PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2023-D31

PROVIDER –
University of Missouri Health Care

RECORD HEARING
October 13, 2021

PROVIDER NO. –
26-0141

FISCAL YEAR END –
June 30, 2010

vs.

MEDICARE CONTRACTOR –
Wisconsin Physicians Services, Inc.

CASE NO. –
14-1112

INDEX

ISSUE STATEMENT

Whether the Centers for Medicare & Medicaid Services ("CMS") correctly refused to exclude the Missouri Psychiatric Center unit ("MUPC") of the University of Missouri Health Care's ("UMHC" or "Provider") from the inpatient prospective payment system ("IPPS") for the cost reporting period ending June 30, 2010 ("FY 2010"), allowing it to be paid instead under the inpatient psychiatric facility prospective payment system ("IPF-PPS")?[1]

DECISION

After considering the Medicare law, regulations and program instructions, the arguments presented and the evidence submitted, the Provider Reimbursement Review Board ("Board") finds that the CMS correctly refused to exclude the UMHC MUPC from the IPF-IPPS for FY 2010 and that the UMHC MUPC was properly paid under the IPPS for FY 2010.

INTRODUCTION

UMHC is an acute care hospital located in Columbia, Missouri.[2] The UMHC's designated Medicare contractor[3] was WPS Government Health Administrators ("Medicare Contractor").

UMHC submitted its Medicare cost report for FY 2010, which included a protested item for the payment impact related to CMS' determination to deny "excluded unit" status to its psychiatric unit. On June 6, 2013, the Medicare Contractor issued the Notice of Program Reimbursement for FY 2010 to UMHC and, on December 2, 2013, UMHC timely filed its appeal.[4] Previously, the Medicare Contractor filed a jurisdictional challenge regarding this cost issue.

On July 29, 2021, the Board approved a hearing on the record. UMHC was represented by Evan Z. Reid, Esq. of Lewis, Rice & Fingersh, LLC. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services, LLC.

STATEMENT OF FACTS AND RELEVANT LAW

A. Overview of Facts and Relevant Law

The parties have stipulated to the following facts:

1. On April 3, 2009, the Curators of the University of Missouri approved a plan under which UMHC would open and operate a unit providing comprehensive and clinically integrated inpatient psychiatric services. See Exhibit P-1.

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[1] Provider's Final Position Paper (hereinafter, "Provider's FPP") at 1 (Feb. 3, 2021).
[2] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 1 (Mar. 4, 2021).
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs, as appropriate and relevant.
[4] Provider's FPP at 4 (items numbered 15 & 18).

2. In its letter dated April 16, 2009, UMHC submitted to the CMS Regional Office, with Wisconsin Physicians Services ("WPS") copied, a CMS-855A requesting to expand its services to include an exempt psychiatric unit, to be known as the University of Missouri Psychiatric Center ("MUPC"), effective at the beginning of the cost reporting period on July 1, 2009. CMS Form 855A is a Medicare enrollment application. See Exhibit P-2.

3. On June 17, 2009, WPS, based on its review, recommended that the CMS-855A be accepted and forwarded it to the CMS Regional Office and the State Survey Office for further review. See Exhibit P-3.

4. On June 30, 2009, UMHC sent its self-attestation to the Missouri Department of Health and Senior Services ("DHSS"), the survey agency for the state. See Exhibit P-4.

5. That same day, DHSS requested additional information from UMHC from that which had been previously submitted. See Exhibit P-5.

6. After a series of emails between UMHC and DHSS (dated June 30, 2009, July 10, 2009 and July 31, 2009), UMHC responded to the request for additional information on August 5,2009. See Exhibit P-5.

7. On October 2, 2009, Dean Linneman, the Administrator of the Section for Health Standards and Licensure of DHSS wrote to Jennifer King of the Division of Survey and Certification at the federal Department of Health and Human Services ("DHHS"), supporting the request for exclusion from IPPS made by UMHC for MUPC for FYE 6/30/2010, effective July 1, 2009. The [Medicare Contractor] alleges that this same document indicates that certain timelines had not been adhered to. See Exhibit P-6.

8. On January 8, 2010, Jim Steele, the Executive Director of MUPC, wrote to Judy Baker, the Regional Director of DHHS, asking for her assistance in obtaining a response to the exclusion request for MUPC for FYE 6/30/2010. See Exhibit P-7.

9. On January 12, 2010, Ms. Baker acknowledged receipt of the letter from Mr. Steele. See Exhibit P-8.

10. On February 9, 2010, Ms. Baker wrote to Mr. Steele indicating that the exclusion request for MUPC for FYE 6/30/2010 was still under consideration. See Exhibit P-9.

