HCFA Rulings

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HCFAR 83-1-1

MEDICARE PROGRAM

Provider Reimbursement Review Board

Provider Reimbursement Review Board Decision on the Lack of Jurisdiction

HCFAR 83-1

Summary: This Ruling restates Medicare policy on the limits of the jurisdiction of the Provider Reimbursement Review Board (PRRB).

Citations: 42 U.S.C. 1395oo; 42 CFR 401.108, 405.1835 and 405.1877 (Section 1878 of the Social Security Act); 47 FR 54302, December 2, 1982.

Pertinent History: Section 1395oo of the United States Code (U.S.C.) provides that, under the Medicare program, a provider of services has the right to obtain judicial review of any final decision of the PRRB (related to a cost report or request for hearing filed timely), or of any reversal, affirmance, or modification by the Secretary, by a civil action begun within specified time limits. A provider also has the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the PRRB determines that it is without authority to decide the question. (Again, certain time limits apply.)

HCFAR 83-1-2

The following information is taken from a United States Circuit Court of Appeals decision of April 26, 1982 (Highland District Hospital v. Secretary, 676 F. 2d 230 (6th Cir., 1982)). Highland District Hospital sought judicial review of a PRRB decision that the PRRB lacked jurisdiction to review a determination by Highland's fiscal intermediary, Blue Cross of Southwest Ohio, disallowing certain cost reimbursements requested by Highland.

Highland, the only acute care hospital in Hillsboro, Ohio, owns a three floor building in which it operates a hospital on the first and second floors. During 1974 and 1975, the first and second floors of Highland (approximately 50-60 acute care beds) were certified as a Medicare provider of inpatient medical services. The third floor of the building was operated by Highland as a skilled nursing facility (SNF)

which was certified as a separate Medicare provider of extended care services (approximately 30-35 beds).

At various times during 1974 and 1975 all of the first and second floor acute care beds were occupied. As additional acute care patients required admission, Highland set up beds in the hallways on the first and second floors, and either assigned newly admitted patients directly to hallway beds or transferred patients from room beds to hallway beds. Some of the patients in the hallway beds and the room beds were eligible for Medicare.

In 1974, Highland determined there were available beds located in the SNF on the third floor and transferred patients who were in hallway beds on the first and second floors to room beds on the third floor. Highland also reassigned portions of its staff and available hospital services and equipment so that acute care patients treated on the third floor received the same level of care they

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previously received on the first and second floors. Thereafter as new acute care patients were admitted, each was assigned to the first available bed in a room whether it was on the first, second or third floor. Vacant beds on the first and second floors were created either by discharge of a patient or by transfer of a patient to a bed on the third floor when acute care was no longer required.

The district court found and the Secretary conceded at oral argument that the level of care provided by Highland to acute care patients was identical, whether a patient was in a room or hallway on the first or second floors or on the third floor.

To qualify for cost reimbursement under Medicare, a hospital or a SNF, as a provider under 42 U.S.C. 1395x(u) must, among other things, enter into an agreement with the Secretary that meets the requirements of 42 U.S.C. 1395cc. Highland Hospital and the Highland SNF entered into a provider agreement with the Secretary and each is a Medicare provider. Part of the agreement binds the provider not to charge a Medicare beneficiary for any services payable under the program except in very limited circumstances, but instead to look only to Medicare for payment. Payment for provider services is based on the lower of the reasonable cost or the customary charge for the services (42 U.S.C. 1395f(b)). The reasonable cost of hospital acute care is generally greater than for the extended care provided by a SNF.

Day-to-day administration of the Medicare program is handled by fiscal intermediaries, which are private nongovernmental entities nominated by a provider or a group of providers. Fiscal intermediaries enter into contracts with the Secretary, under the authority delegated by Congress in 42 U.S.C. 1395h, to

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serve as the Secretary's agent for various functions, including auditing provider cost reimbursement requests.

Highland's cost reimbursement requests for 1974 and 1975 included a request for hospital cost reimbursement for the acute care services provided to Medicare patients on the third floor. Those services were provided in beds in which extended care services were normally provided by the Highland SNF. Blue Cross disallowed a part of these requests for each year, though transferring certain staff, operating, and diagnostic facility costs attributable to third floor acute patients to the cost reimbursement request of the Highland SNF. Apparently the balance of the hospital cost reimbursement requests for services provided on the third floor were disallowed by Blue Cross under 42 CFR 405.1803(a) which contains the requirements for an intermediary determination of program reimbursement and notice of the amount. The amount in dispute was found by the district court to aggregate to approximately $200,000.

