PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D14

PROVIDER-
Mercy Hospital
Miami, FL

Provider No: 10-0061

Cost Reporting Period Ended –
December 31, 2001

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
First Coast Service Options

CASE NO.: 05-0828

INDEX

ISSUE:

Whether the provider has a right to hearing on correction of its cost report to reclassify certain nurse expenses.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. See, 42 U.S.C. §1395h, 42 C.F.R. §§413.20 and 413.24.

Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. Those cost reports show the costs incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

This appeal was timely filed from a Notice of Program Reimbursement dated September 2, 2004 for the Provider's fiscal year ending on December 31, 2001. The initial hearing request identified six issues for appeal. The Intermediary has challenged the Board's jurisdiction only as to issue #4 from that hearing request: whether the Intermediary's exclusion of psychiatric nurse costs was improper when the nurses were hospital employees.

PARTIES' POSITIONS:

The Intermediary challenges jurisdiction on the grounds that it made no adjustment for psychiatric nursing services; therefore, there is no determination from which the provider may appeal.

The Provider does not dispute the Intermediary's statement that no adjustment was made. The Provider explains that prior to the issuance of the NPR, it repeatedly discussed with the Intermediary that it misclassified costs for certain psychiatric nurses as private duty nurse costs on the cost report when in fact those nurses were hospital employees. The Provider states that, during the audit, it repeatedly requested that the Intermediary correct the improper classification and the Provider furnished its own notes of a meeting and several emails between itself and the Intermediary pertaining to this issue. In its jurisdiction brief, the Provider included a signed statement from a former employee detailing conversations with the Intermediary regarding the psychiatric nursing costs issue. According to the statement, the Intermediary representative advised that she would "resolve this through a reopening rather than resolving it now due to time

constraints," and "this is time consuming and will have to be addressed via reopening." The Provider did not request reopening of the NPR,[1] however, and rather appealed directly from the NPR.

The Intermediary does not directly dispute the facts as alleged in the Provider's submission, but states in its Final Position Paper that the Provider has failed to present documentation to support its claim regarding the psychiatric nurses.

The Provider further contends that the Intermediary has a duty to correct errors in the cost report resulting in over or under payment. It relies on CMS Medicare Manual, Financial Management, Pub. 100-6, Ch. 8, § 30.2 to assert that the Intermediary's goal in carrying out an audit is to arrive at an accurate settlement of the cost report. The Provider argues that the Intermediary failed in its responsibilities at audit because it was aware of the misclassification of the disputed nursing costs yet failed to correct the error prior to issuing the NPR.

The Provider argues that because the Intermediary failed to meet its obligation under the Manual to make adjustments during the audit that would result in an accurate final cost report and because of its ongoing dialogue with the Intermediary regarding the nursing costs issue prior to issuance of the NPR, the Board has jurisdiction over this issue under 42 U.S.C. §1395oo(a), even in the absence of an audit adjustment. The Provider relies on Athens Community Hospital v. Schweiker, 743 F.2d 1 (U.S. App. D.C. 1984) (Athens II) which held that a claim presented up until the issuance of the NPR satisfies jurisdictional requirements for a hearing under 42 U.S.C. §1395oo(a). The Provider argues alternatively that the Board has discretion to hear the appeal under 42 U.S.C. §1395oo(d).

FINDINGS AND CONCLUSIONS:

The Board concludes that the Provider does not have a right to a hearing under 42 U.S.C. §1395oo(a) and the Board declines to exercise its discretionary authority to hear the appeal under section 1395oo(d).

The Board's jurisdiction is established under 42 U.S.C. §1395oo(a). It provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> > (1) such provider
> >
> > (A)(i) 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 this report.

[1] In Your Home VNA v. Shalala, 525 U.S. 449 (1999), the Supreme Court held that whether to reopen is within the intermediary's sole discretion pursuant to 42 C.F.R §405.1885 and neither administrative nor judicial review of that decision is available.

Bethesda Hospital Association v. Bowen, 485 U.S. 399 (1988), dealt with the Board's authority to hear appeals of matters without their having been included in the cost report or having an adverse intermediary determination. In Bethesda, the provider failed to claim a cost because a regulation dictated that it would be disallowed. In those circumstances, the Court found the plain meaning of section 1395oo(a) to resolve the question of whether the Board had jurisdiction. It stated:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations*. No statute or regulation expressly mandates that *a challenge to the validity of a regulation* be submitted first to the fiscal intermediary. Providers know that, under the statutory scheme, the fiscal intermediary is confined to the mere application of the Secretary's regulations, that the intermediary is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the intermediary to do otherwise would be futile. (emphasis added; footnotes omitted).

Id. at 404.

Although its finding that the Board had jurisdiction was based on the express language of section 1395oo(a), the Supreme Court found further support for its conclusion in the language of 1395oo(d). Section (d) provides that:

> [A] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Supreme Court commented that subsection (d):

> . . . allows the Board, once it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary. The only limitation prescribed by Congress is that the matter must have been "covered by such cost report," that is, a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed.

Id. at 406.

Relevant to this case, the Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here. Id. at 404-405 (emphasis added).

The Supreme Court has not had an opportunity to squarely address whether the provider has a right to a Board hearing on a cost unclaimed through inadvertence rather than futility. However, other courts have examined how the Bethesda principles are to be applied when a provider inadvertently fails to include a claim for reimbursement on its cost report but later includes the item in an appeal from the NPR.

In Little Company of Mary Hospital v. Shalala, 24 F. 3d. 984, (7th Cir. 1994), jurisdiction was found lacking in an appeal of an item not discovered by the provider for over two years after filing its cost report. The Seventh Circuit cites the Bethesda dictum as "strongly suggest[ing] that a hospital that does not ask for all of the costs for which it is entitled to be reimbursed cannot, on appeal to the Board, first ask for new costs" because "such a provider, the Court strongly hints, should not be permitted to later claim to be 'dissatisfied' with the reimbursement it receives. . ." [2]

The weight of authority, though, holds that the Board has discretion to hear such appeals pursuant to 42 U.S.C. §1395oo(d) once jurisdiction is invoked under section 1395oo(a), but that it is not required to do so. MaineGeneral Medical Center v. Shalala, 205 F.3d 493 (1st Cir. 2000); Loma Linda Univ. Medical Center v. Leavitt, 492 F.3d 1065 (9th Cir. 2007); HCA Health Services of Oklahoma v. Shalala, 27 F.3d 614 (D.C. Cir. 1994); UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008). Those cases also find support in Bethesda.