11. On March 5, 2010, CMS denied UMHC's CMS-855A, stating in its letter that UMHC had failed to comply with the following

regulations: 42 C.F.R. §§ 412.22, 412.25, 412.27. In its letter, CMS also stated that a request for an exception to these requirements was also denied. See Exhibit P-10.

12. UMHC filed its cost report for the reporting period beginning July 1, 2009 and ending June 30, 2010 under protest. See Exhibit P-11.

13. WPS issued its Notice of Amount of Program Reimbursement for UMHC's hospitals and clinics on June 6, 2013. See Exhibit P-13.

14. UMHC alleges that the amount of reimbursement given to UMHC for FYE 6/30/2010 was $861,884 less than it would have been if CMS had not declined to exclude UMHC's psychiatric unit from the IPPS and instead include[d] it in IPF PPS. The MAC cannot verify this alleged amount.

15. On May 21, 2010, CMS approved the exclusion of MUPC from IPPS for FYE 6/30/2011. See Exhibit P-14.

16. The parties agree that all exhibits referenced herein are authentic copies of the originals.[5]

UMHC is appealing the Medicare Contractor's removal of the protested item on its FY 2010 cost report relating to CMS' determination to deny "excluded unit" status to its psychiatric unit. On March 5, 2010, CMS issued the determination letter ("Excluded Unit Determination") denying UMHC's request that its psychiatric unit be excluded from IPPS for FY 2009. The Excluded Unit Determination explained that, "[a]fter a thorough review, we have concluded that the information submitted to support the psychiatric unit's exclusion from IPPS did *not* meet the regulations specified at 42 C.F.R. § 412.22, § 412.25, and § 412.27" and that "[a] request for exception to these requirements is also denied *based on review by CMS's Regional Office and Central Office*."[6]

UMHC previously appealed the Excluded Unit Determination to the Department of Health and Human Services' Departmental Appeals Board ("DAB") in April 2010. UMHC filed an appeal at the DAB as CMS directed it to this tribunal within the Excluded Unit Determination.[7] Notwithstanding, the CMS representatives subsequently requested that the DAB dismiss UMHC's appeal because the DAB was without jurisdiction to hear the appeal pursuant to the DAB's governing regulations at 42 C.F.R. Part 498.[8] UMHC states that it withdrew the DAB appeal as a result of CMS' motion for dismissal based on lack of jurisdiction.[9]

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[5] CN 14-1112, Joint Stipulations of Facts (May 21, 2021).
[6] Individual Appeal Request, Tab 3, Form A (Request for PRRB Hearing) and Exhibit B (Letter from CMS, Mar. 5, 2010) (emphasis added).
[7] Provider's FPP at 9-10.
[8] More specifically, CMS maintained that the DAB lacked jurisdiction since a "PPS exclusion" determination is not an initial determination appealable to the DAB as defined in 42 C.F.R. § 498.3. Medicare Contractor's Jurisdictional Challenge, Jurisdictional Exhibit I-1 at 5 (Sept. 17, 2014).
[9] Provider's FPP at 10. *See also infra* note 21.

On November 19, 2010, UMHC submitted its FY 2010 cost report to the Medicare Contractor. The as-filed cost report included a protested amount of $861,884 on Line 30 of Worksheet E, Part A. This protested amount represents the alleged loss on the cost report that resulted from CMS' denial of the request to exclude the psychiatric unit from the IPPS. UMHC maintains that its psychiatric unit met the criteria to be *excluded* from the IPPS at the beginning of the cost reporting period, even if its application to be excluded was then still under review as of that point in time.[10] On June 6, 2013, the Medicare Contractor issued the Notice of Program Reimbursement ("NPR") for FY 2010 which removed the protested amount.[11]

On December 2, 2013, UMHC timely filed this appeal with Board. UMHC and the Medicare Contractor exchanged Preliminary Position Papers on August 28, 2014 and December 12, 2014, respectively.[12]

On September 23, 2014, the Medicare Contractor filed a jurisdictional challenge and, on October 17, 2014, UMHC filed its response to the jurisdictional challenge. On April 16, 2020, the Board issued its jurisdictional determination finding that it had "jurisdiction under 42 U.S.C. § 1395oo(a) over UMHC's appeal from its NPR to challenge the disallowance of the protested item and the related cost report items associated with the $861,884 reimbursement impact."[13]

