PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD

2015-D21

PROVIDER –
Wilmington Treatment Center
Wilmington, North Carolina

Provider No.: 34-0168

vs.

MEDICARE CONTRACTOR –
Palmetto GBA

DATE OF HEARING -
June 3, 2014

Cost Reporting Period Ended -
September 30, 2001

CASE NO.: 08-0028

INDEX

ISSUE STATEMENTS

ISSUE 1: Whether the Medicare Contractor's adjustment to the provider-based physician professional component was proper.

ISSUE 2: Whether the Medicare Contractor's recoupment of payments related to the denial of inpatient admissions was proper.

ISSUE 3: Whether the Medicare Contractor's adjustment disallowing costs related to Wilmington's partial hospitalization program was proper.

DECISION

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board makes the following findings on the three issues:

ISSUE 1 – The Board finds that the Medicare Contractor's adjustment using the 1999 percentage to allocate physician costs for fiscal year ("FY") 2001 between Part A and Part B for the provider-based physician professional component was proper. Accordingly, the Board affirms the Medicare Contractor's adjustment related to this issue.

ISSUE 2 –The Board finds that the Medicare Contractor's recoupment on the FY 2001 cost report of $193,604 for denied inpatient admissions was proper and was not a duplicate recovery. Accordingly, the Board affirms the Medicare Contractor's adjustment related to this issue.

ISSUE 3 – The Board finds that the Medicare Contractor's adjustment on the FY 2001 cost report to remove all outpatient charges associated with the Provider's partial hospitalization program was improper. Accordingly, the Board reverses the Medicare Contractor's adjustment related to this issue.

INTRODUCTION

Wilmington Treatment Center ("Wilmington") is a 27-bed hospital that specializes in the inpatient ***and*** outpatient treatment and care of persons with alcohol and/or substance abuse issues and conditions. Located in Wilmington, North Carolina, Wilmington offers various services including: (1) comprehensive inpatient treatment; (2) outpatient partial hospitalization or day treatment for those individuals who need structured services but who do not require 24-hour medical management or clinical supervision; (3) outpatient services and assessments for substance abuse; and (4) individual and group therapy for alcohol or substance abuse. Wilmington is staffed by licensed physicians, physicians' assistants, nurses, and therapists.

During FY 2001, Wilmington's assigned Medicare contractor was Cahaba Safeguard Administrators ("CSA" or "Cahaba") (collectively referred to as the Medicare Contractor").[1] The Medicare Contractor issued a Notice of Program Reimbursement ("RNPR") for FY 2001 on

[1] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to as Medicare contractors.

July 27, 2007 and determined that Wilmington had been overpaid by more than $335,000. Wilmington timely filed an appeal of the RNPR with the Board on October 5, 2007. Wilmington's appeal meets the jurisdictional requirements of 42 C.F.R §§ 405.1835-1841.

The Provider Reimbursement Review Board ("Board") held a hearing on the record. Wilmington was represented by Robert Wanerman, Esq. of Epstein Becker & Green P.C. The Medicare Contractor, was represented by Arthur E. Peabody, Jr., Esq. of the Blue Cross and Blue Shield Association.

STATEMENT OF THE FACTS

Wilmington appealed three adjustments including: 1) allocation of costs for professional services; 2) denial of reimbursement for inpatient admissions as medically unnecessary, and adjusted certain outpatient costs related to Wilmington's partial hospitalization program.[2] On its 2001 cost report, Wilmington reclassified the salary costs for its medical director, Patrick D. Martin, M.D., from its routine cost center to its partial hospitalization/outpatient cost center based on the responsibilities specified in a written contract. These responsibilities included 7 day per week, 24-hour coverage of daily patient rounds, conducting admission histories, physical and mental status exams, conducting team and professional staff meetings, utilization review and other quality assurance activities.[3]

Regarding the second issue, on April 25, 2006, the Medicare Contractor notified Wilmington that the Carolinas Center for Medical Excellence, a quality improvement organization ("QIO") under contract with CMS, determined that 23 inpatient admissions during FY 2001 were medically unnecessary.[4] Wilmington did not contest these findings and assumed that the Medicare Contractor had taken steps to recoup the money previously paid to Wilmington for these admissions.[5] The RNPR notified Wilmington that the Contractor removed $193,604 to recoup this overpayment.