MaineGeneral Medical Center v. Shalala, 205 F.3d 493 (1st Cir. 2000) involved hospitals that listed zero for reimbursable bad debts on their cost reports and did not discover the mistake until after the NPRs had been issued. The Providers appealed several items adjusted by the NPRs but also included a claim for the bad debts. The Board dismissed the bad debts claim for lack of jurisdiction because they had not been claimed on the cost report despite there being no legal impediment to doing so. MaineGeneral relied on a pre-Bethesda First Circuit decision, St Luke's Hospital v. Secretary, 810 F.2d 325 (1st Cir. 1987) in which costs were self-disallowed, not

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[2] The Seventh Circuit reached the same conclusion in Little Company of Mary Hospital v. Shalala, 165 F.3d 1162 (7th Cir. 1999) (Little Company of Mary II).

inadvertently omitted. However, it found that the St. Luke's court had nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised before the intermediary and held that it does, but that the power is discretionary. The St. Luke's Court expressly rejected the provider's assertion that the court should order the Board to hear the case, stating, "The statute [1395oo(d)] does not say that the Board must consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so." St. Luke's at 327-328.

Because St. Luke's was on point and had not been overruled by Bethesda, the First Circuit found it was bound by it and held that the Board had "statutory jurisdiction" to hear MaineGeneral's claim, but that it was not required to hear it. 205 F.3d. at 497. The First Circuit advised that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The court further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued." Similarly, St. Luke's opined that even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly. St. Lukes at 329.

In Loma Linda Univ. Med. Ctr. v. Leavitt, 492 F.3d 1065 (9th Cir. 2007), the Ninth Circuit "joined" the First Circuit's view as expressed in MaineGeneral and St. Luke's. It held that "once the Board acquires jurisdiction pursuant to 42 U.S.C. §1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's [NPR], it has discretion under 1395oo(d) to decide whether to order reimbursement of a cost or expense . . . even though that particular expense was not expressly claimed or explicitly considered by the intermediary." 492 F.3d at 1068.

In Loma Linda the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The NPR did not include any adjustments for interest. Loma Linda appealed six other items adjusted on the cost report and, when it discovered the error later, added the interest expense issue to its pending appeal. The Ninth Circuit stated, "There is no dispute that 1395oo(a) is the gateway provision for Board jurisdiction" but the question that remained was what "dissatisfaction" with a final intermediary determination meant. "Loma Linda was undoubtedly 'dissatisfied' with [the intermediary's] final determination of 'the total program reimbursement due,' for it appealed. . . . At this point, the Board had jurisdiction for a hearing that, according to the clear language of the text, was 'with respect to . . . the cost report.' This being so, 1395oo(d) kicked in. . . . So, once jurisdiction over the . . . cost report attached . . . Loma Linda could identify additional aspects of the intermediary's determination that were covered in the cost report, and the Board had authority to deal with them." Loma Linda at 1070. "[T]he Board had discretion to receive evidence and take action in accord with 1395oo(d) on this matter even though the interest expense was not expressly claimed and had not been explicitly considered by the intermediary." Id at 1073. The Court responded to the Secretary's concerns regarding the prospect of increased, time-consuming and complicated appeals, skirting available remedies and time limits, and gamesmanship by saying, "Congress chose to give the Board wiggle room to decide matters . . . which were not explicitly presented to, or considered by, the intermediary." The Court found

that the Board could address these concerns through its authority in 1395oo(e) to make rules and establish procedures necessary to carry out the provisions of 1395oo. Id. at 1073.

In UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008), the District Court reached the same conclusion as the First and Ninth Circuits. As in MaineGeneral and Loma Linda, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied but it also included costs for its clinical medical education programs omitted entirely from the cost report. Though not directly on point, the D.C. District Court found guidance in the decision in HCA Health Services of Oklahoma v. Shalala, 27 F.3d 614 (D.C. Cir. 1994) because it dealt with the "fundamental, jurisdictional difference between an appeal predicated upon an original NPR and one that is predicated on a revised NPR." 539 F.Supp. 2d at 77. The HCA Court explained that 1395oo(d) "allows the Board, once it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary." 27 F.3d at 617. Relying on HCA, the D. C. District Court concluded that the provider had obtained jurisdiction under section 1395oo(a) by claiming dissatisfaction with the total amount of reimbursement determined in the NPR after which any expense incurred in the cost report period was "fair game for a challenge by virtue of subsection (d)." 539 F. Supp. 2d at 77. The Court refused the provider's request for it to order the Board to hear the claim inadvertently omitted, saying "the Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis." Id. at 79.

In summary, the Bethesda decision firmly establishes that not only does the provider have a right under section 1395oo(a) to appeal any item claimed on the cost report and adjusted by the intermediary, it also has a right to appeal those items not specifically claimed but which are pre-determined by the agency to be disallowed. The circuit and district court cases discussed above further establish that, once the Board obtains jurisdiction under subsection (a), then the Board has *discretion* under section 1395oo(d) to consider any matter covered by the cost report i.e. any expense incurred within the fiscal period, but it is not required to do so.

This case presents circumstances, not explicitly addressed in the cases discussed above, but which the Provider asserts requires the Board to hear the appeal of the nursing cost issue under the pre-Bethesda Athens II decision. In its initial Athens decision,[3] the D.C. Circuit held the Board did not have jurisdiction to hear a claim for income tax and employee stock option costs the provider had failed to claim in its cost report. On rehearing, and after two additional rounds of briefing, the Court "finally arrived at what [the Court] think[s] is the most tenable reading of the statute." Athens II at 2. It held "the PRRB has jurisdiction over costs that are specifically claimed – meaning that the provider requested reimbursement in a timely manner—*as well as those cost issues raised by a provider prior to the intermediary's issuance of the NPR.*" (emphasis added). Athens II at 5-6.