B. The Parties' Position

UMHC claims that, as of July 1, 2009, it met all the requirements of 42 C.F.R. §§ 412.22, 412.25, and 412.27 for exclusion from IPPS. UMHC refers to its application for Medicare enrollment, Form CMS-855A, and alleges the application contained all of the information required by regulation, as well as the information required by the Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1") §§ 3001.5 and 3001.6. UMHC also asserts the application was submitted 2½ months before the start of the reporting period (*i.e.*, was submitted on April 16, 2009). UMHC states the information in the application specifically demonstrated compliance with the general criteria set forth in 42 C.F.R. § 412.25, and compliance with the psychiatric unit-specific criteria set forth in § 412.27.[14]

UMHC contends the Medicare Contractor's argument that CMS must make its determination *before the beginning of the cost period* has no support in any statute, regulation, case, or hearing decision. In support, UMHC points to 42 C.F.R. § 412.25(c)(1) which states: "[t]he status of a hospital unit may be changed from not excluded to excluded *only* at the start of the cost reporting period."[15]

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[10] Board's Jurisdictional Decision at 2 (Apr. 16, 2020).
[11] Provider's Appeal Request at Form A, Tab 1 (showing Audit Adjustment No. 18 on page 9 "[t]o remove protested amount") (Dec. 2, 2013).
[12] Board's Jurisdictional Decision at 2.
[13] *Id.* at 5. The Board's jurisdictional decision did not reach the question of whether or not the Board has the authority to review or revise CMS' Excluded Unit Determination. However, as CMS explained in the preamble to the 1984 Final IPPS Rule, "**Regardless of the authority making the determination of hospital status, this determination applies to the intermediary's determination of the total amount of prospective payment due the hospital for the applicable cost reporting period."** (emphasis added). 49 Fed. Reg. 277 (Jan. 3, 1984). *See also Abbott-Northwestern Hosp. v. Leavitt*, 377 F.Supp.2d 119 (D.D.C. 2005).
[14] Provider's FPP at 2-3.
[15] *Id.* at 6 (quoting 42 C.F.R. § 412.25(c)(1)) (emphasis added).

UMHC contends it was denied due process by CMS' determination letter dated March 5, 2010, because the letter did not specify "how the information provided by UMHC failed to comply with any, or all, of the cited regulations."[16] UMHC contends the letter constituted a constitutionally inadequate notice in violation of the Fifth Amendment, and that fundamental due process rules require CMS to provide the reason for denying the exclusion. UMHC states that, because CMS failed to provide its reasoning, and because CMS provided erroneous instructions on how to appeal its decision, the proper remedy for this appeal is for CMS to be denied the opportunity to now explain the reasons for its March 5, 2010 determination.[17]

DISCUSSION, FINDINGS OF FACT AND CONCLUSIONS OF LAW

At the outset, the Board notes that UMHC's appeal to the Board is *not* an appeal of the Excluded Unit Determination itself, but rather is an appeal of the NPR issued by the Medicare Contractor for FY 2010. More specifically, UMHC appealed the disallowance of an item(s) on its cost report which was filed under protest, pursuant to 42 C.F.R. § 1835(a)(1)(ii) (2008). As such, the Board found that it has jurisdiction under 42 U.S.C. § 1395oo(a) over UMHC's appeal from its NPR to challenge the disallowance of the protested item and the related cost report items associated with the $861,884 reimbursement impact.[18]

That said, the Board recognizes that, in filing its appeal on December 2, 2013, UMHC's dissatisfaction with the removal of the protested item, pursuant to § 1395oo(a), stems ultimately from its dissatisfaction with the Excluded Unit Determination *that had been issued more than 3¾ years earlier* on March 5, 2010. More specifically, UMHC's dissatisfaction is directly related to the effectuation of the Excluded Unit Determination in the FY 2010 cost report and the resulting impact on its FY 2010 reimbursement (*i.e.*, the estimated $861,884 impact). While the Board has jurisdiction to hear the merits of the FY 2010 cost report items impacted by the Excluded Unit Determination, the Board finds that it is not clear that the Board has the *authority*[19] to review, question, or otherwise revise the Excluded Unit Determination that underlies the FY 2010 cost report items at issue (*i.e.*, whether the Board has the authority to grant the relief requested).

In this regard, the Board notes that the Excluded Unit Determination did *not* provide any appeal rights ***to the Board***. Rather, it included the following instructions directing appeals to the DAB:

> If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 C.F.R. § 498.40, et seq. A written request for a

[16] *Id.* at 9.
[17] *Id.* at 10-11.
[18] Board's Jurisdictional Decision at 5.
[19] This should not be confused with jurisdiction. *See generally Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (S. Ct. 2013). *See also* 42 C.F.R. § 405.1801(a) (definition of "Contractor determination" at paragraph (2) stating "[w]ith respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412 of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination."

hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to:

Department of Health and Human Services
Departmental Appeals Board
Civil Remedies Division
Attention: Oliver A. Potts, Chief
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201

A copy of your request for a hearing must be sent to your State Agency and the following offices:

Branch Manager
Division of Survey and Certification
Centers for Medicare and Medicaid Services
601 E. 12th Street – Room 235
Kansas City, MO 64106

A request for hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. Counsel at a hearing may represent you at your own expense.

