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# *CENTERS FOR MEDICARE & MEDICAID SERVICES*
## *Decision of the Administrator*

| **In the case of:** | **Claim for:** |
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| **Harbor Healthcare & Rehabilitation Center**<br><br>**Provider**<br><br>**vs.**<br><br>**Blue Cross/Blue Shield Association Empire Medicare Services (n/k/a National Government Services-NY**<br><br>**Intermediary** | **Provider Reimbursement for Cost Reporting Period Ending:**<br><br>**12/31/96 and 12/31/97**<br><br>**Review of:**<br>**PRRB Decision 2007-D64**<br>**Dated: August 24, 2007** |

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). Comments were received from the Intermediary, requesting reversal of the Board's decision. Subsequently, the parties were notified of the Administrator's intent to review the Board's decision. Comments were also received from the Provider, requesting affirmation of the Board's decision. CMS' Office of Financial Management (OFM), submitted comments requesting reversal. Accordingly, this decision is now before the Administrator for final agency review.

## ISSUES AND BOARD'S DECISION[1]

Issue No. 2 is whether the sampling methodology used by the Intermediary to disallow charges for the Provider's rehabilitation services was proper.

[1] Issue No. 1 involved whether the Intermediary's notification of the reopening of the Provider's 1996 and 1997 final settled cost reports was timely. The Majority of the Board concluded that the Intermediary's notice was proper and timely. Two Board members dissented on this issue. The Administrator summarily affirms the Majority decision on this issue.
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The Board, reversing the Intermediary's adjustments, held that the Intermediary's use of the sampling methodology to reduce the Provider's therapy costs did not meet the relevant audit standards. The Board found that the Intermediary failed to use any of the Provider's records in the sample and failed to justify the rationale for the application of the sample. Instead, the Intermediary sampled data from another provider and used the results of that analysis to deny the therapy costs on the Provider's cost reports. The Board found that, pursuant to CMS' manual instructions, the Intermediary may use a sampling methodology to determine the propriety of costs. However, the Intermediary must use competent evidence to support its adjustments, and that the evidence must be relevant, reliable and logically related to the issue under review. In addition, the evidence obtained, the procedures applied, and the tests performed to support the results of the audit must be documented.

In this case, the Board noted that the record was limited, and that information concerning the Department of Justice (DOJ) investigation was limited to the material provided in the Intermediary's exhibits. The Board also noted that the Intermediary presented no testimony concerning the nature of the fraud, its scope or what procedures were utilized to select the sample that formed the basis of the disallowance of the therapy costs at issue.

On review of the evidence presented, the Board found that, while it accepted that Whitehorse inflated some of its therapy service claims, there was no direct evidence of the extent of the problem at the Provider's facility. The record indicated that the only sample taken was from another facility, not the Provider. The Board also noted that, although the auditor wrote that witness interviews showed that the same practice occurred at four facilities, there was no evidence of this in the record in the form of witness testimony, affidavits or other documents. In addition, the Board found that a sample that included only one of four providers and only a month of data was both too small to yield meaningful results and was not representative of the total population.

Finally, the Board noted that, although the Provider was given an opportunity to submit any documentation or information for consideration in modifying the Intermediary's proposed adjustments, the Board found that the Provider was neither given guidance on what documentation to submit nor furnished with any information concerning the basis for the Intermediary's disallowance until the day prior to the Board hearing. The Board also noted that the defendants in the fraud case were ordered to pay restitution. The Board found that if these funds were recovered to repay Medicare for the amount is was overcharged, the Board questioned whether the funds should also be recovered from the Provider. Thus, reversing the Intermediary's adjustment, the Board concluded that the sample used

by the Intermediary to disallow the costs at issue was not a competent sample or a valid basis for determining that the costs claimed by the Provider were not proper.

SUMMARY OF COMMENTS

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary argued that it adjusted the Provider's inflated therapy costs based on a DOJ fraud investigation. The Intermediary noted that DOJ found that Whitehorse Rehabilitation Services, the Provider's therapy contractor, had altered its therapy logs to support inflated costs, and that the scheme extended to all providers serviced by Whitehorse, including the Provider. The Intermediary argued that it properly utilized the percentages calculated by the DOJ in the course of its investigation, to make the appropriate adjustments. In addition, the Intermediary noted that the criminal judgments provided for the manager and owner of the contract therapy company to make restitution. However, the Board's implication that the government is recouping the funds both from the Provider and the criminal defendants is in error. The Intermediary pointed out that the restitution has been ordered to be paid to the Provider, not Medicare. In this case, the Provider, a skilled nursing facility, is being paid pursuant to the prospective payment system and, as such, the listing by the Provider of these as "refunds" on a cost report does not reduce their Medicare costs. Thus, the Intermediary concluded that absent the adjustments at issue, the Provider would be able to retain the inflated costs submitted as a result of the fraud of the contract therapy company and the restitution reported on the cost reports of the years in which they are received.

The Provider also submitted comments. The Provider maintained that the Board provided a thorough analysis of the law and the presented expert opinion correctly concluded that no legal basis was presented for the disallowance.