Pertinent to the third issue, Wilmington's partial hospitalization program ("PHP") had been the subject of questions beginning in 1997 and early 1998 when the Medicare Contractor questioned Wilmington's claims for PHP services based on a lack of documentation regarding physician involvement in treatment, group therapy documentation and bundling of charges.[6] Per the request of the Medicare Contractor, on June 2, 1998 Wilmington submitted a corrective action plan to address these PHP documentation issues.[7]

On October 23, 2000 the Medicare Contractor notified Wilmington that its PHP continued to be noncompliant with Medicare requirements for PHP services, confirmed that Wilmington's PHP had been on **prepayment** review and that its denial rate over the past 6 months had been over 68 percent.[8] In a meeting with Wilmington on December 5, 2000, the Medicare Contractor

[2] Provider's Position Paper submitted November 7, 2013 at 2-3.
[3] *Id.*, at 3.
[4] Intermediary's Supplemental Final Position Paper, submitted April 11, 2014, Exhibit I-14 at 4-9.
[5] *Id.*, at 11.
[6] Medicare Contractor's Supplemental Final Position Paper, Exhibit I-16 at 1.
[7] *See id.* at 2; Medicare Contractor's Final Position Paper, Exhibit I-15.
[8] Medicare Contractor's Supplemental Final Position Paper, Exhibit I-17 (emphasis added).

informed Wilmington that it had 30 days to send in a new corrective action plan and that it "would remain at 50 percent **prepayment** review until a significant change had been noted and sustained."[9]

On January 12, 2001, the Medicare Contractor confirmed that the requested corrective action plan "has overall *satisfactorily addressed* all the areas that were of concern to us with regards to compliance with Medicare guidelines for Partial Hospitalization Program services."[10] The Medicare Contractor stated that Wilmington would remain on focused medical review until Wilmington's PHP achieved a denial rate below 15 percent for two consecutive quarters.

The Medicare Contractor sent two more letters addressing Wilmington's adherence to the corrective action plan: in August 1, 2001 the Medicare Contractor told Wilmington that "[w]e have been monitoring your adherence to your corrective action plan and continue to find that your denial rate for services remains high," in particular noting that 9 denials were due to Wilmington's failure to submit medical records.[11] On October 25, 2001, the Medicare Contractor told Wilmington that it "continued to bill incorrectly for PHP services" as Wilmington was "billing revenue code 915 with HCPCS code 90853 multiple units without documentation to support this" and that the Medicare Contactor "was returning claims to allow [Wilmington's] billing area to accurately bill according to the services being provided."[12]

Finally, pertinent to the last issued, on August 20, 2001, Wilmington leased the Hope House of Wilmington, Inc. ("Hope"). Hope was responsible for providing 3 live-in managers as well as providing transportation, cleaning and security services for its residents. One of these managers was to be on duty during specified hours 7 days per week.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

ISSUE 1 - PROVIDER-BASED PHYSICIAN PROFESSIONAL COMPONENT

Wilmington contends that the compensation for professional services claimed for FY 2001 was denied on the grounds that Wilmington "did not provide time studies to properly determine the professional components."[13] Wilmington recognizes that the Medicare Contractor based its determination on Medicare's Provider Reimbursement Manual ("PRM"), Pub. No. 15-1 § 2313, and Pub. No. 15-2 § 3615. However, Wilmington asserts that these references do not make time studies a condition of payment for the costs of physicians' services. As a preliminary matter, Wilmington argues that it had already reclassified the costs for the services of its medical director on its FY 2001 Medicare cost report and, as a result, the Medicare Contractor's adjustment unnecessarily duplicated Wilmington's reclassification.

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[9] *Id.*, Exhibit I-18 at 5.
[10] Medicare Contractor's Final Position Paper, Exhibit I-19 at 1. *See also id.*, Exhibit I-18 (copy of Wilmington's Jan. 3, 2001 corrective action plan).
[11] Medicare Contractor's Supplemental Final Position Paper, Exhibit I-19.
[12] Medicare Contractor's Supplemental Final Position Paper, Exhibit I-20.
[13] *See* Provider's Position Paper at 4.