[3] Athens Community Hospital, Inc. v. Schweiker, 686 F 2d 989 (D.C. Cir. 1982).

Other federal courts and even the D.C. Circuit itself have since questioned the authority of Athens II in light of the subsequent Bethesda decision. [4] The D. C. Circuit in HCA remarked that the Athens II decision, which definitively held that the PRRB does not have jurisdiction over appeals regarding costs not specifically claimed for reimbursement, had been "undercut by Bethesda." 27 F.3d at 621. The First Circuit in St Luke's rejected the view expressed by the D.C. Circuit's pre-Bethesda decision in Athens II, noting it focused on whether the Board *must* consider issues not raised below. To the extent Athens II went beyond holding that the Board "need not" do so, St. Luke's found the reasoning unpersuasive. St. Luke's at 329. It also found the practical problems the Athens II Court raised "disappear once one realizes that the Board has discretion not to consider issues not raised below." St. Luke's at 330.

Because the Athens II court found the Board was barred altogether from review of a cost not considered by the intermediary,[5] its authority has been discredited. However, none of the post-Bethesda comments regarding Athens II have dealt directly with the question of whether a claim raised during audit, prior to issuance of the NPR, preserves a *right* to a hearing by the Board on that cost under 1395oo(a) as opposed to the power of the Board to review the cost under its subsection (d) discretionary powers.

Even if the Athens II holding were authoritative as to a provider's right to hearing on any "cost issue raised by a provider prior to issuance of the NPR," the Board majority finds guidance in applying the principle insufficient because in Athens II providers had not raised the issue prior to the NPR. On the contrary, the Athens II provider had not discovered the error until four years after the NPR was issued and only then sought to amend the cost report. The intermediary treated the amended cost report as a request for reopening and denied it. The Athens II Court concluded the Board did not have jurisdiction because the intermediary was never given the opportunity to make a final determination about the expenses in dispute. Athens II at 10. Its emphasis on the necessity of an intermediary determination leads the Board majority to conclude that the Athens II holding cannot be read as expansively as Provider asserts in this case. To do so would require us to ignore much of the Court's analysis that an intermediary determination is a condition precedent for a right to appeal.[6]

We acknowledge that Intermediaries do make adjustments favorable to providers during the audit process and it is not unusual for intermediaries to accept additional claims for costs not previously made on the cost report during this reconciliation process. If the Intermediary agrees to accept these submissions and makes a determination on those items, the Board majority agrees that jurisdiction under section 1395oo(a) attaches because the NPR clearly encompasses a determination on those matters. However, for the reasons discussed below, the Board majority disagrees that merely raising a cost issue with the intermediary prior to the NPR preserves a *right* to hearing before the Board.

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[4] UMDNJ noted that the D.C. Circuit in HCA has since acknowledged that the holding of Athens II has been "undercut by Bethesda" insofar as the jurisdictional limitations of the PRRB are concerned, but that the Court has not again had occasion to affirmatively rule on the confines of Board jurisdiction.

[5] The Athens II court in analyzing subsection (d) language regarding the PRRB's power "to make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination," referred to it as a "second jurisdictional grant." 743 F.2d at 4. The Court also referred to subsection (d) as defining the Board's jurisdiction and subsection (a) as describing the Board's functions. 743 F.2d at 6. The jurisdiction/functions division was found to be the opposite in Bethesda.

[6] See e.g. 743 F.2d at 6-7.

This case illustrates the practical problems that would arise in applying the Athens II rule that a provider has a *right* to a hearing by "raising" cost issues prior to the NPR. First, determining whether the provider had sufficiently disclosed it is seeking reimbursement and whether that disclosure was made at a time that it could reasonably be taken into account when the intermediary issued its final determination of total reimbursement could require an examination of evidence more extensive and complex than even the merits of a reimbursement issue demands. That would be antagonistic to the concept of jurisdiction being a threshold question to determine whether the Board even had authority over the appeal. For example, in this case, the Provider's claim that it met the Athens II standard for right to a hearing, if contested, may require at least an analysis of multiple witness's testimony (much of it dependent on hearsay), a series of emails, and a review of documentation Provider represents it furnished in support of its claim. Assuming timing is relevant, it would also require inquiry into the dates of communications and the status of the audit when those communications were made.

Second, requiring the Intermediary to process any "cost issues raised" prior to the NPR but not included on the cost report is potentially so disruptive as to make the process dysfunctional. Understanding why requires an understanding of the audit and settlement process.

The cost report itself is a voluminous document consisting of numerous schedules, worksheets, and supplemental worksheets. It is comprised of various categories of provider costs and typically includes hundreds to thousands of expense classifications depending on the size and scope of services offered by the provider. These expenses are classified and grouped into the cost report's prescribed cost centers, consisting of up to twenty four general service and seventy revenue producing cost centers. See, CMS Pub 15-1 §2302. Individual expense items lose their identity in the cost report through this grouping process. The expenses are then adjusted to exclude any nonallowable costs. Expense elements cannot be excluded from the cost report under this process unless eliminated by the provider.

The remaining allowable costs still pertain to all patients treated, both Medicare and non-Medicare. After the processes of grouping, reclassifying and removing expense elements is completed, an aggregation process determines Medicare's portion of these expenses. There are numerous limitations, exclusions, and adjustments that may be applied through the apportionment and aggregation processes.

After the Intermediary receives the cost report from the provider, it is required to make a determination of acceptability within thirty days of receipt. Then within sixty days of the acceptance of the provider's cost report, an initial/tentative settlement is issued. The cost report is then subject to desk review[7] to determine its adequacy, completeness and the accuracy and reasonableness of the data contained therein. The objective of the desk review is to determine whether the cost report can be settled without an audit or whether an in-house or field audit is necessary.

