payment levels. 42 C.F.R. §§413.350(a)(b) and 413.64(h)(6). However, a PIP provider still must submit billings to the fiscal intermediary. 42 C.F.R. §413.64(h)(7). At the close of the fiscal year, all providers must submit a cost report to the fiscal intermediary showing the Medicare patient days amounts due and payments received during the fiscal year. The fiscal intermediary reconciles the amounts claimed against payments made, determines the balance due to and from the provider, and issues the provider's Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the total amount of program 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 – 405.1837.

If the fiscal intermediary determines an overpayment has occurred, it must notify the provider of its intent to offset or recoup the funds and give the provider an opportunity to respond. 42 C.F.R. § 405.373(a). If the provider submits a response, CMS or the fiscal intermediary "must within 15 days . . . consider the statement (including any pertinent evidence submitted), together with any other material bearing upon the case, and determine whether the facts justify" the offset or recoupment. 42 C.F.R. § 405.375(a).

There is no right of appeal of that determination to the Board. 42 C.F.R. §415.375(c). If no response is receive the fiscal intermediary may begin offsetting or recouping an overpayment notwithstanding a provider's appeal of the payment determination from which the overpayment arises. 42 C.F.R. §405.373(d).

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This appeal was filed on behalf of five Triad Health Management (Triad) providers. After Triad took over operation of several SNF facilities, Mutual of Omaha (Mutual) continued to make PIP payments to the former operator, Mariner Health Care, Inc. (Mariner), even though the former operator was no longer providing services. CMS seeks to recoup the improper payments made to the prior owner from Triad's Medicare accounts receivable. Triad asserts the overpayment must be recouped from the former operator to whom the overpayment was made and seeks to terminate the recoupment action against Triad with this appeal.[1]

Before filing this appeal with the Board, the Providers filed an action in Federal district court against CMS seeking declaratory and injunctive relief to bar the recoupment. The D.C. District court dismissed the case, citing in part the Providers' failure to exhaust administrative remedies by pursuing an appeal from their NPRs with the Board. [2]

The Providers' submission alleges the following facts: Prior to December 1, 2006, the Providers that are the subject of this appeal were leased and operated by Brian Center Nursing Care/Austell, Inc., a wholly owned subsidiary of Mariner. After several years of litigation, Mariner vacated the facilities and Triad took over operation of the Provider facilities on December 1, 2006.

On November 30, 2006, Triad filed Medicare Provider/Supplier Enrollment applications with its fiscal intermediary, Blue Cross Blue Shield of Georgia (Georgia). The applications indicated that as of December 1, 2006, Mariner no longer leased and operated the facilities and Triad sought assignment of Mariner's five provider agreements, effective December 1, 2006.

On November 30, 2006, one day before vacating the facilities that would be operated by Triad, Mariner's Executive Vice President and Chief Financial Officer (CFO) sent a letter to Mutual, Mariner's fiscal intermediary. In that letter, Mariner stated that it did "not approve or authorize any changes in ownership or transfer of [the] facilities licenses or Medicare numbers to any person or entity" noting that "we are aware that a person and/or entity may be applying for a license to operate the facilities we currently operate and/or seek a Change

[1] See, Provider Hearing Request, Exhibit. 15 Second Affidavit of Jack C. Tranter. This document indicates that if Triad entered a repayment plan it must include the entire amount claimed by the Intermediary as an overpayment and Triad would not be able to contest the liability for the alleged overpayment if it entered a payment plan.

[2] See, Triad at Jeffersonville I, LLC v. Leavitt, 563 F. Supp. 2nd 1 (D.D.C. 2008).

of Ownership (CHOW) without our support or authorization."[3] The CFO's letter also directed Mutual to continue making Medicare payments to Mariner.

In mid-January 2007, Triad contacted their fiscal intermediary (Georgia) to check on the status of the assignment of provider numbers. They were told they had used outdated forms and the applications had been returned. Triad filed new applications on January 30, 2007. These applications also identified Mariner as the former operator and Mutual as the former fiscal intermediary.[4]

CMS approved the applications in letters dated April 12, 2007. The approval letters acknowledged Triad's notification to CMS of the change of ownership effective December 1, 2006 and advised that, in such changes of ownership, the Medicare provider agreement is "automatically assigned to the new owner who is subject to all the terms and conditions of the provider agreement."[5] Meantime, unknown to Triad, Mutual continued making PIP payments of almost $2 million to Mariner up through April 18, 2007.[6] Triad does not receive PIP payments; it submits monthly bills to its fiscal intermediary Blue Cross Blue Shield of Georgia. After it received the April, 2007 approval from CMS, Triad then submitted bills to its fiscal intermediary back to December 1, 2006.

When Triad discovered payments were being made to Mariner, Triad asked Mariner to return the money to Mutual, but Mariner did not comply. CMS notified Triad that the money would be recouped through withholding of money owed to Triad by the Medicare program. Triad sued CMS and sought a preliminary injunction prior to the issuance of Triad's NPRs.[7]

The Providers do not dispute that payments made to Mariner after it ceased providing services creates an overpayment nor do they dispute the amount of the overpayment. Rather, the Providers dispute their liability for the overpayment.