Wilmington argues that, while there is no doubt that physician compensation must be allocated if the physician serves both Medicare and non-Medicare patients, nothing in the Medicare regulations or manuals requires: (1) a particular method for substantiating Wilmington's costs; (2) prior approval for an allocation method; or (3) time studies to be conducted.[14] PRM 15-1 § 2182.3(E)(4) gives the provider wide discretion in maintaining records:

> While we do not require the maintenance of daily logs or time records to support provider services rendered by physicians, adequate documentation must be maintained to support the total hours for these services to permit application of RCE [reasonable compensation equivalent] limits. This includes work or teaching schedules, workload counts, or other documentation to substantiate these costs.

Further, Wilmington contends that any allocation of time necessary to apply the reasonable compensation equivalent ("RCE") limits is irrelevant to this appeal because PRM 15-2 § 3615, which was cited by the Medicare Contractor as the basis for its adjustment, *expressly* exempts medical director costs from those limits.[15] Similarly, Wilmington contends that the manual provisions cited by the Medicare Contractor do not *require* that a provider prepare time studies; rather, the manual instructions explain that time studies are one of several possible allocation methods, and contain specifications for time studies for those providers that elect to use them.[16]

Wilmington further contends that the only compensation that the medical director received for his services at Wilmington was his salary. To the extent that any allocation was necessary, Wilmington used a reasonable allocation method based on the duties enumerated in the contract with the medical director. That work encompassed both administrative services that benefited Wilmington and patient services covered and reimbursable under Part A; none of the enumerated obligations under this contract called for the medical director to furnish services that are typically covered or reimbursable under Medicare Part B.[17] In this regard, Wilmington maintains that the patient care activities that the medical director may have conducted are a normal part of the operations of any hospital and should not be misconstrued as billable individual patient care.[18] This is reinforced by the fact that none of the Part B claims filed either by the medical director or on his behalf were for services rendered at the Wilmington.

Wilmington disputes the Medicare Contractor's contention that the medical director was expected to provide direct patient care as it fails to distinguish between medical care provided by an attending physician to a patient to treat an illness with the activities performed by a physician as an administrative function to a hospital as required under relevant state law. Wilmington maintains that the medical director's function here falls squarely within the scope of North

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[14] *See* 42 C.F.R. §§ 413.24, 415.60(f)(i); PRM 15-1 § 2313.2.
[15] Provider's Position Paper at 5 (quoting PRM 15-2 § 3615 which states: "RCE limits are not applicable to a medical director, chief of medical staff, or to the compensation of a physician employed in a capacity not requiring the services of a physician, e.g., controller").
[16] *See* 42 C.F.R. § 415.60.
[17] *See* Medicare Contractor's Supplemental Final Position Paper, Exhibit I-10 (copy of contract between Wilmington and the medical director).
[18] 10A N.C. ADMIN CODE 13B.1905, and 13B.3202 (copies at Provider Exhibit P-5).

Carolina regulations that govern the licensing of hospitals and that it should not be penalized for complying with North Carolina law.[19] Accordingly, Wilmington believes it properly reclassified these costs on Worksheet A-8.[20]

The Board finds that the contract between Wilmington and the medical director did not allocate the physician's time to Part A services in compliance with the requirements of 42 C.F.R. § 415.60(f)(l). Specifically, this regulation states:

> The intermediary pays the provider for those costs *only if* (i) the provider submits to the intermediary a *written allocation agreement* between the provider and the physician that *specifies the respective amounts of time the physician spends in furnishing* physician services to the provider, physician services to patients, and services that are not reimbursable under either Part A or Part B of Medicare . . . .[21]

Therefore, the Board finds that Wilmington did not have a signed written agreement with the medical director that was in compliance with the stated regulation. Contrary to Wilmington's insinuation, the fact that medical directors are exempt from RCE limits does not exempt medical directors from the requirements of 42 C.F.R. § 415.60(f)(l). Lacking a written allocation agreement, time studies or other documentation, the Board finds that Wilmington did not maintain sufficient documentation to support the allocation of physician time spent performing administrative duties as required by the regulation.