At this point the cost report is either settled without further review or audited to verify the information reported and claimed as reimbursement. This process culminates in issuance of a Notice of Program Reimbursement (NPR), a written notice reflecting the intermediary's

[7] Contractors are instructed to use the specific CMS Uniform Desk Review program that is in effect at the time the desk review is preformed for each provider.

determination of the total amount of reimbursement due the provider. 42 C.F.R. §405.1803. The intermediary must include in the NPR an explanation of why its determination of the amount due differs from the provider's amount and include appropriate references to law and instructions. The fact that the reimbursement impact for a single expense item cannot be determined without subjecting that item to the complex cost finding and apportionment process means that submitting new information that alters inputs that go into the final determination or that require the audit process be redone understandably creates a potentially very expensive and delayed settlement process, particularly if the new source data must also be verified.

Therefore, the Board majority concludes that for a provider to have a *right* to a hearing on a cost issue, the expense must be in the cost report unless a predetermination has been made that the cost would be disallowed, as in the Bethesda circumstances, where the Secretary has advised that inclusion is not required, or other circumstances make inclusion impossible or unnecessary. Once the Board acquires jurisdiction over the cost report via the Provider's exercise of its right to appeal, then the Board has discretion to hear other matters not previously considered by the Intermediary.

The Board majority finds the statutory language of section 1395oo(a) fully supports its interpretation which is consistent with a functional process but also adheres to the principles enunciated in Bethesda and the MaineGeneral line of cases. The statute makes *a timely filed* cost report an absolute prerequisite for a Board hearing. The particulars of cost reporting are left to regulations and cost report forms and instructions. The cost report requires a complete and timely submission that permits the intermediary to determine the actual amount due. Failure to submit correct and complete information will inevitably lead to an inaccurate determination through no fault of the intermediary.

Nothing in the statute provides for corrections to the cost report submissions after the filing deadline established by regulation; however, the Secretary, by regulation, established two avenues for correction: the amended cost report and reopening. Neither is relevant here because the Provider did not seek relief through either process despite being invited to address the private duty nursing issue via reopening. A reading of 1395oo(a) to permit use of the appeal process as the vehicle for completing or correcting an otherwise incomplete or incorrect cost report as the Provider would have us do in this case, undermines not only the statute's threshold requirement for appeal of a timely filed cost report but also the Secretary's regulatory framework for making corrections.

In summary, the Board majority concludes that, absent the narrow exceptions discussed above, a provider's *right* to appeal under section 1395oo(a) requires a claim for reimbursement in a timely filed cost report. The Provider failed to make a proper claim in its cost report even though there was no impediment to its doing so. Consequently, it does not have a right to hearing on the issue but must rely on the Board's discretionary power under section 1395oo(d) to address the matters not considered by the Intermediary. The Board majority declines to exercise that power in the circumstances of this case.

DECISION AND ORDER:

The Provider does not have a right to hearing under 42 U.S.C. 1395oo(a) and the Board majority declines to hear the matter under its discretionary powers pursuant to section 1395oo(d). In that all other issues over which the Board has jurisdiction under section 1395oo(a) have been resolved or transferred to group appeals, this case is dismissed.

Board Members Participating

Suzanne Cochran, Esq.
Yvette C. Hayes (dissenting opinion)
Michael D. Richards, C.P.A.
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.

For the Board:

Suzanne Cochran, Esq.
Chairperson

DATE: March 11, 2010

Dissenting Opinion of Yvette C. Hayes:

I respectfully dissent with the Board majority's conclusion that the Provider does not have a right to a hearing under 42 U.S.C. §1395oo(a) for the nursing costs issue stated as:

> [w]hether the Intermediary's exclusion of psychiatric nurse costs was improper when the nurses were hospital employees.

The Provider explains that it misclassified costs of certain psychiatric nurses as private duty nurse costs on the cost report, in effect, "self-disallowing" these costs in error. Although this error was brought to the Intermediary's attention during the audit, the fiscal intermediary declined to review the issue prior to issuance of the NPR and advised the Provider that the issue may be resolved through a reopening. The Provider did not request reopening of the NPR, however, and rather appealed directly from the NPR.

It is the Provider's position that the Intermediary has a duty to correct errors in the cost report if they are raised and or discovered during its review or audit in order to effectuate an accurate settlement of the cost report. See CMS Pub. 100-6, Ch. 8, §30.2. I agree. The question of "how" to properly raise this claim to preserve a provider's right to a Board hearing is at the center of this dispute.

The Board majority found that the Provider does not have a right to a hearing under 42 U.S.C. §1395oo(a) and even if it did, the majority is exercising – what it defines as its - discretionary authority under §1395oo(d) to refuse to hear this particular issue under appeal.

The Board's jurisdiction is established under 42 U.S.C. §1395oo(a). It provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such report by a Provider Reimbursement Review Board . . . if –
>
> (1) Such provider –
>
> (A)(i) 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.
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> (2) The amount in controversy is $10,000 or more, and
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> (3) Such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i).

The Board majority noted situations where "a provider simply neglects to include an item on the cost report for which it would be due reimbursement" separates this case from Bethesda Hospital Association v. Bowen, 485 U.S. 399 (1988)[8], where the Supreme Court commented:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs* to which they are entitled under applicable rules.

Id. at 404-405. (emphasis added)

To the contrary, I find that the Provider did not simply neglect to include an item on the cost report. The costs were reported on the cost report as "private duty nursing costs" a non-reimbursable cost; nor did it fail to *request* from the intermediary reimbursement for the costs at issue, but that request was denied at the time of review or audit and put-off, or deferred as an issue subject to "reopening." It is not contested that this request was made to the Intermediary.

As stated in the Board majority's findings, the Supreme Court found further support for its conclusion that the PRRB had jurisdiction in the language of section 1395oo(d), which states:

> [A] decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Supreme Court further commented that language in subsection (d):

> . . . allows the Board, *once it obtains jurisdiction pursuant to subsection (a)*, to review and revise a cost report with respect to matters not contested before the fiscal intermediary.

[8] In *Bethesda*, the US Supreme Court held that the Board may not decline to consider a provider's challenge to a regulation of the Secretary on the ground that the provider failed to contest the regulations validity in the cost report submitted to its fiscal intermediary. It found the plain language of §1395oo(a) demonstrates that the Board had jurisdiction to entertain this action and that there was no merit to the Secretary's contention that a provider's right to a hearing before the Board extends only to claims presented to a fiscal intermediary because the provider cannot be "dissatisfied" with the Intermediary's decision to award the amounts requested in the provider's cost report. The Court found this *strained interpretation* offered by the Secretary to be inconsistent with the express language of the statute.