Blue Cross' determination not to allow Highland cost reimbursement for the acute care services provided to patients treated in the SNF beds was based on Section 3101 of the Medicare Part A Intermediary Manual, which reads:

"When patients requiring extended care services occupy beds in a hospital, they are considered inpatients of the hospital. In such cases, the services furnished in the hospital will not be considered extended care services, and payment may not be made under the program for such services …. Such a situation may arise where the hospital is part of an institution having a distinct part SNF (skilled nursing facility), and either there is no bed available in the

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distinct part SNF or for any other reason the institution fails to place the patient in an appropriate bed. The same rule applies where the hospital is a separate institution. For the same reason, where patients who require inpatient hospital services occupy beds in a skilled nursing facility, payment cannot be made on their behalf for the services furnished to them in the SNF."

The rationale for this exclusion stems from the fact that generally hospitals may only be reimbursed under Medicare for "inpatient hospital services", 42 U.S.C. 1395d(a)(1), which are defined in 42 U.S.C. 1395x(b) as "services furnished to an inpatient of a hospital … by the hospital". The Secretary concluded that inpatients may be treated only on the physical premises of a hospital and thus inpatient hospital services may be furnished only on the physical premises of a hospital. Patients treated in a bed located in a SNF are classified by the Secretary as patients of the SNF rather than as inpatients of the hospital. The hospital thus cannot receive Medicare reimbursement for services provided to those Medicare patients, notwithstanding that the services provided to them are identical to services provided to patients treated on the physical premises of the hospital.

Following Blue Cross' rejection of the Highland cost requests, Blue Cross notified the various patients who had received acute care services on the third floor that payment could not be made to Highland Hospital on their behalf and as a result they were responsible for amounts owed to Highland. Under 42 U.S.C. 1395cc(a)(1)(A), Highland Hospital was free to bill these patients once Blue Cross denied cost reimbursement on their behalf, since a provider agrees not to charge

Medicare beneficiaries only where a payment may be made on their behalf under the program. Presumably the individual patient would be liable only for the difference between the charges for services provided by Highland Hospital and the amount of cost reimbursement, if any, paid to the Highland SNF on his or her behalf.

Highland requested a hearing before the PRRB and argued that patients treated on the third floor of its building were placed in a designated area of the SNF meeting the requirements of a "hospital", as defined in 42 U.S.C. 1395x(e), and that they received services identical to those described in 42 U.S.C. 1395x(b). Highland concluded by stating "we can find no provision in the law which would deny payment for the care given to these patients".

The PRRB dismissed Highland's requests for review. The PRRB ruled that the disallowed costs involved a question of "coverage of inpatient hospital services received in the skilled nursing facility" and stated it could not "take jurisdiction in coverage issues," citing 42 U.S.C. 1395y. The PRRB also held that the annual costs transferred to the SNF were in aggregate less than the $10,000 jurisdictional minimum for PRRB review, 42 U.S.C. 1395oo(a)(2).

Highland then filed an action seeking judicial review under 42 U.S.C. 1395oo(f). The district court dismissed the complaint on motion of the Secretary. In its memorandum opinion, the district court rejected the Secretary's argument that the PRRB's dismissal of Highland's appeal request was not a "final determination" by the PRRB permitting Highland to invoke 42 U.S.C. 1395oo(f). Cleveland Memorial Hospital v. Califano, 444 F. Supp. 125 (E.D.N.C.1978). The district judge concluded, after quoting extensively from

Mount Sinai Hospital of Greater Miami, Inc. v. Weinberger, 517 F. 2d 329, 334-336 (5th Cir. 1975), cert. denied, 425 U.S. 935 (1976), that (1) the PRRB correctly determined a question of coverage was involved and that therefore it was without jurisdiction; and (2) Highland had not exhausted the administrative remedies available under 42 U.S.C. 1395ff(c), from which judicial review would be available.

