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DECISION

THE COMPTROLLER GENERAL
OF THE UNITED STATES
WASHINGTON, D.C. 20548

FILE: B-164031(3).125

DATE: NOV 7 1977

MATTER OF: Lynnwood Manor Health Care Center-Medic
Overpayments

DIGEST:

GAO is prohibited from reviewing "reasonable cost determinations" under Medicare Program for use by provider in, or to collaterally attack, specific administrative adjudication or determination by Secretary of HEW or his agent, due to specific language of 42 U.S.C. § 405(h), made applicable to Medicare Program by 42 U.S.C. § 1395ii, prohibiting any governmental agency from reviewing findings of fact or decisions of Secretary, except where otherwise provided.

This decision is in response to an appeal filed by Mr. Gordon H. Flattum, attorney-in-fact for Lynnwood Manor Health Care Center, Lynnwood, Washington, from an opinion of settlement of the Claims Division of the United States General Accounting Office concluding that $7,726 was due the United States. The alleged debt arose as the result of the participation of Lynnwood Manor Health Care Center, Provider No. 50-5102, in the Medicare Program of the Social Security Act, 42 U.S.C. § 1395 et seq., during the period January 1, 1967 to November 27, 1969. (References hereafter, unless otherwise noted, will be to sections of Title 42, U.S.Code.)

Under the Medicare Program, a provider (1395x(u)) of covered services may be paid "the reasonable cost of such services" (1395f(b)), as determined pursuant to subsection 1395x(v) and the appropriate regulations (20 C.F.R. § 405.401 et seq.), from the Federal Hospital Insurance Trust Fund (1395g) in lieu of charging the beneficiary patients (1395cc(a)(1)(A)), other than for certain stated exceptions, including co-insurance and deductibles, provided for in section 1395cc(a)(2)(A). Instead of receiving payments directly from the Department of Health, Education, and Welfare (HEW), a provider may nominate a public or private organization to act as a fiscal intermediary, and the Secretary of HEW is authorized to enter into an agreement with such organization providing, inter alia, for the determination by such organization of the amount of payments due the provider and the making of such payments to the provider on behalf of HEW. (1395h(a)). Payments are to be made to the provider not less often than monthly (1395g), and interim payments may be made prior to incurring of associated costs, with any necessary adjustments on account of previously made overpayments and underpayments to be made on a retroactive basis at

the end of the accounting period. (1395g and 1395x(v)(1)). Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. (20 C.F.R. § 405.406(b)). The fiscal intermediaries are to make such audits of the records of providers as may be necessary to insure that the payments are proper. (1395h(a)).

The facts in this case, as disclosed by the file, are as follows: Lynnwood Manor Health Care Center (Provider) nominated, and HEW entered into an agreement with, Mutual of Omaha Insurance Company (Intermediary) to perform the functions of a fiscal intermediary. After receipt of Provider's first cost report covering calendar year 1967, Intermediary audited Provider's books and records to verify the costs reflected in the cost report and determined that Provider had been overpaid in the amount of $17,034.00. The cost reports for succeeding periods were similarly audited. Various adjustments were periodically made, due to overpayments and underpayments, resulting in an HEW and Intermediary determination that $7,726.00 was due the United States from Provider. During this process, Provider disputed certain of the cost determination adjustments. The most significant of the disputed issues concerned:

(1) the proper cost reporting method to be used in completing the required reports;

(2) auto expenses;

(3) overhead or indirect costs of ancillary services;

(4) allocation of General and Administrative Expenses to the skilled nursing facility unit cost center; and

(5) allocation of the nursing director's salary.

Subsequently, pursuant to regulations promulgated under the Federal Claims Collection Act of 1966, 31 U.S.C. §§ 951-953 (1970), the claim against Provider was forwarded to our Claims Division for collection. See 4 C.F.R. Part 105.

In a letter dated December 15, 1975, forwarded to GAO, Provider asserted, in part, the following:

"The most prevalent issue is that the Intermediary, Bureau of Health Insurance and Social Security Administration review personnel are sole judge as to determining the method of reimbursement and interpreting the related regulations. In other words, there are no regulations allowing an appeal to any court or other independent review. * * *

* * * * *

"We are requesting your assistance to obtain an impartial review * * * as we have no recourse under regulation with which we can continue our efforts to obtain a reasonable settlement for the services provided to the Medicare Program beneficiaries."

The Director of the Claims Division, GAO, in a lengthy response dated May 10, 1976, asserted that he believed the adjustments made were correct and, accordingly, "Further disagreements to these findings must be resolved by litigation." Nevertheless, subsequently, at an informal meeting with staff of that Division, Provider requested that GAO actually audit its cost reports. In addition, Provider formally appealed the response of the Claims Division to the Comptroller General for a "comprehensive review."

As noted above, the chief reason for its request [illegible] audit by our Office is the Provider's belief that he lacked a forum for impartial review. We recognize that the Health Insurance for [illegible]ged Act (Medicare), Title I of Pub. L. No. 89-97, approved July 30, 1965, 42 U.S.C. § 1395 et seq., originally specifically authorized a hearing by the Secretary and judicial review of the Secretary's final decision only regarding: (1) the determination of whether an individual is entitled to benefits under part A or part B, (2) the determination of the amounts of benefits to which a beneficiary is entitled under part A, (3) the determination that an institution is not a provider of services, and (4) the termination by the Secretary of an agreement with a provider. See 42 U.S.C. § 1395ff(1970). No provision was made for such proceedings for a provider dissatisfied with a final determination of its fiscal intermediary as to the amount of program reimbursement due.