> The only limitation prescribed by Congress is that the matter must have been "covered by such cost report," that is, a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed.

Bethesda at 406.

The Supreme Court plainly held that before subsection (d) can be applied, the Board must have jurisdiction under subsection (a). In addition, it held that the matter at issue does not have to be contested (or adjusted) by the Intermediary. In this case, there is no dispute that the matter at issue - psychiatric nursing costs - was incurred within the period that is covered by the cost report although not expressly claimed as an allowable cost.

Although the Supreme Court has not had an opportunity to squarely address whether the provider has a right to a Board hearing on a cost [or reimbursement] unclaimed through inadvertence rather than futility, I find that the weight of authority holds that the once the Board has statutory jurisdiction pursuant to 42 U.S.C. §1395oo(a), it has the power to decide an issue that was not first raised before the intermediary under 1395oo(d), but that [the Board] is not required to do so. (MaineGeneral Medical Center v. Shalala, 205 F.3d 493 (1st Cir. 2000); Loma Linda Univ. Medical Center v. Leavitt, 492 F.3d 1065 (9th Cir. 2007); UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008).

The one exception can be found in the 1994 Seventh Circuit Court decision of Little Company of Mary Hospital v. Shalala, 24 F. 3d. 984, (7th Cir. 1994), where jurisdiction was found lacking, the case was much more complex than in this instant case. It involved a provider's "failure to exhaust" administrative remedies by not requesting or submitting a request for correction of erroneous DRG assignments with 60 days of receipt of its [remittance] advice. The Court agreed with the Secretary that it would be incongruous to allow a hospital to conduct an end-run around the prescribed procedures by waiting until the year-end cost report is issued to first object to a DRG assignment that could have been properly challenged earlier when the PPS payment was originally made. The Court found that this "failure to exhaust" coupled with, the court's belief that the Bethesda dictum "strongly suggest that a hospital . . . cannot, on appeal to the Board, first ask for new costs" precludes the provider from now claiming to be "dissatisfied."

In MaineGeneral Medical Center v. Shalala, 205 F. 3d 493 (1st Cir. 2000), the Court found it was bound by St. Luke's Hospital v. Secretary of HHS, 810 F.2d 325 (1st Cir. 1987) decision because it was "on point and remains good law." The Court also concluded that the Supreme Court decision in Bethesda, taken as a whole, does not undermine the holding of St. Luke's. Therefore, in accordance with St. Luke's, the First Circuit held that the Board has statutory jurisdiction to hear MaineGeneral's claims, but that it is not required to hear it. 205 F.3d at 497. In other words, the Board has the power to decide the question at issue even though it was not first raised before the intermediary, but that power is discretionary.[9]

[9] The Magistrate Judge in the U.S. District Court for the District of Maine went even further and held that "the Board's decision to review the claims is clearly discretionary under §1395oo(d), and it was well within its authority to refuse to hear the claims." (as quoted from *MaineGeneral*). The decision of the district court was vacated and the case remanded to the Provider Reimbursement Review Board.

The First Circuit's advice or instructions to the Board on how to make the case for "refusing to hear inadvertently omitted claims" by establishing a "rule of consistency" was described as a rational approach in light of the fact that providers have the ability to request a reopening from its intermediary (or that the providers still have another recourse to correct for omitted claims) up to 3 years after NPR is issued. This rationale fails to acknowledge that the intermediary has complete discretion as to if it will or will not reopen a cost report, or that the intermediary could also adopt its own policy to not reopen for claims of omission and its decisions would be final with no administrative or judicial review. See Your Home Visiting Nurse Servs. Inc. v. Shalala, 119 S. Ct. 930, 933-934 (1999).

As of the August 2008 update of the Board's rules and instructions, the Board had not established such a policy regarding unclaimed costs or reimbursement. The Board is currently deciding this matter on a case-by-case basis which means there is no final resolution to the question – whether the Board will hear an issue not first raised before the intermediary, even if it has the power to do so. At present, the decision to hear or not hear a provider's claim may vary depending on the very composition of Board members which would serve to undermine the principle of consistency the courts were cognizant of.

This "discretionary" power that the courts have found the Board has could be used as a means to cut off a provider's statutory right so exercised. The appeals process is the only avenue available to providers where they are the moving party and have some say or some assurance that the matter may be heard on the merits versus refused or denied for lack of interest or limited resources. If the only recourse a provider has is to request a reopening via amended cost report or other correspondence, then that is no recourse at all, in light of the potential of the Intermediary to exercise its unreviewable discretion to not reopen. In my solitary opinion, it is quite possible that taking the opposite approach - accepting jurisdiction and hearing the issue on the merits – would have the desired effect of unclogging the Board's docket of cases brought forth which do not require the expertise of the Board to decide a matter in dispute based on the facts and law.

As stated by the Board majority, in Loma Linda Univ. Med. Ctr. v. Leavitt, 492 F.3d 1065 (9th Cir. 2007), the Ninth Circuit "joined" the First Circuit's view as expressed in MaineGeneral and St. Luke's. The Court noted that 42 U.S.C. § 1395oo(a) is the gateway provision for Board jurisdiction and held that:

> Section 1395oo(a) plainly says that a provider . . . may obtain a Board hearing with respect to the cost report when it is dissatisfied with the intermediary's final determination of the amount of *total reimbursement*. Id. at 1070.

The dispute in Loma Linda concerns what §1395oo(a) means when it allows a Board hearing for a provider who is "dissatisfied" with a final determination of its intermediary. The Secretary's position is that a provider cannot be "dissatisfied" with respect to costs for which it could have claimed reimbursement from its intermediary but did not. The Provider's position is that its "dissatisfaction" was established "when it filed an appeal from [the Intermediary's] final determination, and that the PRRB thereafter had power under §1395oo(d) to make revisions to

matters covered by that cost report regardless of whether such matters were considered by the intermediary." Id.