The Board also rejects Wilmington's contentions that the medical director contract did not "call[] for the medical director to furnish services that are typically covered or reimbursable under Medicare Part B" and that this is "reinforced by the fact that none of the Part B claims filed either by [the medical director] or on his behalf were for services rendered at [Wilmington]."[22] First, Wilmington has presented no evidence to support its assertion that the medical director only billed for patient care services furnished off site (*i.e.*, outside Wilmington). More importantly, contrary to Wilmington's contention, the Board finds that Wilmington's contract with the medical director did contemplate that the medical director would furnish patient care billable under Medicare Part B in addition to the normal medical director duties;[23] and to this end, the contract required the medical director to maintain and furnish to Wilmington, documentation allocating his time on a bimonthly basis.[24] The Board's findings are supported by

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[19] Provider's Position Paper at 6-7.
[20] *See* Provider's Position Paper at 7.
[21] (Emphasis added.)
[22] Provider's Position Paper at 7.
[23] *See* Medicare Contractor's Supplemental Final Position Paper, Exhibit I-10 at §§ 1(c), 1(e), 1(g), 1(j), 3(b) (copy of contract between Wilmington and the medical director). For example, § 1(c) of the contract specifies that "Physician shall complete all medical record entries and insurance reporting requirements for *Physician's patients* in and/or discharged from the Facility on a timely basis . . ." (Emphasis added.) Similarly, § 1(e) of the contract specifies that the medical director is responsible for providing 24/7 "coverage" where "coverage" included "Daily Rounds, Admission Assessments, Treatment Team Meetings, ..."
[24] *See id.*, Exhibit 10 at § 1(d) (stating: "d) Physician shall maintain records of the time spent in carrying out Physician's obligations under this agreement, which records shall be in such form and detail as Facility shall specify; Physician shall deliver these records to Facility on a bi-monthly basis . . . .").

the fact that the Medicare Part B physician fee schedule includes payment for inpatient initial hospital care and inpatient discharge management.[25] Therefore, the Board finds that this contract does not comply with the requirements of PRM 15-1 § 2182.3 and Wilmington did not maintain auditable documentation in order to allocate costs between Medicare Parts A and B.[26]

ISSUE 2 – RECOUPMENT OF PAYMENTS RELATED TO THE DENIAL OF INPATIENT ADMISSIONS

Wilmington contends that the Medicare Contractor's action to remove $193,604 from Worksheet E, Part A, Line 24, of its FY 2001 cost report duplicates action already taken to recoup the Medicare reimbursement paid to Wilmington for the inpatient admissions in question. Accordingly, Wilmington argues that including the same amount in the RNPR resulted in a duplicate recovery for the Medicare program.[27]

The Board has reviewed the submitted documentation for the recoupment of payments related to the denial of inpatient admissions and could find no evidence in the record to suggest that the Medicare Contractor recouped the payment twice as alleged by Wilmington. In support of its allegation, Wilmington refers to a letter dated April 25, 2006 as providing notification of the denied claims.[28] Wilmington claims that: "Cahaba then took steps to recoup the monies previously paid to WTC[Wilmington]. It is WTC's understanding that those funds were recovered through this process."[29]

However, there is nothing in the April 25, 2006 letter describing how these monies would be recouped and Wilmington has presented no evidence to support its "understanding." Rather, the only description in the record of how the monies would be recouped is in the letter issued on November 10, 2006 (shortly after the April 25, 2006 letter)[30] from the Medicare Contractor to Wilmington. This letter clearly specifies that recoupment would be done through cost report adjustments. Specifically, the November 10, 2006 letter states the following:

> **Overpayment-Recoupment – Inpatient. . . .** At this time, CSA's Benefit Integrity Unit has requested CSA's Audit and Reimbursement Department to make the appropriate *cost report adjustments* to remove . . . Medicare reimbursement for the denied claims identified for fiscal years 2001, 2002, and 2003.[31]

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[25] *See* Medicare Carriers Manual, Part III, CMS Pub. 14-3, §§ 15505-15505.2 (2001) (discussing physician fee schedule payments for initial hospital care services under CPT codes 99221-99223 and for subsequent hospital visits and discharge management under CPT codes 99231-99239).

[26] The Board recognizes that, in support of its position, Wilmington cited to the Board's decision in *Methodist Hosp. v. Blue Cross and Blue Shield Ass'n,* PRRB Dec. No. 2000-D32 (Mar. 23, 2000), *rev'd*, Adm'r Dec. (May 24, 2000). However, the Board finds that the facts in this case can be distinguished from those in *Methodist.* Specifically, unlike the contracts in *Methodist*, the contract between Wilmington and the medical director does not stipulate that all of the services provided by medical director are Part A services and, thereby, does not meet the requirements of PRM 15-1 § 2182.3.