A Provider Reimbursement Review Board was created to hear such provider complaints by subsection 243(a) of the Social Security Amendments of 1972, 42 U.S.C. § 1395oo (Supp. V, 1975), with provision for judicial review. Its application, however, was specifically

limited to cost reports of providers for accounting periods ending on or after June 30, 1973. Subsection 243(c) of the Social Security Amendments of 1972, Pub. L. No. 92-603, approved October 30, 1972, 86 Stat. 1329, 1422. The accounting periods relevant to this case were all for periods ending prior to June 30, 1973; therefore, Provider is correct that the procedures set forth in the amendment are not directly applicable to Provider's situation.

Nevertheless, despite the lack of statutory requirement, Provider was given various administrative opportunities to present its complaints. At the request of Provider, Intermediary made an informal review of the final adjustments for all accounting periods. When Provider formally requested an appeal from these adjustments, the Mutual of Omaha Provider Appeals Committee did hold a hearing and rendered a decision. Thereafter, the Social Security Administration reviewed this decision, at the request of Provider, and did authorize certain deductions from the final determination of the amount of overpayment. We appreciate that these proceedings were conducted by personnel of the Intermediary, the Bureau of Health Insurance and the Social Security Administration, as agents for the Secretary of HEW and that the Provider contends that these entities may not be wholly disinterested. Nevertheless, it is our understanding that the courts have determined that this basic administrative structure alone does not so taint the proceedings as to render the reviews less than impartial for purposes of constitutional due process. In this regard, see St. Louis Univ. v. Blue Cross Hosp. Serv., 537 F. 2d 283 (8th Cir. 1976); Woodland Nursing Home Corp. v. Weinberger, 411 F. Supp. 501 (S.D.N.Y. 1976); and Faith Hosp. Serv. v. Blue Cross Hosp. Serv. of St. Louis, 393 F. Supp. 601 (E.D.Mo. 1975).

Equally important, we note that numerous providers, dissatisfied with determinations made, actions taken, or proceedings undertaken by the Secretary or the intermediary regarding accounting periods ending prior to June 30, 1973, did find independent forums in the courts, although the Medicare statute then in force did not specifically authorize judicial review regarding the particular questions. See, e.g., Mount Sinai Hospital of Greater Miami, Inc., v. Weinberger, 376 F.Supp. 1099 (S.D.Fla. 1974), rev'd on other grounds 517 F. 2d 329 (5th Cir. 1975), rehearing and rehearing en banc denied 522 F. 2d 179 (5th Cir. 1975), cert. denied 425 U.S. 935 (1976); Aquavella v. Richardson, 437 F. 2d 397 (2d Cir. 1971); Kingsbrook Jewish Medical

Center v. Richardson, 486 F. 2d 663 (2d Cir. 1973); Dr. John T. MacDonald Foundation, Inc., v. Mathews, 534 F. 2d 633 (5th Cir. 1976); Rothman v. Hospital Service of Southern California, 501 F. 2d 956 (9th Cir. 1975); Columbia Heights Nursing Home & Hospital, Inc., v. Weinberger, 380 F. Supp. 1066 (M.D.La. 1974); Americana Nursing Center, Inc., v. Weinberger, 387 F. Supp. 1116 (S.D.Ill. 1975); Saint Francis Memorial Hospital v. Weinberger, 413 F. Supp. 323 (N.D. Calif. 1976); Woodland Nursing Corp. v. Weinberger, supra. Compare St. Louis Univ. v. Blue Cross Hosp. Serv., supra; Schroeder Nursing Care, Inc., v. Mutual of Omaha Ins. Co., 311 F. Supp. 405 (E.D. Wis. 1970). We note in particular Whitecliff, Inc., v. United States, 536 F. 2d 347 (Ct. Cl. 1976), in which certain issues similar to those raised by Provider were involved. These courts founded jurisdiction primarily upon the judicial review provisions of the Administrative Procedure Act (APA), as amended, 5 U.S.C. §§ 701-706 (1970), particularly 5 U.S.C. § 704 providing in part that "* * * final agency action for which there is not other adequate remedy in a court are subject to judicial review."

Accordingly, we cannot agree with the Provider's contention that he had no recourse to the court system. In any event, however, we must conclude that GAO is precluded from considering this matter further by subsection 205(h) of the Social Security Act, as amended, 42 U.S.C. § 405(h) (1970), made applicable to the Medicare Program by section 1872 of the Social Security Act, 42 U.S.C. § 1395ii(1970). Subsection 205(h) provides:

> "The findings and decisions of the Secretary [of HEW] after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter." (Emphasis added.)

There is no provision in chapter XVIII of the Social Security Act (Medicare), 42 U.S.C. § 1395 et seq., for review by GAO of "reasonable cost determinations" made by the Secretary or by his agent on his behalf. In view of the specific language of subsection 205(h), supra, prohibiting any governmental agency from reviewing the findings of fact or decisions of the Secretary in such circumstances, we must deny Provider's request in the present context. We are prohibited from reviewing "reasonable cost determinations" under the Medicare Program for use by a Provider in, or to collaterally attack, a specific administrative adjudication or determination of the Secretary.

See 31 Comp. Gen. 695, 708 (1952).

In summary, therefore, we conclude that we are precluded from considering this matter further for the purposes of Provider's request by subsection 205(h) of the Social Security Act, as amended, 42 U.S.C. § 405(h)(1970), made applicable to the Medicare program by section 1872 of the Social Security Act, 42 U.S.C. § 1395ii (1970). Accordingly, we must deny Provider's request that we perform an independent audit for the purpose of settling the Government's claim against him.

R.F.KELLER

(Deputy) Comptroller General
of the United States