The Providers contend the regulations regarding successor liability for Medicare overpayments do not apply. The regulation regarding assignment of agreements do not address the situation where a liability arises after the assignment and where Mariner was not a "provider of services" to the residents of the facilities at the time the PIP payments were made. The CHOW occurred on December 1, 2006 when Triad began operating the facility. Triad maintains that no amount of due diligence could have revealed that it would have been responsible for CMS' overpayments to Mariner that were paid after Triad began operating the facility. Triad also alleges that CMS was on notice of the CHOW when Triad filed the application forms on January 30, 2007 and it was not proper for CMS to continue to make PIP payments to Mariner because there was no evidence that the qualifying criteria set forth in the regulations, at 42 C.F.R. § 413.64(h), had been met. Finally, the Providers assert

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[3] Provider Hearing Request, Ex. P-7.
[4] Id. Exhibits P-9 and P-10.
[5] Id. Exhibit P-11
[6] Triad at Jeffersonville (Provider No. 11-5413) PIP payments were made through May 2, 2007. See Provider Exhibit P-12.
[7] Id. Triad at Jeffersonville I, LLC vs. Leavitt, supra at note 2.

successor liability does not apply because Mariner fraudulently directed Mutual to continue to make PIP payments to Mariner and then concealed the receipt of funds by failing to file terminating Medicare cost reports after the CHOW.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board concludes that it does not have jurisdiction over the appeal. The statute and regulations permit an appeal to the Board by a provider which is dissatisfied as to the "total amount of program reimbursement" due the provider for items and services furnished to Medicare beneficiaries. In this case, the Providers do not dispute the amount of the Intermediary determination which is a prerequisite to Board jurisdiction under 42 U.S.C. §1395oo(a) and 42 C.F.R. § §405.1835-405.1847. The amounts determined as proper for the services provided in the cost report period under Triad's operation is not challenged nor is the amount of the improper payments to Mariner. The only dispute is which entity is responsible for repayment of the overpayment, a question beyond the Board's jurisdiction to decide.

This case is analogous to the Board's decisions in Heritage Health care, Inc. v. Mutual of Omaha[8] (Heritage). In Heritage, the provider accepted assignment of the prior owner's provider numbers and was subject to an overpayment incurred by the previous owners. The new owner believed that the amount the intermediary sought to recoup should have been discharged through the prior owner's bankruptcy. As in the current case, there was no dispute as to the amount of the overpayment or the amount due for the successor's services; the only issue before the Board was whether the overpayment obligation should be considered discharged through the bankruptcy. The Board held that it lacked jurisdiction over the recoupment action because those matters are specifically excluded from the Board's authority. The Administrator declined review.[9]

The Board finds further support for lack of jurisdiction in the regulatory prohibitions of overpayment recoupment actions. 42 C.F.R. §§ 405.1801(a)(4), 405.376(j) and 401.625 preclude Board appeals over actions taken by CMS or the intermediary regarding the compromise of an overpayment claim, or termination or suspension of a collection action on an overpayment claim.

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[8] See, Heritage Healthcare v. Mutual of Omaha PRRB Decs. 2004-D8 and D9 ¶¶ 81,098 and 81,099.

[9] Although it appears from the D.C. District Court's order of dismissal in Triad, 563 F. Supp. 2d, supra that CMS may have defended that action by asserting failure to exhaust administrative remedies, the Administrator has consistently upheld the Board's decisions that it has no jurisdiction to determine which entity is responsible for an overpayment or to order suspension of recoupment actions. See e.g., the following Board decisions issued in letter format to the parties: The Willough at Naples, PRRB Case Nos. 07-2332 and 07-2333 (August 25, 2008); Eagle Healthcare, Inc. 95, 98-99 Medicare Overpayment Group, PRRB Case No. 05-0058G (December 12, 2008) and Christian Ministries Riverdale, PRRB Case Nos. 08-1697 and 08-1696 (September 11, 2008). Because of the large number of jurisdictional decisions the Board issues it does not publish all of its jurisdictional decisions, but notifies the parties of jurisdictional decisions in letter format. Those decisions that are published are issued when the topic would be of interest or instructive to other parties with cases before the Board.

Section 405.1801(a)(4) states that for purposes of § 405.376 concerning claims collection activities, the term "final determination" does not include an action by CMS with respect to a compromise of a Medicare overpayment claim, or termination or suspension of collection action on an overpayment claim. . . Section 405.376 is contained in Subpart C of Title 42 which deals with the policies and procedures for handling incorrect Medicare payments and recovery of overpayments. Within that subpart, 42 C.F.R. § 405.376(j) states that "[a]ny action taken by CMS under this section regarding the compromise of an overpayment claim, or termination or suspension of collection action on an overpayment claim, is not an initial determination for purposes of appeal procedures under subpart . . . R of this part." This position is repeated in 42 C.F.R. § 401.625, which deals with claim collection action under the Federal Claims Collection Act (dealing with recoupment of overpayments over $100,000). The CMS Pub. 100-6, Chapter 3 entitled *Overpayments*, Section 90.2 addresses the protest of a liability resulting from an overpayment. The provider may reply to an intermediary's notice of overpayment and indicate dissatisfaction with some aspect of the overpayment decision. Such a protest is considered a request for appeal; the intermediary will conduct the appeal and determine if the provider is liable for repayment

DECISION AND ORDER:

The Board finds that it lacks jurisdiction over the appeal and hereby dismisses the case. Review of this decision is available under the provisions of 42 U.S.C. §1395oo(f)(1) and 42 C.F.R. §§405.1875 and 405.1877.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Yvette C. Hayes
Michael D. Richards, CPA
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Suzanne Cochran, Esquire
Chairman

DATE: April 17, 2009