CENTERS FOR MEDICARE AND MEDICAID SERVICES
Order of the Administrator

In the case of:	**Claim for:**
Triad 2007 Liability for Periodic Interim Payments to Former Owner Group	**Reimbursement Determination for Cost Reporting Periods ending: Various**
Provider	
vs.	
Blue Cross Blue Shield Association/ Blue Cross Blue Shield of Georgia	**Review of: PRRB Dec. No. 2009-D21 Dated: April 17, 2009**
Intermediary	

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). Comments were received from the CMS' Office of Financial Management (OFM), the Providers and the Intermediary requesting reversal and remand of the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue was whether the Board has jurisdiction over a challenge to an overpayment recoupment action involving the Providers' liability for erroneous payments made to the former owners of the skilled nursing facilities (SNFS) after the change of ownership.

The Board held that it did not have jurisdiction over the Providers' appeals. The Board found that the Providers' did not dispute the amount of total program reimbursement, which is a prerequisite to Board jurisdiction. Furthermore, the regulations at 42 C.F.R. §§ 405.1801(a)(4), 405.376(j) and 401.625 precluded

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.

Finally, to support its claimed lack of jurisdiction, the Board relied on Heritage Healthcare v. Mutual of Omaha, PRRB Decs. 2004-D8 and D9. In Heritage, the Board held that it lacked jurisdiction over the recoupment action because those matters were specifically excluded from the Board's authority.

COMMENTS

OFM submitted comments requesting that the Administrator reverse the Board's decision. OFM disagreed with the Board's interpretation that it lacked jurisdiction over the Providers' appeal. OFM believed the Providers' are entitled to a hearing before the Board "with respect to such cost reports." The Intermediary included all payments made to the Providers, relating to the cost reporting periods of December 1, 2006 through June 30, 2007, on worksheet E-1 "payments to providers."

The Providers submitted comments requesting that the Administrator reverse the Board's decision. The Provides contended that the Board has jurisdiction in this matter because the Providers disputed the Intermediary's "final determination" as to the amount of total program reimbursement due the Providers. Furthermore, the Board's decision is inconsistent with the position taken by CMS in Triad at Jeffersonville I v. Leavitt, 563 F. Supp. 2d 1 (D.D.C. 2008). As such, this case should be reversed and remanded for further proceedings.

In addition, the Providers disagreed with the Board's reliance on Heritage. In Heritage, the Board lacked jurisdiction because the appeal had not been filed within the 180-day time frame, an issue not present here. Moreover, the provider in Heritage, appealed from a CMS letter not from a "final determination" or Notice of Program Reimbursement (NPR). Finally, the provider in Heritage, did not dispute the amount of reimbursement due, as has the Providers in the instant case.

The Intermediary submitted comments stating that the Board was incorrect in rejecting jurisdiction. The Intermediary requested that the Board's decision be remanded to the Board for further proceedings.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Pursuant to § 1878 of the Act, a provider has a right to a hearing before the Board, if such provider:

> (A)(1) 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 such report….
>
> (2) the amount in controversy is $10,000 or more, and
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i)….
>
> (b) The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matter in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is in the aggregate, $50,000 or more. (Emphasis added).

Consistent with the statutory language of § 1878 of the Act, the regulation at 42 C.F.R. § 405.1837(a)(2008) sets forth that a provider as part of a group appeal, has a right to a hearing before the Board, if:

(1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a), except for the $10,000 amount in controversy requirement under § 405.1835(a)(2) of this subpart:[1]

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[1] The regulation at 42 C.F.R. § 1835(a) sets forth that a provider has a right to a hearing before the Board, if:

(1) the provider has preserved the right to claim dissatisfaction with the amount of Medicare payment for specific item(s) at issue, by either-

(i) including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or

(ii) Effective with cost reporting periods that ends on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest…; and

(2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulation or CMS Ruling that is common to each provider in the group; and

(3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with § 405.1839 of this subpart.

According to 42 C.F.R. § 1801(a)(2008), an "intermediary determination" is defined as:

> A determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

With respect to the determination of the intermediary, the regulation at 42 C.F.R. § 405.1803 specifically requires an intermediary determination to be made pursuant to notice of amount of program reimbursement or "NPR" and also allows the use of the notice as a basis for recovery of overpayments. Subsection (c) states:

> The intermediary's determination contained in its notice is the basis for making the retroactive adjustment…to any program payments made to the provider during the period to which the determination applies, including recoupment under § 405.373 from ongoing payments to the provider identified in the determination. Recoupment is made notwithstanding any request for hearing on the determination the provider may make under §§ 405.1811 or 405.1835.

The Administrator finds that, under the statutory and regulatory scheme, the Board has jurisdiction over a Provider's timely appeal of an NPR, which would include adjustments made pursuant to 42 C.F.R. § 1803(c), on worksheet E-1 of the cost report.

In this case, the record shows that on September 26, 2008, the Intermediary sent the respective Providers their individual NPRs which included adjustments to

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(2) The amount in controversy… is $10,000or more; and…
(3)(i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination; ….

worksheet E-1 of the cost report.[2] The record shows that the amount in dispute as a result of the adjustments exceeds the monetary threshold. Finally, the record shows that the Providers' appealed within 180 days of their respective NPRs (group appeal request dated November 25, 2008).[3] Thus, under the statutory and regulatory scheme, the Administrator finds that the Board had jurisdiction over the Providers' timely appeal of their NPRs including the overpayment adjustments.

[2] Providers' Exhibit P-14.

[3] The matter in this case does not involve the compromise, or suspension of collection action, of a claim or overpayment. In addition, this case involves the appeal from the NPR and not a demand letter as in Heritage.

Accordingly,

The decision of the Board is vacated and the case is remanded to the Board; and

That, on remand, the Board shall further develop the record as to the issues raised in this appeal concerning the Providers' liability for the erroneous payments made to the former owner after the change of ownership.

That the Board shall render a decision regarding the Providers' liability with respect to the erroneous payments made to the former owners of the SNFs after the change of ownership.

That the final decision of the Board be subject to the provisions of § 1878(f) of the Act and 42 C.F.R. § 1875.

Date: **6/9/2009**

/s/
Michelle Snyder
Acting Deputy Administrator
Centers for Medicare & Medicaid Services