The Court held that [the Provider] was "undoubtedly 'dissatisfied' with [the Intermediary's] final determination of the 'total program reimbursement due, *for it appealed*. Its appeal was on time and the amount [in dispute] exceeded the jurisdictional minimum." It found all threshold jurisdictional requirements were met "for a hearing that, according to the clear language of the [statute], was 'with respect to the cost report.' This being so, § 1395oo(d) kicked in." Id. at 1071. (emphasis added.)

As the Supreme Court put it, §1395oo(d) "sets forth the powers and duties of the Board once its jurisdiction has been invoked." *Bethesda Hosp*., 485 U.S. at 405. Those powers and duties are to base its decision on the record, which is to include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board"; to affirm, modify or reverse a final determination "with respect to a cost report"; and to make other revisions "on matters covered by such cost report [10]. . . even though such matters were not considered by the intermediary in making such final determinations." Thus, § 1395oo(d) squarely allows the Board to modify a final determination based on evidence that was not considered by the intermediary, and to make revisions on a cost or expense incurred during the year being reported even though the cost wasn't claimed and the matter wasn't considered by the intermediary. Congress could not have intended an *absolute exhaustion rule* in the face of this explicit power. To the contrary, it found that the Congress spoke quite directly to the precise question and opted for Board discretion to go beyond the record adduced for, and considered by, the intermediary. Id. (emphasis added)

I agree with the Loma Linda Court's reasoning that if Congress' intent was to *limit* the Board's review to just the matters adjusted[11] for by the intermediary or to just the evidence explicitly presented to, or considered by the intermediary at the time of its determination, it could have expressly done so. Congress did exactly the opposite, it gave the Board expanded powers to decide matters covered by a cost report that is properly before it and to address and revise as necessary any issue that may arise during the conduct of such hearing.

The Loma Linda Court also noted its interpretation of the interplay between §§1395oo (a) and (d) as conferring discretion on a Board with jurisdiction over a cost report under §1395oo(a) to base its decision on:

> evidence or costs and expenses not claimed by the provider or considered by the intermediary if the cost or expense were incurred within the period for which the cost report was prepared. [12]

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[10] A "matter covered by such cost report" is "a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed." Id at 406; *Adams House Health Care v. Bowen*, 862 F.2d 1371, 1375 (9th Cir. 1988) (adopting the *Bethesda Hospital* definition).

[11] As described by the Secretary/CMS/FI as an "adverse audit adjustment."

[12] See *Bethesda Hosp.*, 485 U.S. 405-06 (finding that its conclusion was required by §1395oo(a) but was supported by the design of the statute as a whole as well as by §1395oo(d), and observing of §1395oo(d) that it "allows the Board, once it obtains jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary" so long as the matter is covered by the cost report).

Id. at 1072.

The Ninth Circuit's view that the Board's jurisdiction is *discretionary* was further explained as:

> What we did in [Adams House] was explain that the discretionary language in St. Luke's does not describe the Board's power to *accept* or *reject* appeals; rather, "it describes the Board's options once an appeal is filed."[13]

The Loma Linda Court stated that it was guided by this construct in holding that once jurisdiction has been obtained over a cost report because of a provider's dissatisfaction with the intermediary's final determination of the total reimbursement amount due, the Board then has discretion to consider evidence that was not before the intermediary; to affirm, modify or reverse the final determination; and to revise matters covered in the cost report that the intermediary did not consider.

I agree with the Board majority that, in UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008), the District Court reached the same conclusion as the First and Ninth Circuits. The D.C. Circuit found that the plaintiff was clearly "dissatisfied" with the fiscal intermediary's determination of total reimbursement for it appealed multiple issues in each NPR. As in Loma Linda, at this point, the Board had jurisdiction for a hearing that according to the clear [and unambiguous] language of the statute, was with respect to the provider's cost reports for the years in question. Loma Linda, 492 F. 3d at 1071.

The D.C. Circuit had not had occasion to affirmatively rule on the confines of the Board's jurisdiction post-Bethesda.[14] However, in a related jurisdictional issue, in HCA Health Services of Oklahoma, Inc. v. Shalala, 27 F.3d 614 (1994), it contrasted the broad scope of the Board's initial review of an NPR available under §1395oo with the more circumscribed review process of a revised NPR. The District Court upheld the Board's interpretation of the statute, which limited the Board's jurisdiction to only specific issues that were the subject of the reopening . . . by holding that:

> Hearing rights before the Board challenging an intermediary's decision [on] reopening are issue-specific: the separate and distinct determination gives a right to a hearing on the matters corrected by such determination. Thus, a revised NPR does not open the entire cost report to appeal. It merely opens those matters adjusted by the revised NPR.

Id. at 622 (internal citations omitted)

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[13] See *Adams House Health Care v. Bowen*, 862 F.2d 1371, 1375 (9th Circuit 1988) (Emphasis added). The court went further and held " [t]he Board has no discretion to reject an appeal, for as 42 U.S.C. §1395oo(a) provides,[a]ny provider of services which has filed a required cost report within the time specified in regulations *may* obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board. . . . The word "may" in the emphasized language connotes not contingency but entitlement. Id. at 1375-76.

[14] Pre-Bethesda, the D.C. Circuit definitively held that the PRRB does not have jurisdiction over appeals regarding costs not specifically claimed for reimbursement. Athens Community Hospital v. Schweiker, 743 4.2d 1 (1984) (Athens II).

In so finding, the D.C. Circuit Court determined that the reopening process was a creation of the regulations, authorized by the Secretary's general rule-making authority under 42 U.S.C. §§1302 and 1395h. Id. at 618. As such, the reopening process was not governed by the provisions of §1395oo of the Medicare statute.

I agree with the Court's findings above and go one-step further to find that the converse is also true, that § 1395oo of the Medicare statute does not expressly state that it is subject to any exhaustion requirement such that would entail the provider first having to request a reopening for a matter before requesting an appeal. The appeals and reopening processes are not mutually exclusive, but rather separate and distinct processes governed by different rules. There is no requirement in the statute or regulations that dictates that one process must occur before the other to preserve a provider's appeal rights or that even implies that appeal rights do not kick in until a provider has exhausted other administrative remedies – such as filing an amended cost report or requesting a reopening.