[27] *See* Provider's Position Paper at 9-10.

[28] *See* Medicare Contractor's Supplemental Final Position Paper, Exhibit I-14 at 4.

[29] Provider's Position Paper at 9.

[30] *See* Medicare Contractor's Supplemental Final Position Paper, Exhibit I-14 at 11.

[31] (Emphasis added.)

Accordingly, based on the record before it, the Board finds that the Medicare Contractor recouped the $193,604 at issue only once and this was through the FY 2001 audit adjustments under appeal.

ISSUE 3 – PARTIAL HOSPITALIZATION PROGRAM

The Medicare Contractor essentially challenges Board jurisdiction over the cost report adjustment disallowing Wilmington's outpatient PHP charges for FY 2001 because Wilmington "failed to avail itself of available [other] administrative remedies in a timely manner."[32] Specifically, the Medicare Contractor asserts that its Benefit Integrity Department and the Quality Improvement Organization (collectively the "QIO/BI") reviewed certain Medicare claims for psychological services, made specific determinations, and notified the Provider in its April 26, 2006 letter of its right to request reconsideration through the claims appeals process. The Provider failed to exercise its remedy to contest claims denials.[33]

Further, the Medicare contractor asserts the QIO's findings sent to Wilmington by letter dated November 10, 2006 were: (1) Wilmington's PHP failed to meet the Medicare program requirement under 42 U.S.C. § 1395x(ff)(3)(A) specifying that PHPs provide less than 24-hour daily care; and (2) Wilmington's charges for outpatient PHP services furnished during FY 2001 should be recouped through adjustments to the FY 2001 cost report.[34] As a consequence, the Medicare Contractor issued the RNPR at issue to make an adjustment to disallow all charges for PHP services from Wilmington's FY 2001 cost report.

The Medicare Contractor argues in the alternative that, if the Board determines that jurisdiction is appropriate, then the Board should find that Wilmington consistently did not qualify under the federal statutory criteria because Wilmington's PHP failed to provide services that were less than 24-hour daily care consistent with 42 U.S.C. § 1395x(ff)(3)(A). Specifically, the Medicare Contractor maintains that the record establishes that Wilmington's PHP functioned as a residential treatment facility because its PHP patients were provided 24-hour supervision, meals, transportation, and housing.[35]

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[32] Medicare Contractor's Supplemental Final Position Paper at 9. In this regard, the Medicare Contractor maintains that the Board has consistently held that it lacks jurisdiction when a provider fails to avail itself of available administrative remedies in a timely manner. *See id. (*citing to *Western Reserve Care Sys.*, PRRB Case No. 06-0367, Letter Decision, Feb. 1, 2006; *Lake Charles Memorial Hospital*, PRRB Case No. 09-1259, Letter Decision Nov. 15, 2011; and *Santa Cruz MSA Hospital Wage Index Group Appeal*, Letter Decision, Mar. 16, 2012 (copies *available at* Medicare Contractor's Supplemental Final Position Paper, Exhibit I-15)).

[33] *See* Medicare Contractor's Supplemental Final Position Paper at 7-9.

[34] *See id.* at 7-8. 42 U.S.C. § 1395x(ff)(3)(A) defines a PHP as "a program which is furnished by a hospital to its outpatients . . . and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care.." The Medicare Contractor maintains that, during FY 2001, Wilmington's PHP was a residential treatment program for which there is no Medicare coverage as supported by its findings that Wilmington's PHP "furnishe[d] 24/7 supervision including housing, meals, medication management, and transportation to patients receiving its PHP services." Medicare Contractor's Final Position Paper at 16.

[35] *See, e.g.*, Palmetto GBA's Supplemental Final Position Paper, Exhibits I-14, I-21 (medical notes reflect residential services), I-22 (medication administration), I-23 (visits to the facility connote residential nature of the program), I-24 (medication for insomnia), I-25 (discharge instructions). Documentation indicates that Wilmington experienced chronic non-compliance with Medicare regulations. *See, e.g.*, Medicare Contractor Exhibits I-16, I-17 (Wilmington continues to be in non-compliance), I-18 (problems same as 1998), I-19 (compliance plan needs review or changes), and I-20 (lack of compliance).

