PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON-THE-RECORD
2011-D44

PROVIDER –
Kingsbrook Jewish Medical Center
Brooklyn, New York

Provider No.: 33-0201

vs.

INTERMEDIARY -
BlueCross BlueShield Association/
National Government Services, Inc.

DATE OF HEARING -
August 12, 2010

Cost Reporting Period Ended -
December 31, 2000

CASE NO.: 05-1144

INDEX

ISSUES:

Whether the Provider's cost reimbursement should be computed taking into account the charges included in the Provider's log of late charges which have not been billed to Medicare.

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 & 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 to organizations known as fiscal intermediaries (FI) and Medicare administrative contractors (MAC). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. 42 C.F.R. § 413.20. The 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) provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy for a single provider must exceed $10,000 for an individual appeal (or $50,000 for a group); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination. 42 U.S.C. §1395oo(a); 42 C.F.R. §§405.1835-.1837.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Kingsbrook Jewish Medical Center (Provider) is a hospital located in Brooklyn, New York. On September 24, 2004, National Government Services[2], formerly Empire Medicare Services, (Intermediary) issued a NPR for the fiscal year ending December 31, 2000. The Provider filed a timely appeal with the Board on March 18, 2005.

On May 7, 2010, the parties requested a hearing on the record for the instant case. The Board granted the parties' request. The Provider was represented by Dennis M. Barry, Esq. of King & Spalding, LLP. The Intermediary was represented by L. Sue Anderson, Esq. of Blue Cross Blue Shield Association.

[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] On March 18, 2008, National Government Services was awarded the MAC for Jurisdiction 13- Connecticut and New York.

PARTIES' STIPULATIONS:

The Provider and Intermediary stipulated to the following facts:[3]

1) The Provider is Kingsbrook Jewish Medical Center, Medicare Provider Number 33-0201 ("KJMC"). The Intermediary is National Government Services ("NGS") (formerly Empire Medicare Services).

2) The Intermediary issued a notice of program reimbursement ("NPR") dated September 24, 2004 for the Provider's 2000 fiscal year. Ex. P-14 to the Provider's Supplemental Position Paper. The Provider timely filed a notice of appeal to the Board from the NPR for fiscal year 2000. Ex. P-17 to the Provider's Supplemental Position Paper.

3) Effective January 1, 1998, KJMC converted from charging patients an all-inclusive rate to the more common industry practice of charging separately for each item and service.

4) KJMC (through an outside contractor) has furnished to NGS a log of charges listing services furnished to Medicare patients in 2000 that were not billed to Medicare. KJMC has represented to NGS that its log of late charges identified charges only for patients for whom a Medicare-covered inpatient stay or a Medicare-covered outpatient encounter had been reported on the PS&R [Provider Statistical & Reimbursement Report] and the dates of service for the listed late charges coincided with those Medicare-covered services.

5) The Provider has furnished to the Intermediary data regarding these charges, including without limitation, for each charge, the patient's name, HIC [health insurance claim] number, KJMC's internal identifying numbers for the patient's account, dates of admission and discharge for an inpatient stay or the date of service for an outpatient stay, the charge service date, the charge code from KJMC's charge master, the applicable revenue code, the charge amount, the bill date, and the date the listed charge was posted. KJMC has summarized its log of late charges in Provider Exhibit P-5 to the Provider's Supplemental Position Paper.

6) NGS has not fully audited the log of late charges submitted to it by KJMC but has talked with an individual knowledgeable about how that log was compiled, and NGS has performed some preliminary testing on that log. NGS believes that the methodology described by KJMC's agents and representatives should have produced a listing of charges that were furnished to Medicare patients as part of a covered inpatient stay or outpatient encounter but were not billed to Medicare and which were not reflected in the PS&R listing of Medicare charges used to settle KJMC's 2000 Medicare cost report. NGS believes that the late charges reported by KJMC in the log it has furnished to NGS should generally be accurate.

7) If the Provider prevails in this appeal, the Provider's data should be audited or otherwise tested by the Intermediary in order to calculate the precise amount payable to KJMC.

[3] *See,* Stipulations of the Parties.

The parties will determine whether these charges have been included in total charges to determine the final ratio consistent with cost apportionment methodology.

8) The parties agree that the only remaining issue is:

> Whether the Provider's cost reimbursement should be computed taking into account the charges included in the Provider's log of late charges, which have not been billed to Medicare?

JURISDICTION:

In the process of changing from an all-inclusive rate method of charging patients to the fee-for-service method, the Provider determined that there were charges for services furnished to Medicare patients in 2000 that had not been billed. As a result, those charges were not used by the Provider in its filed Medicare cost report to apportion the costs of covered services to Medicare; nor were they used when the Intermediary issued the NPR since these charges were not reflected in the Provider Statistical & Reimbursement Report (PS&R). The question of whether the Board had jurisdiction then arose.

PARTIES' CONTENTIONS:

The Provider contends it was underpaid substantially during the fiscal year at issue because Medicare late charges have not been taken into account in calculating the Provider's cost reimbursement for its excluded psychiatric unit, rehabilitation unit and outpatient services.[4] The Provider acknowledged its decrease in Medicare revenue was attributed to its failed conversion in 1998 from an "all inclusive rate" to a "fee for service" provider.[5]

The Provider asserts that in a letter dated December 5, 2002, the Intermediary acknowledged there was an error in the Provider's new billing system, which caused both total charges and Medicare charges to be understated on the Medicare cost report.[6] The Provider requests that it be reimbursed for its "late charges" it discovered through its data match process.[7] Alternatively, the Provider requests that the Board remove the "late charges" the Provider has identified from "total charges" in the apportionment formula, to alleviate the "mis-match" problem within the calculation.