If your hospital would like to pursue exclusion of its psychiatric unit from the IPPS, the hospital must notify our office and the Missouri Department of Health and Senior Services (MO DHSS) in writing and submit the required information **prior to July 1, 2010** to allow sufficient time for review. Please provide our office and the MO DHSS the following information:

- total number of beds, room numbers, number of beds in each room
- square footage of the psychiatric unit

As documented in the enclosed S&C-08-03, Appendix A, V, 3, please also include with your letter:

- a completed, signed and dated Psychiatric Unit Criteria Work Sheet (CMS-437),
- medical record protocols to verify that each patient receives a psychiatric evaluation within 60 hours of admission; that each patient has a comprehensive treatment plan; that

progress notes are routinely recorded; and that each patient has a discharge plan and a discharge summary, and

- a description of the type and number of clinical staff, including a qualified medical director of inpatient psychiatric services and a qualified director of psychiatric nursing services, registered nurses, licensed practical nurses, and mental health workers to provide care necessary under their patients' active treatment plans.[20]

The record reflects that, consistent with above instructions, UMHC did appeal the Excluded Unit Determination to the DAB. However, UMHC abandoned that appeal *without obtaining a decision or ruling from the DAB* because it voluntarily withdrew the appeal based solely on motion for dismissal filed by CMS representatives wherein the CMS representative asserted that the DAB lacked jurisdiction.[21] As the appeal was withdrawn without a ruling or decision by the DAB, it is clear that UMHC abandoned its appeal rights and that the Excluded Unit Determination became the final determination of the Agency. The fact that CMS filed a motion to dismiss the appeal has no bearing on the finality of the Excluded Unit Determination.[22]

Further, the Board has not identified any authority that specifically permits or directs the Board to otherwise review or revise CMS determinations on whether *a distinct unit* of an IPPS hospital should be excluded from IPPS (including whether it met the application filing requirements and met the criteria to be excluded).[23] That said, the Board has identified discussion in the preamble to the January 4, 1984 final rule which supports a finding that appeal rights to the Board exist regarding the exclusion of a whole hospital from IPPS but does not discuss distinct part units.[24]

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[20] Exhibit (hereinafter "Ex.") P-10.

[21] Provider's FPP at 10. The Board notes that the Medicare Contractor's FPP at 5 indicates that the DAB issued a dismissal of UMHC's appeal, for lack of jurisdiction, on June 2, 2010. However, lacking a copy of this dismissal, the Board makes the presumption that the dismissal was simply an acceptance of UMHC's voluntary withdrawal that the Provider discusses in its FPP at 10.

[22] The record does not include a copy of this document and, as a result, the Board does not know upon what basis the CMS representatives were requesting dismissal. Regardless, their position appears moot since the Provider by its own admission in its FPP at 10 appears to have failed to exhaust its administrative remedies by obtaining a ruling from the DAB on that motion for dismissal.

[23] Examples of regulations confirming a provider's right to appeal to the Board a particular determination include, but are not limited to: 42 C.F.R. § 412.108(b)(9) (appeals involving denial of classification as a Medicare dependent hospital); 42 C.F.R. § 412.109(e) (appeals of CMS determination to terminate designation as an "essential access community hospital"); 42 C.F.R. § 412.92(b)(2) (appeals involving denial of classification as an sole community hospital ("SCH")); 42 C.F.R. § 412.92(e)(3)(iii) (appeals of Medicare Contractor determinations involving SCH request for a volume decrease adjustment); 42 C.F.R. § 405.379 (b)(iii) (appeals of overpayments that arise from a cost report determination); 42 C.F.R. § 412.140(e)(3) (appeals of CMS reconsideration decisions related to the Hospital Inpatient Quality Reporting Program); 42 C.F.R. § 476.78 (f) (Quality Improvement Organizations – "Reimbursement for the costs of submitting requested patient records to the QIO in electronic format, by facsimile or by photocopying and mailing is an additional payment to providers under the prospective payment system, as specified in §§ 412.115, 413.355, and 484.265 of this chapter. Appeals concerning these costs are subject to the review process specified in part 405, subpart R, of this chapter.").

