# PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2010-D15

**PROVIDER -**
Affinity Medical Center

Provider No.: 36-0151

Cost Reporting Period Ended -
June 30, 2006

**vs.**

**INTERMEDIARY -**
BlueCross BlueShield Association/
National Government Services

**CASE NO.:** 08-1816

**INDEX**

**Issue:**

Does the Board have jurisdiction over the resident-to-bed ratio where an alleged error in the filed cost report was discovered by the Provider after the final determination was issued?

**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 insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and interpretive guidelines published by CMS. 42 U.S.C. §1395h; 42 C.F.R. §§413.20 and 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it 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 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.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the Prospective Payment System (PPS). However, the PPS statute provides for increased payments based on various hospital-specific factors. This case involves one of those factors: graduate medical education.

The Medicare payment methodology for direct graduate medical education (GME) costs is described in 42 U.S.C. §1395ww(h). Section 1395ww(d) provides a separate payment for indirect medical education (IME), i.e., the higher-than-average operating costs that are associated with the presence of residents and the intensity of their training. The IME payment is based on the ratio of residents to the number of beds. The beds in the hospital are counted as specified in 42 C.F.R. §412.105(b). In this case, the substantive issue being appealed relates to the number of beds used to calculate IME payments.

The threshold issue which the Board must address is whether the Provider has a right to a hearing. Under 42 U.S.C. §1395oo(a)(1)(A)(i), any provider which has filed a cost report within the time specified may obtain a hearing by the Provider Reimbursement Review Board (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 . . .

The regulations at 42 C.F.R. §405.1835 provide further details on the right to a hearing. 42 C.F.R. §405.1835(a)(1) states that a provider has a right to a hearing before the Board if:

(1) An Intermediary determination has been made with respect to the provider; . . .

The statute and regulations specify other conditions for a right to a hearing including submission of a timely request and an amount in controversy of at least $10,000.

**Statement of the Case and Procedural History:**

This appeal involves a short cost reporting period from February 1, 2006 through June 30, 2006. The appeal was filed on April 18, 2008, from a Notice of Program Reimbursement (NPR) dated December 13, 2007. The Provider initially appealed various issues, all of which have since been transferred to group appeals. On July 1, 2008, the Provider requested that the issue of indirect medical education (IME) available beds be added to the appeal. The issue was described as:

> Error in the Intern FTE to Available Bed Ratio
>
> The hospital reduced their number of available beds in December 2005. Audit adjustment Number 8 on the 1/31/2006 NPR reflects this adjustment but the 6/30/2006 NPR did not include this adjustment nor the corrected prior year Resident to Bed Ratio.
>
> The result of this error is an understatement of the Resident to Bed Ratio on line 3.17 on worksheet E, part A as well as the understatement of the IME reimbursement on line 3.23 of worksheet E part A by $54,480. This error will also severely impact the reimbursement on the 6/30/2007 Medicare Report when it is finalized.

**Parties' Contentions:**

The Intermediary states that it did not adjust the number of available beds on the cost report; it reviewed the worksheet and accepted the number submitted by the Provider.[1]

The Provider had a 17-bed rehabilitation unit that closed December 31, 2005. For the cost reporting period involved in this case, the Provider reported 100 adult and pediatric beds. The Intermediary reviewed the Provider's claim and the documentation that supported the claim. The Intermediary agreed with the Provider's claim for 100 beds based on the state's registration requirements, the CMS acknowledgement of the closure of the rehabilitation unit, and the fact that the Provider did not exceed the number of registered beds it was allowed by the state.[2] The Provider contends the 100 beds reported were the total of the adult and pediatric beds (83) plus the beds from the closed rehabilitation unit (17). The Provider asserts that the total available beds used to compute IME payments should be only 83.

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[1] See, Intermediary Juris. Br. Ex. I-3.
[2] See, Intermediary Juris. Br. Ex. I-3.