The D.C. District Court was also not persuaded to interpret the statute to grant a hearing based upon a provider's expressed dissatisfaction with *individual* reimbursement determinations[15] when the plain language clearly predicates the Board's jurisdiction on a provider's dissatisfaction with the "amount of *total* program reimbursement." 42 U.S.C. §1395oo(a)(1)(A)(1). . . . As §1395oo(a) explicitly requires only dissatisfaction with the *total* amount of program reimbursement in order to obtain a hearing, and §1395oo(d) allows the Board to consider evidence not put before the intermediary and make modifications based upon that evidence, the Court [rejected] the Secretary's contention that Congress actually intended to impose an issue-specific exhaustion requirement to access administrative appellate review. There is no such limitation on the Board's jurisdiction or upon its power of review once jurisdiction is obtained. Id. at 77-78.

The D.C. District Court also agreed with the First and Ninth Circuit's view that:

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis.

MaineGeneral, 205 F. 3d at 501.

The Court reasoned that this conclusion comports with the plain language of subsection (d) and found that Congress empowered the Board to make such modifications and allowed it to consider evidence not put before the fiscal intermediary, but did not require it to do so. I disagree with the Court's reasoning and observe that 42 U.S.C. §1395oo(d) does not expressly state or imply that the Board does not have to consider evidence not put before the fiscal intermediary. On the contrary it states in relevant part that:

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[15] A final determination by the Intermediary does not indicate that all matters covered in such cost report were reviewed and or considered. When a provider's cost report is audited, a Report on Audit of Medicare Cost Report is usually included as a part of the Notice of Program Reimbursement. The language found in this report indicates its findings with respect to the items tested, and with respect to the items not tested, it commonly attests that nothing came to its attention that caused them to believe that the provider has not complied in all material respects with Medicare laws, regulations, and instructions. The Intermediary does not issue a separate and distinct determination for each and every aspect of the cost report.

> "a decision by the Board *shall be* based upon the record made at such hearing, which *shall include* the evidence considered by the intermediary *and* such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is reviewed as a whole." (emphasis added)

I agree with the Board majority's findings that Bethesda firmly establishes that not only does the provider have a right under section 1395oo(a) to appeal any item claimed on the cost report and [/or] adjusted by the intermediary, [the provider] also has a right to appeal those items not specifically claimed but which are pre-determined by the agency to be disallowed. However, I find that the circuit and district court cases discussed above clearly conclude that, once the Board obtains jurisdiction under subsection (a), then *subsection (d) sets forth the powers and duties of the Board [to decide a matter under appeal]*.[16]

The Provider asserted that this instant case presented circumstances that require the Board to hear the appeal under the pre-Bethesda Athens Community Hospital, Inc., et al. v. Schweiker, 743 F. 2d. 1 (D.C. Cir. 1984) (Athens II). In Athens II, the Court held that "the PRRB has jurisdiction over costs that are specifically claimed -- meaning that the provider requested reimbursement in a timely manner – as well as those costs issues raised by a provider prior to the intermediary's issuance of the NPR." Id. at 5-6.

I agree that Athens II, which held that a claim presented up until the issuance of the NPR satisfies jurisdictional requirements for a hearing under 42 U.S.C. §1395oo(a), addresses the precise issue at hand and supports the Provider's position that even in the absence of an audit adjustment, a claim to correctly report psychiatric nursing costs was made both at the time of the audit and again through the appeals process.

The Board majority did not find the Athens II holding authoritative as to a provider's right to a hearing on any "cost issue raised by a provider prior to issuance of the NPR"; it found the guidance insufficient because the providers in Athens II did not raise the issue prior to the issuance of the NPR but sought permission to amend their cost report. Their request was rejected by the Intermediary[17] and its subsequent attempt to add the issue to a pending appeal was denied.

As the Board majority acknowledged, intermediaries do make adjustments favorable to providers during the audit process and it is not unusual for intermediaries to accept claims for costs not previously made on the cost report during this reconciliation process. If the Intermediary agrees to accept these submissions and makes a determination on those items, the Board majority found that a right to appeal that matter under section 1395oo(a) attaches. However, the majority disagrees that merely notifying the intermediary of a claim prior to issuance of the NPR preserves a right to hearing before the Board. I concur with the Board majority's finding that

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[16] See Bethesda Hosp., 485 U.S. at 405.

[17] In a detailed decision entitled "Notice of Refusal to Reopen" in which the Intermediary addressed the merits rather than the timeliness of the claim. Athens Community Hospital, Inc. v. Schweiker, 686 F. 2d 989, 992 (D.C. Circuit 1982)(Athens I)

raising a potential issue at the time of audit does not, in and of itself, preserve a right to a Board hearing. The Provider must follow up with either a request for reopening[18] or an appeal, as the Provider did in this case.

The Board majority was convinced that applying the Athens II standard would require a great deal of effort to determine whether the provider had sufficiently disclosed it is seeking reimbursement and whether that disclosure was made at a time that it could reasonably be taken into account when the intermediary issued its final determination of total reimbursement [without] requiring an examination of evidence more extensive and complex than even the merits of a reimbursement issue demands. It also found that such a process would be antagonistic to the concept of jurisdiction being a threshold question to decide whether the Board had authority over the appeal. In addition, the Board majority found that requiring the Intermediary to process any "cost issues raised" prior to the NPR but not included in the cost report could be disruptive to the entire audit and settlement process. These concerns have been addressed in CMS Pub. 100-6, Chapter 8.

The CMS Pub. 100-6, Chapter 8 – Medicare Financial Management Manual (June 12, 2009) explains the procedures to be applied/implemented by contractors to ensure that acceptable cost reports are submitted by providers in a timely manner, that they are appropriately reviewed, and are properly settled.

In Section 30 of the above Manual it states that all providers receiving payments under Part A and B of Title XVIII of the Act are subject to audit. It also goes further to describe the purpose of the Medicare audit:

> In carrying out your audit responsibilities, your primary goal is to arrive at a correct settlement of the cost report. In so doing, preserve the provider's interest and rights but at the same time apply program policies to specific situations to assure compliance with these policies. Your authority does not extend to determining whether program policies and procedures are appropriate or should be applied in a given circumstance. Rather, your responsibility is to enforce such policies and procedures. Take corrective action where noncompliance exits.