The Provider contends that its claim for late charges must be accepted for several reasons. First, CMS's policy of excluding late charges from the cost apportionment calculation results in inaccurate payment to the Provider.[8] Second, CMS's regulations have previously been interpreted to allow an Intermediary to use a log of unbilled late charges to correct the Provider's cost reimbursement.[9] Third, CMS has attempted to change its policy without going through the

[4] Provider's Supplemental Position Paper at 2.
[5] *Id.* at 4.
[6] *Id* at 19, Provider's Exhibit P-2.
[7] *Id.* at 20.
[8] *Id.* 9.
[9] *Id.* at 13.

requisite notice and comment rulemaking procedures.[10] And finally, omitting late charges creates a "mis-match" of Medicare charges and total charges violating Medicare apportionment principles.[11]

The Intermediary maintains that CMS' longstanding policy, as reflected in claims processing manual dated August 1993 (CMS Pub. 13.3, Transmittal No. IM-93-2), does not allow the filing of late charges through the submission of a patient log.[12] Further these charges should have been submitted within the applicable timely filing requirements. Since, the Provider filed these late charges beyond the timely filing date, the Intermediary cannot agree to add these charges to the cost report.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board concludes that the Provider does not have a right to a hearing under 42 U.S.C. §1395oo(a).

The Board's jurisdiction is established under 42 U.S.C. §1395oo(a). It provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report.

The issue appealed in this case pertains to the late charges which were not billed to Medicare. Those late charges were never included as Medicare charges on Worksheet D in the cost report as filed. However, they were included in total charges on Worksheet C in the cost report.

The adjustments proposed by the Intermediary, specifically, adjustment numbers 206, 209 and 210 relate to Medicare charges on worksheet D.[13] However, per the description for these adjustments "to adjust Provider's cost report to Intermediary data," these adjustments apparently have nothing to do with unbilled late charges. Moreover, there appears no adjustments were made to total charges on Worksheet C. Therefore, the Board finds that the Provider never claimed late charges on its cost report as filed and that the Intermediary never proposed any adjustment for late charges.

In determining jurisdiction, the Board considered the D. C. Circuit Court ruling in *Athens*

[10] *Id.* at 15.
[11] *Id* at 18.
[12] Intermediary's Supplemental Position Paper at 3.
[13] Provider's Exhibit P-15.

Community Hospital v. Schweiker, 743 F.2d 1, 240 U.S. App. D.C. 1 (1984) (*Athens II*), in which the court held that a claim presented up until the issuance of the NPR satisfies jurisdictional requirements for a hearing under 42 U.S.C. §1395oo(a). The Provider argues that it claimed Medicare late charges prior to issuance of the NPR, as mentioned in a letter from the Intermediary dated December 5, 2002. However, review of the letter shows it was for a different fiscal year and appeal, and therefore irrelevant to the present case. The Board also finds that the Medicare program has a protocol for submitting charges and claiming cost reimbursement. Charges and costs cannot be claimed informally or in letters, memoranda or emails. Charges must be billed on approved forms and costs must be claimed on accepted cost reports. If additional costs are to be claimed, there are provisions for the submission of amended cost reports. The Provider never submitted an amended cost report.

The Board also considered the Provider's contention that omitting the late charges creates a "mis-match" of Medicare charges and total charges violating Medicare apportionment principles. According to the regulations the stated objective of the method of apportionment is to have the Program's share of a provider's total allowable costs be the same as the Program's share of the provider's total services. 42 C.F.R. § 413.50(b). The regulations discuss the use of charges as a basis for apportionment. Charges are used to measure the amount of services for which third-party payers have responsibility and also to determine payment on a cost basis. 42 C.F.R. §413 50(h) and (i). In this approach the amount of charges for services for a particular third-party payer as a proportion to a provider's total charges to all patients is used to determine the provider's costs for which that payer is responsible.

In this case the total charges, billed and unbilled, must be used to create the "cost-to-charge ratio." This fulfills the regulatory requirement for charges to measure the amount of services. If a Medicare service is not billed; just like if a Medicare service is not covered, it becomes a non-Medicare services. The properly matched "cost-to-charge ratio" must be applied to the covered Medicare charges for proper apportionment. Since certain Medicare services have not been billed, there is no way of knowing whether the unbilled service is covered. It is not the Program's responsibility to address Medicare covered charges beyond the normal billing and adjudication process laid out in the regulations. Consequently, the Board concludes it has no jurisdiction over the late charges.

It has been established through case law that once jurisdiction is obtained under 42 U.S.C. §1395oo(a), subsection (d) gives the Board discretionary power to review additional matters not considered by the Intermediary.[14] In this case, however, the only issue appealed relates to late charges omitted by the Provider. There is no mention of dissatisfaction with disallowances of any costs on the cost report and, consequently, there is no jurisdictionally valid appeal under 42 U.S.C. §1395oo(a). Therefore, the Board does not have the discretionary power to review additional matters under 42 U.S.C. §1395oo(d).

[14] See, MaineGeneral Medical Center v. Shalala, 205 F.3d 493 (1st Cir. 2000); Loma Linda Univ. Med Ctr v. Leavitt, 492 F.3d 1065 (9th Cir. 2007); and UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008), discussing the application of Bethesda Hospital Assoc. v. Bowen, 485 U.S. 399 (1988), to costs inadvertently omitted from the cost report.

DECISION AND ORDER

The Board concludes it lacks jurisdiction over the unbilled Medicare late charges, and as this is the only issue in dispute, the Board also dismisses the case. 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

Yvette C. Hayes
Keith E. Braganza, CPA
John Gary Bowers, CPA

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: September 14, 2011