Highland then appealed to the circuit court and argued that the district court erred in ruling that the PRRB lacked jurisdiction to review the determinations by Blue Cross. The Secretary responded that the PRRB and the district court correctly held that Blue Cross' determination was one of "coverage," thus precluding PRRB review. According to the Secretary, administrative and judicial review was available only to the individual beneficiaries under 42 U.S.C. 1395ff(b), or in the alternative, to Highland only under 42 CFR 405.710, 405.720 and 405.730 rather than through the PRRB under 42 U.S.C. 1395oo(a) and (f) and 42 CFR 405.1835 and 405.1877.

The review procedure Highland sought to invoke is set forth in 42 U.S.C. 1395oo and more fully described in regulations at 42 CFR 405.1835 and 405.1877. Section 1395oo(a) of the U.S.C. provides in part:

"Any provider of services which has filed a required cost report within the time specified in regulation may obtain a hearing with respect to such cost

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report by a Provider Reimbursement Review Board … if –

1) such provider –

   (A) 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) …."

Administrative review by the Secretary on his own motion and judicial review are authorized by 42 U.S.C. 1395oo(f); however, a provider has no right to demand administrative review (42 CFR 405.1875).

Section 1395oo(f) of the U.S.C. reads in part:

"(1) A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board or of any reversal, affirmance, or modification by the Secretary by a civil action commenced within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is

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received …. Such action shall be brought in the district court of the United States for the judicial district in which the provider is located …." The scope of both administrative and judicial review is limited by 42 U.S.C.

1395oo(g):

"The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in §1395y of this title shall not be reviewed by the Board, or by any court pursuant to any action brought under subsection (f) of this section."

The jurisdiction of the PRRB is thus contained in 42 U.S.C. 1395oo(a) as restricted by 42 U.S.C. 1395oo(g). The PRRB is empowered to decide questions relating to its own jurisdiction to grant a hearing, including determining issues of timeliness and amount in controversy (42 CFR 405.1873(a)). It is clear, however, that a determination by a fiscal intermediary that Medicare payment is not available for items and services because they are excluded under 42 U.S.C. 1395y is outside the jurisdiction of the PRRB (42 CFR 405.1873(b)).

Both the PRRB and the district court agreed with the Secretary's position that Highland's appeal from the denial of its reimbursement requests could not be heard by the PRRB because a question of "coverage" was involved. Yet neither the statute nor the regulations employ or define the term "coverage" in delineating PRRB jurisdiction. The legislative history, while making it clear that questions of coverage are outside that PRRB review process, does not define what is or is not a coverage question.

The term "coverage" in this context is used, apparently for the only time, in the Report of the House Ways and Means Committee on the Social Security Amendments of 1972, Pub. L. 92-603, 86 Stat. 1329 (1972):

"Provider reimbursement review board. – Under present law there is no specific provision for an appeal by a provider of services of a fiscal intermediary's final reasonable cost determination. Although the HEW has developed administrative procedures to assist providers and intermediaries to reach reasonable and mutually satisfactory settlements of disputed reimbursement items, your committee believes that it is desirable to prescribe in law a specific procedure for settling disputed final determinations applying to the amount of program reimbursement. This procedure would not apply to questions of coverage or disputes involving individual beneficiary claims." H.R. Rep. No. 231, 92nd Cong., 2nd Sess., (1972), reprinted in (1972) U.S. Code Cong. and Ad. News 4989, 5094.

In Mount Sinai Hospital of Greater Miami, Inc. v. Weinberger, supra, the Fifth Circuit defined "coverage" questions as those issues framed by 42 U.S.C. 1395d and 1395y. Section 1395d(a)(1)-(3) of the U.S.C. defined the hospital insurance benefits covered by Medicare, consisting of inpatient hospital services, extended care services and home health services. Section 1395y of the U.S.C. defines exclusions from the general definition of the scope of benefits in 42 U.S.C. 1395d. Under this analysis, a service is "covered" if it falls within the scope of benefits defined by 42 U.S.C. 1395d and is not excluded by 42 U.S.C. 1395y. A "coverage" issue thus is involved where the question is whether services provided fall within the scope of benefits defined by 42 U.S.C. 1395d or are excluded by 42 U.S.C. 1395y.