At the outset, the Board notes that a PHP is an ***outpatient*** program. On July 19, 2005, the Medicare Contractor notified Wilmington "of the results of a record review on certain ***inpatient*** claims suspended during the time period of March 21, 2003 until January 3, 2005."[36] Specifically, of the 33 claims suspended, 13 claims were denied.

On April 25, 2006, the Medicare Contractor notified Wilmington by letter that the QIO had completed a post-payment medical review of 120 ***impatient*** hospital claims (30 claims from FYs 2000 – 2003) and the projected overpayment based on the sample was $362,235.90. The portion of the overpayment pertaining to FY 2001 was $193,603.69 (which is the subject of Issue 2 above). [37] The Medicare Contractor notified Wilmington that it had the right to request a reconsideration of the determinations made on the denied claims within 60 days of its receipt of the letter.

On November 10, 2006, the Medicare Contractor sent Wilmington a letter which included a discussion about the status of both ***inpatient*** and ***outpatient*** recoupment and to inform it of the Medicare Contractor's "overpayment recoupment plan". For **inpatient** recoupment, the letter stated that no reconsideration requests were received for the claims that were denied in the April 25, 2006 letter and therefore the appropriate cost report adjustments would be made.[38] The letter also included the following discussion and findings with respect to ***outpatient*** services furnished by Wilmington:

> With respect to the **outpatient** PHP services, CSA determined that the program provided at [Wilmington] did not meet the requirements of the Social Security Act, the Medicare Payment Rules, and the Local Coverage Decisions. Medicare requires that patients admitted to a partial hospitalization program do not require 24 hours per day level of care, and must have an adequate support system to sustain/maintain themselves outside the partial hospitalization program. CSA found that [Wilmington's] PHP patients were provided meals, transportation, housing and 24-hour supervision. It is CSA's expectation that [Wilmington] will not bill Medicare for PHP services unless they meet the Medicare coverage requirements. . . .
>
> Overpayment Recoupment – **Outpatient**. CSA's Benefit Integrity Unit has requested CSA's Audit and Reimbursement Department to make the appropriate cost report adjustments to remove outpatient Partial Hospitalization Program (PHP) charges for all claims paid by Medicare for fiscal years 2001, 2002, and 2003.[39]

Based on this letter, the Board rejects the Medicare Contractor's assertion that Wilmington failed to avail itself of certain other appeal rights afforded to it to contest either of the following

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[36] Medicare Contractor's Supplemental Final Position Paper, Exhibit I-14 at 10.
[37] *See id.*, Exhibit I-14 at 4-9.
[38] *See id.*, Exhibit I-14 at 11.
[39] *See id.*, Exhibit I-14 at 11.

determinations: (1) Wilmington's PHP failed to meet the Medicare program requirement specifying that PHPs provides less than 24-hour daily care; and (2) Wilmington's charges for outpatient PHP services furnished during FY 2001 should be recouped through adjustments to the FY 2001 cost report. The Medicare Contractor's contentions suggest that Wilmington had appeal rights through the claims appeals process.[40] However, none of the Medicare Contractor's documentation indicates that any previously adjudicated claims for ***outpatient*** PHP services from FY 2001 had been reopened, reconsidered and denied to trigger such appeal rights. Outside of the RNPR at issue, the November 10, 2006 letter is the only document in the record that discusses either of the above determinations. While that letter discusses the finding above it did not identify any post-pay claim denials and did not include ***any*** discussion or notification of appeal rights. Rather, it is the RNPR that includes the notice of appeals rights which Wilmington exercised. The only other document in the record that discusses any appeal rights is the April 25, 2006 letter to Wilmington, and it is not relevant because it only addresses the post-payment medical review of ***inpatient care*** without any reference to Wilmington's ***outpatient*** PHP.

Further, the Board's review of Medicare regulations and guidance in effect during 2001 suggests that there was not a separate process for certifying or revoking certification of a PHP at a hospital.[41] The Medicare program regulations governing survey, certification, enforcement, and appeals are located in 42 C.F.R. Subchapter G and, in particular, specify that an initial determination must "set forth the basis or reasons for the determination, the effect of the determination, and the party's right to reconsideration, if applicable, or to a hearing."[42] However, during 2001, the regulations did not address or appear to encompass outpatient PHPs at a hospital. Accordingly, the Board concludes that Wilmington was not notified of and did not, in fact, have any formal appeal rights associated the determinations made in the November 10, 2006 letter concerning Wilmington's PHP. Accordingly, the Board finds that, pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1889 (2007), it has jurisdiction over the Medicare Contractor's adjustment on the RNPR to disallow all of Wilmington's FY 2001 charges for its outpatient PHP.