OFM commented, requesting reversal of the Board's decision. OFM argued that although the sampling methodology used was unique and departed from the normal practices, unique methods are appropriate and necessary to determine the appropriateness of payments when, as in this case, fraud is involved. OFM maintained that the Provider records alone probably cannot show how Whitehorse, the therapy contractor, inflated their invoices that they submitted to the Provider. Thus, the Intermediary in this case had to rely on different levels of evidence and sampling to reach its conclusion. In addition, OFM pointed out that the Intermediary proposed its adjustments and gave ample opportunity for the Provider to dispute the adjustment or provide documentation refuting its calculation. However, OFM noted that no response or information was received from the Provider. OFM concluded that, at a minimum, the Board should have remanded

the case to the Intermediary to determine if additional audit work could have refined the adjustment.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, exhibits, and subsequent submissions. All comments are included in the record and have been considered.

As background, the Department of Justice United States Attorney for the District of Delaware audited and determined that various therapy costs claimed by certain nursing homes in Delaware were fraudulently billed. The audit stemmed from the criminal indictment and conviction of the owner and manager of Whitehorse/Whiteoak Rehabilitation Services, Inc. (Whitehorse) for fraud.[2] According to the indictment, both criminal defendants either altered the logs or directed their employees to alter the logs by increasing the number of units listed on the logs. The altered logs were used by the criminal defendants to prepare monthly invoices or bills that were sent by Whitehorse to each nursing facility to which it provided services.[3] Whitehorse provided services to the Provider in this case, as well as three other nursing facilities in Delaware.[4] The Provider subsequently used these invoices to claim Medicare reimbursement. The United States Attorney's office developed a percentage of the therapy estimated to be "bad" from altered logs at one location for the month of January 1996 and determined through witness interviews that the same thing occurred at all four facilities during the entire time the company served those locations.[5] The percentages were then applied to all speech and occupational therapy invoices for all four facilities.[6] Thus, the Intermediary, at the direction of the United States Attorney, reopened the Provider's cost reports for fiscal years ending December 31, 1996 and 1997, applied the percentages as determined by the United States Attorney's office and removed inappropriate therapy costs.[7] The Provider subsequently appealed the Intermediary's determination to the Board.

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[2] See Intermediary's Exhibit I-11 and Exhibit I-12.

[3] See Intermediary's Exhibit I-11.

[4] See Intermediary's Exhibit I-7.

[5] Id.

[6] Id.

[7] See Intermediary's Exhibits I-2 and I-3.

Based on the foregoing facts and circumstances in this case, the Administrator finds that the Intermediary properly adjusted the Provider's subject cost reports to remove the inappropriate therapy costs. The Administrator notes that the dispute in this case involves the propriety of the Intermediary's adjustments to recoup certain therapy costs based on percentages derived from a sample, developed by the United States Attorney's office. The Provider argued and the Board agreed that the methodology used by the Intermediary was not valid as it did not meet certain audit standards. However, the Administrator finds that the circumstances surrounding the adjustments involved fraud, thus, unique methods were necessary to determine the appropriateness of payments.

Generally, standard audit and sampling methodology are measurements of payment errors. However, these methodologies are not measurements of fraud. Fraud, by its very definition, involves a knowing misrepresentation or concealment of a fact.[8] Thus, given the covert nature and level of evidence necessary to meet the definition of fraud, methods used to establish fraud might be considerably different than those used to detect other payment areas and are not necessarily addressed by typical auditing procedures.[9]

In this case, the United States Attorney's office established that there was a pattern of fraudulent billing by a therapy contractor who serviced the Provider, as well as three other Delaware providers. Based on this pattern of fraud, sample logs from one of the facilities serviced by the subject therapy contractor were reviewed. This review resulted in the development of percentages of "bad" or "inflated" therapy services, which were then applied to all speech and occupational therapy invoices in all four providers.[10]

The Administrator takes judicial notice of these criminal fraud proceedings and the factual and legal findings therein contained. Notably, the standard of proof for criminal fraud is significantly higher than the burden of proof for an APA-guided administrative hearing. Therefore, the factual findings in the criminal matter that this same pattern of fraud occurred at the Provider involving the same criminal defendants need not be readjudicated in this administrative case, as the Board seems to suggest, and those findings are herein adopted.

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[8] See Black's Law Dictionary, Seventh Edition.

[9] The Administrator also notes that various court cases had upheld very limited sampling.

[10] See U.S. Department of Justice letter, dated November 12, 2002 Intermediary Exhibit I-8.

Further, the Administrator finds that this methodology is valid and reasonable under the circumstances of this case.[11] Thus, despite the Provider's argument and the Board's statement to the contrary, the Administrator finds that the methodology established by the Department of Justice United States Attorney's Office and applied by the Intermediary in this case was reasonable, appropriate and supported by the record. Consequently, the Intermediary's adjustment is affirmed.

[11] The Administrator also finds that the Provider was given the opportunity to rebut the Intermediary's adjustment prior to the hearing. The Administrator finds that the Board's statement that the Intermediary only provided specific guidance two days before the hearing is incorrect. Initially, the Intermediary requested additional documents. The record shows that the Intermediary sent an e-mail dated December 12, 2006, again asking if the Provider wanted to submit any additional documents. In response to that prompting by the Intermediary, the Provider only at that time requested specific guidance by e-mail dated December 13, 2006. The Intermediary responded by e-mail dated December 19, 2006, giving specific suggestions as to what to furnish prior to the scheduled January 10, 2007 hearing. See Intermediary Exhibits I-9 and I-10. Consequently, the Provider was belated in asking for guidance and specific guidance was furnished several weeks prior to the hearing.

DECISION

The decision of the Board on Issue No. 2 is reversed, consistent with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 10/22/07

/s/
Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services