In this case, Blue Cross determined that Highland was not entitled to cost reimbursement for acute care services provided in the SNF because in its view those services were not inpatient services under 42 U.S.C. 1395d. "Inpatient hospital services" are defined in 42 U.S.C. 1395x(b) as various listed "items and services furnished to an inpatient of a hospital … by the hospital". As noted earlier, the Secretary does not regard a patient in a SNF bed as a patient of the hospital, but rather as a patient of the SNF. Any service provided to such a patient thus cannot by definition qualify as "inpatient hospital services" under 42 U.S.C. 1395d and 1395x(b) because they were not provided to an inpatient of the hospital, even though an identical service provided to a patient in an acute care bed in the hospital would qualify.

Highland held the position that the portion of the SNF into which acute care patients were placed constituted a ''hospital" under 42 U.S.C. 1395x(e) so that patients treated there were inpatients of a hospital and thus received inpatient hospital services. At its core, the dispute is whether acute care services provided to persons on the premises of a non-hospital provider qualify as "inpatient hospital services" under 42 U.S.C. 1395d. Clearly a question of 42 U.S.C. 1395d "coverage" is involved.

In the opinion of the circuit court, the PRRB's determination that it lacked jurisdiction and the district court's holding to that effect were correct.

The circuit court's conclusion that Highland is not entitled to PRRB review of Blue Cross' disallowance of cost reimbursement for acute care services provided in the SNF does not leave Highland without the opportunity to recover its cost. The provider agreement Highland entered into with the Secretary obligated it not to charge Medicare patients for any items or services for which

such individual is entitled to have payment made under 42 U.S.C. 1395cc(a)(1)(A), but instead to look only to the government for payment. Once Blue Cross determined payment could not be made to Highland on behalf of Medicare acute care patients treated in the SNF on the third floor, Blue Cross notified those patients that payment would not be provided by Medicare.

Highland was then no longer bound by its agreement not to charge these patients for acute care services provided in the SNF and was free to do so. As Medicare beneficiaries, the patients had available to them procedures for administrative and judicial review of the fiscal intermediary's determination of noncoverage (42 U.S.C. 1395ff(b)). Each beneficiary could demand reconsideration under 42 CFR 405.710(a), a hearing before an administrative law judge under 42 CFR 405.720, Appeals Council review under 42 CFR 405.724 and judicial review under 42 CFR 405.730 as authorized by 42 U.S.C. 1395ff(b). The scope of administrative review available to beneficiaries on reconsideration under 42 CFR 405.710(a) of initial determinations under 42 CFR 405.704(a), is much broader

than that available to providers under 42 CFR 405.710(b) of initial determinations under 42 CFR 405.704(b).[1] Specifically, issues of "coverage" and "any other issue having a present or potential effect on the amount of benefits to be paid" are included (42 CFR 405.704(a)(l)(13)).

Since each patient was contractually liable to Highland for the services provided, each had the incentive to invoke the administrative and judicial avenues of review available. The decision by Blue Cross was in no sense

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unreviewable; the review proceedings simply had to be invoked by the putative beneficiaries rather than by Highland as the provider.

The intent of the Medicare program, in a general sense, is to provide assistance to the elderly and disabled in meeting medical costs and to provide a coordinated approach for health insurance and medical care for beneficiaries to assure the availability of medical care. Cost reimbursement to providers is but a means of accomplishing those goals, allowing the provider to rely on the Federal government rather than the patient for payment. While a provider such as Highland may with good reason prefer to look to the Federal government rather than to an individual, it has no independent right to cost reimbursement or to choose its debtor; it must follow the review procedures set forth in the statute and regulations. In this instance, Highland had to look to its patients for payment and allow them the opportunity to pursue review of Blue Cross' determination.

Accordingly, the determination by Blue Cross that Medicare payment could not be made on behalf of Medicare patients who received acute care services in the Highland SNF involved a question of coverage under 42 U.S.C. 1395d. Thus, the PRRB was without jurisdiction to hear Highland's appeal requests. The judgment of the district court was AFFIRMED by the circuit court.

Ruling: The PRRB lacks jurisdiction to review determinations based on coverage questions.

Effective Date: December 2, 1982.

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[1] Current 42 CFR 405.710 contains references to the paragraphs of section 405.704 as they existed prior to revision on May 1, 1981. The references to the paragraphs of 42 CFR 405.704 presented in the text are the references as they existed prior to the revision.