The Intermediary contends the Board lacks jurisdiction over the IME bed count issue because there was no adverse Intermediary finding. It argues that "§405.1801 and §405.1803 imply that an identifiable adverse finding, with a corresponding reduction in reimbursement, is necessary to request a Board hearing under section 405.1841(a)." The Intermediary relies on the Board's decision in Maple Crest Care Center v. Mutual of Omaha[3] (Maple Crest) to support its position that the Board lacks jurisdiction over appeals where a provider seeks reclassification of costs to which the intermediary made no adjustments.

The Provider contends that the Board has jurisdiction over the issue under the provisions of 42 U.S.C. § 1395oo(a), asserting the Supreme Court's decision in Bethesda Hospital Association v. Bowen [4] establishes that an adverse determination is not a prerequisite to Board jurisdiction. The Provider contends that the Board's decision in Maple Crest[5] was invalidated by the decisions in St. Luke's Hospital v. Secretary Health and Human Services,[6] (St. Luke's) and Maine General Medical Center v. Shalala,[7] (Maine General) and asserts these cases stand for the proposition that a provider needs to be dissatisfied with only the intermediary's final determination of total reimbursement for the Board to have jurisdiction over any issue.

The Provider notes that it did claim IME reimbursement and the Intermediary did make adjustments involving the IME reimbursement calculation. These facts alone are sufficient for Board jurisdiction and distinguish this case from St. Luke's and Maine General, in which the providers did not claim the costs for which they later sought reimbursement.

In addition, the Provider contends 42 U.S.C. § 1395oo(d), in conjunction with 42 U.S.C. §1395oo(a), supports its position that the only requirement for its right to a hearing on the IME issue is that the matter must have been covered by the cost report period regardless of whether or not expressly claimed. In this case, the Provider filed an appeal of several other issues over which there is no dispute as to jurisdiction. Because there is a jurisdictionally proper appeal for other issues, the Board can decide the IME issue under its discretionary authority under 1395oo(d) and should do so to assure there is an accurate determination of Medicare reimbursement.

**Findings of Fact, Conclusions of Law and Discussion:**

After consideration of the Medicare law and guidelines, the parties' contentions and the evidence presented, the Board majority finds that the Provider does not have a right under 42 U.S.C. §1395oo(a) to a hearing on the issue appealed and the Board declines to hear the matter under its discretionary powers of review pursuant to section 1395oo(d). Since this is the only issue remaining, the Board hereby dismisses the case.

42 U.S.C. §1395oo(a) establishes the Board's jurisdiction. It provides in relevant part:

[3] PRRB Dec. No. 2003-D4, Medicare & Medicaid Guide (CCH) ¶ 80,942.
[4] 485 U.S. 399 (1988)
[5] Id.
[6] 810 F.2d 325 (1st Cir. 1987)
[7] 205 F.3d 493 (1st Cir. 2000)

> 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 . . .

After jurisdiction is established under 42 U.S.C. §1395oo(a) the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. §1395oo(d) which states in relevant part:

> 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 Provider incorrectly claimed 100 IME beds on its cost report as filed. That error was due solely to the provider's negligence. Only in hindsight did the Provider determine that it should have claimed fewer beds for purposes of the IME calculation, thereby increasing the amount of reimbursement. After failing to persuade the Intermediary to reopen its decision to allow the additional reimbursement,[8] the Provider added the issue to its existing appeal.

The Board majority concludes that Provider does not have a right to hearing on the IME issue under 42 U.S.C. § 1395oo(a). In Bethesda Hosp. Association v. Bowen, supra, the provider failed to claim a cost because a regulation dictated that it would have been disallowed. In that situation, the Supreme Court found section 1395oo(a) permitted jurisdiction over the "self disallowed" claim.

> [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.* (Emphasis added).

[8] The Provider did not appeal from that determination in that the Supreme Court held in Your Home VNA v. Shalala, 525 U.S. 449 (1999), that reopening was discretionary and the Board did not have jurisdiction to review the denial.

Id. at 1258, 1259.

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. (Emphasis added).

Id. at 1259.

In this case, the Board has precisely the situation described by the Supreme Court as being "on different ground." While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost unclaimed through inadvertence rather than futility, other appellate courts have done so. The Board finds the Provider's reliance on these cases for support that it has a right to an appeal of this matter under section 1395oo(a) is misplaced.