The Board also rejects the Medicare Contractor's alternative argument that, if the Board determines that jurisdiction is appropriate, the evidence in the record confirms that Wilmington failed to meet the Medicare criterion that PHP services be less than 24-hour daily care. First, the November 10, 2006 letter from the Medicare Contractor to Wilmington does not explain on what basis this finding was made. For example, this letter does not indicate that any ***outpatient*** PHP claims ***from FY 2001*** were reviewed upon which this finding could be based.[43] Indeed, the only claims from the FY 2001 time period mentioned in the letter concern the QIO post-payment medical review of 30 ***inpatient*** claims from FY 2001 and, accordingly, are not relevant to Wilmington's ***outpatient*** PHP.

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[40] *See* 42 C.F.R. Part 405, Subpart H (2002) (regulations governing the Medicare Part B claim appeals process).
[41] *See* 42 C.F.R. § 410.43, 424.24 (2001). *See also* Hospital Manual, CMS Pub. No. 10, § 230.7 (as revised by Transmittal 761 (Sept. 15, 2000)).
[42] 42 C.F.R. § 498.20(a) (2001).
[43] Indeed, outside of the sentence stating that recoupment would be made on the FY 2001 PHP claims, the only reference to PHP claims is in the context of 2005 edits that the Medicare Contractor installed to deny all outpatient PHP claim from Wilmington. *See* Medicare Contractor's Supplemental Final Position Paper, Exhibit I-14 at 11.

The Medicare Contractor does point to the residential services contract with the Hope and certain medical records to support its contention that Wilmington failed to meet the Medicare PHP criterion that PHP services be less than 24-hour daily care. However, the residential services contract with Hope was only effective the last month and half of FY 2001 and there is no evidence in the record indicating that any of Wilmington's PHP patients from FY 2001 received residential services and were Medicare beneficiaries. The medical records are not relevant because, while they do show that several of Wilmington's PHP patients may have received residential treatment services at Hope, they are not from the year at issue but rather are from 2003.[44]

Contrary to the Medicare Contractor's contention, the record before the Board suggests that, during FY 2001, Wilmington's PHP did meet the Medicare criterion that PHP services be less than 24-hour daily care. Specifically, the record reflects that, during FY 2001, Wilmington's PHP was on pre-payment medical review (*i.e.*, medical records were being reviewed for documentation of coverage and medical necessity) and the Medicare program was paying a certain portion of Wilmington's PHP claims.

Finally, the Board finds that the adjustment deleting all of the Wilmington's FY 2001 PHP charges from the cost report is improper because there is nothing in the record to suggest that the original adjudication and payment on these claims[45] was ever reopened and reversed. It is improper to globally disallow claims that have been paid, without reopening and **readjudicating** the Medicare program's original determination of coverage,[46] particularly since the original determinations for some of the claims at issue were made as part of a prepayment focused medical review process.

DECISION

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board makes the following findings on the three issues:

ISSUE 1 – The Board finds that the Medicare Contractor's adjustment to use the 1999 percentage to allocate physician costs for fiscal year ("FY") 2001 between Part A and Part B for the provider-based physician professional component was proper. Accordingly, the Board affirms the Medicare Contractor's adjustment related to this issue.

ISSUE 2 – The Board finds that the Medicare Contractor's recoupment on the FY 2001 cost report of $193,604 for denied inpatient admissions was proper and was not a duplicate recovery. Accordingly, the Board affirms the Medicare Contractor's adjustment related to this issue.

ISSUE 3 – The Board finds that the Medicare Contractor's adjustment on the FY 2001 cost report to remove all outpatient charges associated with the Provider's partial hospitalization program

[44] The contract with Hope was effective August 20, 2001 and Wilmington's FY 2001 ended on September 30, 2001.
[45] Beginning July 1, 2000, the Medicare program began paying outpatient PHP services under the outpatient prospective payment system. *See* 65 Fed. Reg. 18434 (Apr. 7, 2000).
[46] *See* 42 C.F.R. §§ 405.980 – 405.986.

was improper. Accordingly, the Board reverses the Medicare Contractor's adjustment related to this issue.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 3, 2015