[24] 49 Fed. Reg. 234, (Jan. 3, 1984) (discussing appeals of "a hospital's status under the prospective payment system" and suggesting that a hospital may appeal determination on "the hospital's" exclusion from the prospective payment system but it does not mention or discuss distinct part hospital units or explicitly confirm any appeal rights).

Further, outside of one example, the Board has not identified any Board decisions reviewing whether *a distinct part unit* of an IPPS hospital should be excluded from IPPS.[25]

Finally, the Board questions whether it has the ability to otherwise revisit or reopen the Excluded Unit Determination as part of this appeal given that this appeal was filed on December 2, 2013, *substantially more than 3 years after the issuance of the Excluded Unit Determination on March 5, 2010*.[26] In this regard, the Board notes that, when UMHC filed its appeal with the Board, over 3 years had passed since the Excluded Unit Determination had been issued and 42 C.F.R. § 405.1885 generally limits the reopening of final determinations to 3 years.[27] Further, the Board notes that survey and certification matters are very technical in nature.[28] Indeed, as a reflection of the technical nature of these determinations, the Excluded Unit Determination specifically lists the CMS Survey and Certification Division and the Missouri State Survey Office as parties of interest; yet, neither party of interest is involved in the appeal before the Board.

The Board need not definitively resolve these concerns/issues at this time because, as set forth below, it is clear that CMS appropriately refused to exclude the UMHC unit at issue from IPPS. Further, the record is clear that UMHC has failed to meet its burden of proof for this *de novo* hearing.[29]

While the Medicare program reimburses most acute care hospitals for inpatient operating costs using the IPPS, [30] there are exceptions to the IPPS.[31] Both hospitals and hospital units can be excluded from the IPPS.[32] Psychiatric hospital units must meet specific requirements to be

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[25] *See O'Connor Hosp. v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. No. 1999D43 (May 4, 1999) (reviewing CMS' "refusal to exclude the Campbell alcohol and chemical dependency recovery unit [of O'Connor Hospital] from the prospective payment system ("PPS") because it did not meet applicable State licensure law proper"). The following cases are the other two cases cited by the Provider, but they are not directly relevant since they do not relate to a distinct unit of a hospital but rather to the whole hospital: *Community Care Hosp. v. BlueCross BlueShield Ass'n* , PRRB Dec. No. 2005D30 (Apr. 1, 2005); *Cancer Treatment Center of Tulsa v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2008D44 (Sept. 30, 2008).

[26] Here, it is unclear if any Board action on the CMS determination would constitute a "reopening" of that determination. If it were, then 42 C.F.R. § 405.1885 is applicable and the Board would have no authority under that regulation to reopen the CMS determination in the first instance. If not, the basis for the Board to be able to revisit that CMS determination would appear to have to flow from 42 U.S.C. § 1395oo(a)(1)(A)(i) where the Provider 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." (Emphasis added). However, the CMS determination was not made in a review or audit of a cost report. Further, § 1395oo(a)(1)(A)(ii) would not appear to be applicable since they are not seeking payment under § 1395ww(b) or (d) but rather are seeking *exclusion* from § 1395ww(d).

[27] Moreover, if it were considered a reopening, the Board would not have the authority under § 405.1885(a) to reopen since it did not issue the determination in the first instance.

[28] Much of the criteria for a psychiatric unit to be excluded from IPPS are very technical in nature. *See, e.g.*, 42 C.F.R. § 412.27.

[29] *See* 42 C.F.R. § 405.1871(a)(3) (stating "The [Board hearing] decision must include findings of fact and conclusions of law regarding . . . *whether the* ***provider*** *carried its* ***burden of production of evidence and burden of proof*** *by establishing, by a preponderance of the evidence*, that the provider is entitled to relief on the merits of the matter at issue." (Emphasis added)).

[30] 42 U.S.C. § 1395ww(d). *See also* 42 C.F.R. § 412.1(a)(1).

[31] 42 C.F.R. § 412.20.