In Loma Linda Univ. Med. Ctr. v. Leavitt, 492 F.3d 1065 (9th Cir. 2007), 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. Similar to the circumstances here, Loma Linda appealed six other items adjusted on the cost report and, when it discovered the interest error later, added the interest expense issue to its pending appeal. The Ninth Circuit stated:

> We conclude 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 final determination of total reimbursement due for a covered year, 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. (Emphasis added).*

Id. at 1068.

The Ninth Circuit stated it was joining the First Circuit's view as expressed in MaineGeneral Medical Center v. Shalala, 205 F.3d 493 (1st Cir. 2000) and St Luke's Hospital v. Secretary, 810 F.2d 325 (1st Cir. 1987). Id. Maine General involved hospitals that listed zero for reimbursable bad debts on their cost reports. The mistakes were not discovered until after the NPRs had been issued. Providers appealed several items adjusted by the NPRs but also included claims for the bad debts. The Board dismissed the bad debt claim for lack of jurisdiction because they had not

been disclosed on the cost reports despite there being no legal impediment to doing so. The MaineGeneral court relied on its prior decision in St Luke's in which costs were self-disallowed, not inadvertently omitted. However, it found that the St. Luke's decision 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 even though it found the hospitals had a strong equitable argument favoring review under the particular circumstances. St. Luke's at 332. "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." (Emphasis in original). St. Luke's at 327-328. The First Circuit in MaineGeneral 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." MaineGeneral at 501. 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. Luke's at 327.

In UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008) (UMDNJ), the D.C. 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 which were omitted entirely from the cost report. The D.C. Court found guidance in the D.C. Circuit's decision in HCA Health Services of Oklahoma. Inc. v. Shalala, 27 F.3d 614 (D.C. Cir. 1994) that involved an appeal of a reopened intermediary decision. The D. C. District Court also refused Provider's request for it to order the Board to hear a 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." UMDNJ at 79.

The majority takes from these cases the principle that a provider does not have a right to an appeal of an expense inadvertently omitted from the cost report or mistakenly reported. As the Ninth Circuit stated in Loma Linda, "There is no dispute that 1395oo(a) is the gateway provision for Board jurisdiction." Id at 1070. Nor does the case law stand for the proposition that §1395oo(d) is a grant of "alternate" jurisdiction. That view ignores the very essence of the Courts' holdings. These decisions make it clear the Board's power under §1395oo(d) is discretionary. The Board may hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report but the Board is not required to hear those claims. Based on the circumstances of this case, the Board majority declines to exercise its discretionary authority.

**Decision and Order:**

The Board concludes that Provider does not have a right to appeal the IME issue under 42 U.S.C. §1395oo(a) and declines to hear the matter pursuant to its discretionary powers under 42 U.S.C.

§1395oo(d). Since this is the only issue remaining in the appeal, the Board hereby dismisses the case.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§405.1875 and 405.1877.

**Board Members Participating**:

Suzanne Cochran, Esq.
Yvette C. Hayes (Dissenting)
Michael D. Richards, CPA
Keith E. Braganza, CPA
John Gary Bowers, CPA

**For The Board:**

Suzanne Cochran, Esq.
Chairman

**DATE**: March 11, 2010

Affinity Medical Center

Dissenting Opinion of Yvette C. Hayes:

I respectfully dissent with the Board majority's conclusion that the Provider does not have a right to appeal the IME – available bed count issue under 42 U.S.C. §1395oo(a) and declines to exercise its "discretionary" powers under 42 U.S.C. §1395oo(d).