See Section 30.2 (Purpose of Field and In-House Audits)

The Manual reiterates that once the decision is made to perform an in-house or field audit on a given cost report, in the coordination of activities during the audits:

> Your principal goal in carrying out the audit responsibilities is to arrive at a correct settlement of the cost report. In doing

[18] At the time Athens II was decided, there was no bar or deterrent to a provider requesting a reopening from an intermediary to address matters related to omissions or other corrections. Post-Your Home (1999), providers are impelled to establish "placeholder" type appeals as the provider's (in some instances only, if not) last recourse to have a matter hear and considered.

> so preserve both the provider's interest and government's interest.

If goes further and states:

> If during the audit you uncover circumstances in which a provider disadvantaged itself, advise the provider liaison of the issue(s). Also, maintain ongoing communications during the audit by discussing regularly with the provider liaison to handle the following:
>
> > . . . Open audit issues . . .

See Section 60.5 (Coordination of Activities During the Field and In-House Audits)

The Manual also addresses how the finalization of audit adjustments should be handled as follows:

> CMS encourages continuing dialogue during [the period between the pre-exit conference and exit conference] between [the Intermediary/MAC] and the provider for issues where agreement was not reached at the pre-exit conference. However, it is not necessary to consider any documentation that is received after the timetable provided at the pre-exit conference unless prior arrangements with the provider have been made.
>
> While you should not refuse to accept documentation submitted after the established timeframes, you do not need to consider it in the initial NPR issuance. *If a reopening is later granted* ***or a timely appeal is made****, the late documentation may be considered at that time.*

See Section 60.11 (Finalization of Audit Adjustments) (emphasis added)

In summary, Intermediaries are not required to process any issue raised prior to issuance of NPR, but the audit process described above in the Medicare Financial Management Manual does address the steps necessary to ascertain whether an issue has been properly raised with the Intermediary at audit and in this case subsequently via appeal.

The Board majority concluded that for a provider to have a *right* to a hearing [on a cost issue] the expense item must be *in the [filed] cost report* unless a predetermination has been made that the cost would be disallowed: as in the Bethesda circumstances; [or where] the Secretary has advised that inclusion is not required; or other circumstances that make inclusion impossible or unnecessary. I disagree. This conclusion goes against the weight of authority as detailed above of how a provider's right to a Board hearing is established. In addition, as to the merits, the Provider could show that based on what information was available at the time the cost report was filed, a determination was made that the psychiatric nursing costs were for private duty nurses which are not reimbursable under the Medicare program. So for all intents and purposes, the Provider properly excluded from the cost report an item it believed at the time of filing was not

reimbursable. Therefore, the Provider's cost report was filed in compliance with Medicare laws, regulations and instructions.

I agree with the Board majority that the statute makes *a timely filed* cost report an absolute prerequisite for a Board hearing, but the timeliness of the cost report filing or request for hearing is not in dispute. Even if it were in dispute, I find such a timeliness determination occurs once and once established there is no need to revisit or re-decide. I also agree that the failure to submit correct and complete information will lead to an inaccurate determination. However, I do not agree that the Intermediary in this case is entirely without fault but find its refusal to review a potential error at the time of audit could very well have perpetuated an inaccurate determination. But as earlier discussed, the Intermediary is not required to process such requests, the burden falls on the Provider to continue to pursue a correction within the manner prescribed (i.e. request for reopening or appeal).

As the Board majority found, nothing in the statute provides for corrections to the cost report submissions . . . other than the filing deadlines established by regulation and that the Secretary, by regulation, established two [additional] avenues for correction: the amended cost report and reopening.

I respectfully dissent with my colleagues' reasoned and reasonable arguments, but we view the issues differently. I read §1395oo(a) to permit use of the appeal process as a means for correcting an otherwise complete cost report. This view does not undermine the Secretary's regulatory framework for making corrections. I found no statutory or regulatory language that addresses cost report finality; however, I find support for my view in the agency's guidance provided in the Provider Reimbursement Manual (PRM). See CMS Pub. 15, Part 1, Sections 2930 and 2931. (09/93)

In PRM §2930, which address the finality, reopening and correcting of intermediary and Board determinations and decisions, it states in part that:

> . . . there must be a reasonable period of time within which to seek or make corrections wherever an error has been discovered. This section and the next discuss finality and set out the time limits (reopening periods) for making corrections of intermediary determinations . . .

PRM §2930.1 addresses when determinations and decisions become final as follows:

> For the purpose of the reopening and correction provisions of §2931 . . . an intermediary's initial determination . . . becomes final and binding when the specific time limit for appealing such determination or decision expires.

In addition, PRM §2930.1.A states in part that:

> An intermediary's initial determination (Notice of Amount of Program Reimbursement) becomes final and binding upon the expiration of 180 calendar days after the date of mailing of the notice, unless before that time the provider (entity) requests a hearing . . .

Section 2930.1 goes on to say:

> The above-listed determinations and decisions, otherwise final, may nevertheless be reopened and corrected when the specific requirements for reopening and correction set out in §2931 are met.

Based on these provisions and other mechanisms in place to allow for amendments, revisions and/or corrections to previously submitted and or settled cost reports, I find that the cost report as a whole is open to correction or amending until it is considered final and binding. The cost report is final and binding upon expiration of the 180 days from the date of issuance of the NPR, unless the provider has requested a hearing and its request is accepted. If the provider's request for a hearing is denied, then the cost report may still be reopened upon request if made within 3 years of the date of the NPR, with respect to the intermediary's findings on matters at issue. See 42 C.F.R. §405.1885(a).

In conclusion, I find once a provider has met the jurisdictional requirements to a Board hearing under §1395oo(a) and been granted the right to be heard on the merits of its case, the Board's authority to decide the matter and the scope of its review is governed under §1395oo(d). Section 1395oo(d) does not convey discretion on the Board to refuse to hear an appeal or a matter at issue in an appeal, in effect cutting off a provider's right to a Board hearing.

The Provider does have a right to a Board hearing under 42 U.S.C. §1395oo(a) on the psychiatric nurse cost issue. This case should not be dismissed.

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Yvette C. Hayes