[32] 42 C.F.R. § 412.22.

excluded from the prospective payment system and paid under the IPF-PPS.[33] The specific requirements for psychiatric unit exclusion are provided at 42 C.F.R. § 412.27 which states, in part, that the unit must:

> (a) Admit only patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the International Classification of Diseases, Tenth Revision, Clinical Modification.
>
> (b) Furnish, through the use of qualified personnel, psychological services, social work services, psychiatric nursing, and therapeutic activities.
>
> (c) Maintain medical records that permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the unit, . . .
>
> (d) Meet special staff requirements in that the unit must have adequate numbers of qualified professional and supportive staff to evaluate inpatients, formulate written, individualized, comprehensive treatment plans, provide active treatment measures and engage in discharge planning, . . .[34]

The regulation at 42 C.F.R. § 412.25 provides when the status of a hospital unit (as paid or not paid under the prospective payment system) may be changed:

> (c) *Changes in the status of hospital units*. For purposes of exclusions from the prospective payment systems under this section, the status of each hospital unit (excluded or not excluded) is determined as specified in paragraphs (c)(1) and (c)(2) of this section.
>
> (1) The status of a hospital unit **may be** changed from not excluded to excluded **only** at the start of the cost reporting period. If a unit is added to a hospital after the start of the cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.
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> (2) The status of a hospital unit may be changed from excluded to not excluded at any time during a cost reporting period, but only if the hospital notifies the fiscal intermediary and the CMS Regional Office in writing of the change at least 30 days before the date of the change, and maintains the information needed to accurately

[33] 42 C.F.R. §§ 412.25, 412.27.
[34] *See also* PRM 15-1 §§ 3106, 3106A and 3106B (2010).

> determine costs that are or are not attributable to the excluded unit. A change in the status of a unit from excluded to not excluded that is made during a cost reporting period must remain in effect for the rest of that cost reporting period.[35]

The PRM 15-1 § 3001 explains that exclusion from the prospective payment system is mandatory if a hospital unit meets the criteria for exclusion. The PRM 15-1 § 3001 provides the following instructions:

> Hospitals (or their distinct part units) that meet the exclusion criteria . . . must notify (in writing) the HCFA Regional Office (RO) serving the State in which the hospital is located.
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> ****
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> When possible, the hospital must make the notification no later than 5 months before the beginning of the cost reporting period for which it is seeking exclusion. ***The RO determines***, based on information obtained by the State survey agency and the intermediary, whether exclusion is appropriate. If the RO disapproves the exclusion, it notifies the hospital of the decision. If the RO approves the exclusion, it notifies the hospital and the Medicare fiscal intermediary of excluded status and provider identification numbers. The hospital's claim to meeting applicable criteria is subject to verification.[36]

In addition, PRM 15-1 § 3001 states that the "determination of excluded or non-excluded status for a hospital or hospital unit applies to the entire cost reporting period for which the determination is made."

Finally, the State Operations Manual, CMS Pub. 100-07, § 3102 (2010) states that providers must notify their CMS Regional Office if they qualify for exclusion from the IPPS. Further, § 3102 also addresses when providers should provide notification, stating "[w]hen possible, the notification is to be made ***no later than five months before*** *the date the hospital would otherwise become subject to prospective payment*. After receipt of this notification, the RO asks the SA to verify that certain criteria are met for psychiatric units of general hospitals, for rehabilitation hospitals and rehabilitation units of general hospitals."[37]

Additionally, CMS instructed providers in Memorandum S&C-08-03 ("Memo S&C-08-03") dated November 5, 2007 that "proper attestation of compliance with IPPS-exclusion requirements (combined with the accreditation) will permit the State and CMS to act expeditiously on the hospital's application."[38] Memo S&C-08-03 states that "providers will be required to submit an attestation and completed Form CMS-437 . . . indicating that all CMS exclusion requirements are

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[35] 42 C.F.R. § 412.25(c).
[36] (Emphasis added.)
[37] (Emphasis added.)
[38] Ex. C-4 at 1. This memorandum was issued by the CMS Center for Medicaid and State Operations/Survey and Certification Group on November 5, 2007 (copy is available at: Center for Medicaid and State Operations/Survey and Certification Group (last accessed Jan. 19, 2022)).

met."[39] Memo S&C-08-03 further explains the excluded status application process for psychiatric units, as well as other excluded units, stating:

> (d) The provider should return the completed certification packet, along with all other requested materials to the SA [State Survey Agency] no less than 90 days prior to the start of the facility's first or next cost reporting period, as applicable, in order for the RO [Regional Office] to have sufficient time to make a determination to approve or deny the provider's IPPS exclusion status. If the provider submits the application less than 90 days in advance, CMS will continue to process the application, but the provider assumes the risk that the RO review may not be completed in time for payment at the excluded rate to start with the first or next cost reporting period.[40]

State survey agencies are required to "act promptly to review the completed packet and will forward it to the RO as soon as possible in order to permit a final certification determination prior to the start of the provider's cost reporting period."[41]

The facts in this case indicate UMHC requested to expand its services to include an exempt psychiatric unit via a letter dated April 16, 2009, in which UMHC expressed its desired that exempt status would be effective 76 days later, on July 1, 2009, the beginning of its FY 2010. The letter included a Medicare enrollment application, or CMS Form 855A.[42] On June 30, 2009, ***one day before the start of its FY 2010***, UMHC sent[43]:

1. Its self-attestation that "the hospital's PPS Excluded Unit(s) currently meets . . . the applicable requirements for exclusion from PPS for the period beginning: [no period designated]"

2. The required Form CMS-437 to the State Survey Agency which included information on the assignment of physician and nursing personnel to the unit. Significantly, ***all*** of the original entries for the staffing information (*i.e*., both physician and nursing personnel) were crossed out and revised, such that both the original entries and the revised entries were visible. For example, the following original entry was crossed out: "The staffers for MUPC during the summer of 2009 will utilize part-time physicians until four (4) full-time physicians are hired."[44]

Given the number of these cross outs and revisions, it is clear that the operational plans for the unit were *still* in flux at the start of FY 2010. Similarly, it is also not surprising that, upon receiving this information, the State survey agency immediately requested additional information from UMHC.[45] For example, the State survey agency requested more information on the staffing

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[39] *Id.* at 8.
[40] *Id.* at 9.
[41] *Id.*
[42] Ex. P-2; CN 14-1112, Joint Stipulation of Facts at ¶ 2 (May 21, 2021).
[43] Ex. P-4.
[44] *Id*. at 7.
[45] Ex. P-5 at 4 (email from DHHS, dated "Tuesday, June 30, 2009 3:33 PM").

of the unit and this information was provided on August 5, 2009.[46] Similarly, on October 2, 2009, the DHSS responded to a CMS "request for additional information concerning the closing of the Mid-Missouri Mental Health Center [MMMHC] . . . and the creation of a new, exempt psychiatric unit within [UMHC]" and, among other things confirmed:

> This action is not a merger. There is no merger between the MMMHC and the UMHC. There is no joint staffing, therefore an organizational chart cannot be provided as requested. MMMHC ceased all operation of psychiatric beds. UMHC's governing body is the Curators of the University of Missouri and the UMHC has a Director of Nursing with administrative authority over all operations of the UMHC including psychiatric services. Also, UMHC has one medical staff that provides services to the patients being treated in the psychiatric units.
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> MMMHC no longer exists. MMMHC relinquished Joint Commission accreditation when it closed on June 30, 2009. The Joint Commission was notified of MMMHC's intent to close by way of written correspondence. . . . MMMHC is not "part of University Hospital". UMHC notified the Joint Commission of the expanded psychiatry services which began July 1, 2009.[47]

As these examples illustrate, UMHC continued to work with the State survey agency and CMS for multiple months to supply the required information for processing the IPPS exemption application.[48] Moreover, it is clear that the time taken to gather this information was necessary as the State survey agency acknowledged that "[d]elays in meeting certain policy timeframes could ***not*** be avoided."[49]

On January 8, 2010, UMHC requested an update regarding its Medicare enrollment application and "on site review."[50] On February 9, 2010, the CMS Regional Office replied to UMHC, stating that information submitted by UMHC continued to be under review by the CMS Division of Survey and Certification ("CMS DSC"). The CMS Regional Office confirmed in its letter that UMHC "had chosen not to consider a merger of Mid-Missouri Psychiatric Hospital and [UMHC] but have requested an exemption to the regulations requiring information to be submitted to [CMS] DSC prior to the cost report year." CMS further stated that "[CMS] DSC continues their efforts to determine if there are other options within the regulations."[51]

On March 5, 2010, CMS notified UMHC that its psychiatric unit was not able to be excluded from the IPPS *for the cost reporting period beginning July 1, 2009*. CMS advised that: "[a]fter a thorough review, we have concluded that the information submitted [by UMHC] to support the

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[46] Ex. P-5 at 2.
[47] Ex. P-6 at 3-4.
[48] *See generally* Exs. P-5, P-6.
[49] Ex. P-6 at 4 (emphasis added).
[50] Ex. P-7.
[51] Ex. P-9.

psychiatric unit's exclusion from IPPS did ***not*** meet the regulations specified at 42 C.F.R. § 412.22, § 412.25, and § 412.27" *and* that "[a] request for exception to those requirements is also *denied* based on review by CMS's Regional Office and Central Office."[52] Significantly, the record does not include a copy of UMHC's "request for exemption" to 42 C.F.R. § 412.22, § 412.25, and § 412.27 which cover the following areas:

1. § 412.22 addresses the general rules for excluded hospital units;
2. § 412.25 addresses common requirements for excluded hospital units; and
3. § 412.27 addresses additional requirements for excluded psychiatric units.

These regulations govern whether UMHC's psychiatric unit could qualify for excluded status. However, in submitting a request for exemption to these 3 regulations, it is clear that UMHC did *not* qualify under the regulations and that the submission of the request is a *de facto* admission that they did not so qualify. Significantly, UMHC did not include in the record a copy of its request for an exemption, even though an integral part of CMS' March 5, 2010, determination was a denial of UMHC's exemption request. As a result, the Board has no ability to understand what exemptions were requested or to evaluate whether the exemptions were warranted. UMHC complains that the CMS decision was insufficient, but then fails to provide the necessary record to the Board, namely a copy of its exemption request. As such, without evidence to the contrary, the Board must conclude that they were not, and could not be, eligible for excluded status *unless* the requested multiple exemptions had been granted.[53]

Regardless, the Board finds CMS correctly refused to exclude UMHC's psychiatric unit from the IPPS. UMHC misconstrues 42 C.F.R. § 412.25(c)(1) which states in it is entirety:

> The status of a hospital unit may be changed from not excluded to excluded *only* at the start of the cost reporting period. If a unit is added to a hospital after the start of a cost reporting period, it cannot be excluded from the prospective payment systems before the start of a hospital's next cost reporting period.[54]

This regulation simply identifies when a new excluded unit status may take effect and explains that it can take effect *only* at the beginning of a cost reporting period. As a result, it only makes sense that CMS require applications be submitted *well in advance of* the start of the targeted fiscal year to permit sufficient time for processing of an application and ensure that the excluded unit requirements

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[52] Ex. P-10 (emphasis added).

[53] On page 6 of the Provider's Response to the Medicare Contractor's FPP, the Provider recognizes that the Medicare Contractor's contends that UMHC's request for exemption is a tacit admission that UMHC did not meet the requirements. However, the Provider asserts that this contention is a new argument that should be excluded from the Board's consideration because the Medicare Contractor did not raise that contention. First, the Provider does not explain or provide evidence to support its allegation that it is a new argument since the Medicare Contractor's FPP was the first full position paper filed by the Medicare Contractor with the Board. More importantly, the hearing before the Board is *de novo* and the Board does not need the Medicare Contractor to raise that issue/argument in order to consider it. On its own review of the record, the Board can clearly see from the determination at issue that the Provider requested exemptions from the governing regulations. On its face, the mere existence of that request is an admission that it did not qualify under those regulations in the first instance. Indeed, UMHC's assertion that the record demonstrates it met each and every requirement for exclusion from IPPS is hollow when the record before the Board fails to include its request for exemption.

[54] (Emphasis added.)

have been met *as of the start of the fiscal year*. However, as discussed above, the evidence shows that UMHC did not submit a ***complete*** application for exemption ***prior to*** the beginning of the cost reporting period for which it sought exemption (*i.e.*, prior to July 1, 2009). The State Operations Manual, CMS Pub. 100-07, § 3102 instructed UMHC to notify the CMS Regional Office that it qualified for an exemption *no later than* 5 *months* ***prior to*** the date the psychiatric unit would become subject to the IPPS. Further, pursuant to Memo S&C-08-03, UMHC was on notice that, if the exemption application was received ***less than 90 days*** in advance of the beginning of the cost reporting period, CMS would "continue to process the application, but ***the provider assumes the risk*** that the RO review may not be completed in time for payment at the excluded rate to start with the first or next cost reporting period."[55] The record also demonstrates that UMHC's application process was not complete and anything but routine.[56] Indeed, the multi-month information gathering process that resulted in an exemption request being filed sometime after October 9, 2009 (roughly 6 months after the application process was initiated and more than 3 months into the fiscal year) demonstrates that this was an *extraordinary* application requiring at least the required 5 months in advance of FY 2010 (if not more). Accordingly, the Board concludes that CMS correctly refused to exclude UMHC's MUPC from IPPS *for the cost reporting period ending June 30, 2010*.

DECISION AND ORDER

After considering the Medicare law, regulations and program instructions, the arguments presented and the evidence submitted, the Board finds that the CMS correctly refused to exclude the UMHC MUPC from the IPF-IPPS for FY 2010 and that the UMHC MUPC was properly paid under the IPPS for FY 2010.

BOARD MEMBERS PARTICIPATING:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

9/7/2023

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[55] Ex. C-4 at 9 (emphasis added).

[56] It is clear that the application did not contain all the information necessary for CMS and the State Survey Agency to process it. Again, even the State Survey Agency recognized the time taken to request and gather this information was necessary: "[d]elays in meeting certain policy timeframes could not be avoided." Ex. P-6 at 4.