The Intermediary states that it did not *adjust* the number of *available beds* reported on Worksheet S-3, Part 1 of the submitted Medicare cost report.[9] However, it acknowledges that it reviewed the documentation provided in support of the Provider's as-filed amount and accepted or agreed with the number as submitted. Therefore, it is not disputed that the Intermediary made a distinct and separate determination that the bed count as submitted on the FYE 6/30/2006 cost report was accurate; although that finding appears entirely different from the determination made in the prior cost reporting period. It is the Intermediary's position that the Board lacks jurisdiction over the IME bed count because there was no audit adjustment (or identifiable adverse intermediary finding/determination) which is a prerequisite under 42 C.F.R. §§ 405.1801 and 405.1803 for requesting a hearing before the Board under 42 C.F.R. §405.1841(a).

This case is factually distinguishable from the Board's jurisdictional decision cited and relied upon by the Intermediary in support of its jurisdiction challenge.[10] The Provider asserts that it made a claim for IME reimbursement[11] (the number of beds is just one component of determining the IME payment amount) and that the Intermediary did make adjustments with respect to IME reimbursement[12]. In addition, the Provider added the IME available bed issue to its pending appeal on July 1, 2008 after its request to reopen the cost report was denied on May 29, 2008.

It is the Provider's position that it meets the jurisdictional requirements of 42 U.S.C. §1395oo(a) and its dissatisfaction with the Intermediary's determination is the key requirement; an identifiable adverse determination is not a prerequisite to Board jurisdiction under Bethesda Hospital Association v. Bowen, 485 U.S. 399, 404 (1988). In addition, 42 U.S.C. §1395oo(d), in conjunction with §1395oo(a), supports its assertion that the Board has jurisdiction over the IME bed count issue; only limitation is that the matter must have been covered by the cost report period whether or not expressly claimed.

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[9] Worksheet S-3 is used to report Hospital and Hospital Health Care Complex Statistical Data. The current year Resident FTE to Bed ratio was reported on Worksheet E, Part A, Line 3.18 and used in the calculation of total IME reimbursement on Worksheet E, Part A, Line 3.24. See Provider's Jurisdictional Brief, Exhibit 6.

[10] Maple Crest Care Center v. Mutual of Omaha Insurance Co., PRRB Hearing Dec. No. 2003-D4 (November 7, 2002).

[11] The issue in dispute is described as an "Error in the Intern FTE to Available Bed Ratio." The Provider claimed 100 Adults and Pediatrics beds for IME purposes in its short cost reporting period from February 1, 2006 through June 30, 2006.

[12] See Provider's Jurisdictional Brief, Exhibit 7 – Audit Adjustment Report for FYE 6/30/2006. Adjustment No. 7 to adjust IME [FTE]count on W/S S-3, Part 1 from 22.51 to 21.44.; Adjustment No. 13 to adjust the IME *FTE* count for the Current Year (22.51 to 21.44 on W/S E, Part A, Line 3.08) and Prior Year (24.36 to 22.89 on W/S E, Part A, line 3.15) and the Prior Year Resident to Bed ratio (0.243061 to 0.238711 on W/S E, Part A, line 3.19); and Adjustment No. 14 to properly reflect the DRG Amount of $3,748,009 for an increase of $23,712.

The Provider further contends that the PRRB decision in *Maple Crest* relied upon by the Intermediary, as well as the case law relied upon by the Board in making that decision is no longer controlling. Furthermore, the rationale for denying Board jurisdiction in those cases involved the idea that an Intermediary ought to have a chance to address an issue before an issue is brought before the Board. In the present case, the Intermediary did have a chance to address the IME [available] bed count issue. According to the body of case law on this issue, Board jurisdiction is not premised on the existence of an identifiable adverse determination (e.g. an audit adjustment). The Provider notes that because IME costs or reimbursement were claimed this differentiates this case from St. Luke's and MaineGeneral, et al.

The Provider claims that the Intermediary was well aware of the change in the bed count at the Provider for it had made adjustments to the bed count in its FYE 1/31/2006 cost report.[13] However, no adjustments were proposed in the FYE 6/30/2006 cost report to incorporate the prior year audit findings. It is the Provider's assertion that based on the results of the prior year audit of its FYE 1/31/2006 cost report, the available bed count should have been reduced from 100 to 83 Adults and Pediatrics beds.

The issue in this case the Board to decide is whether the Provider's IME reimbursement was correctly reflected on its final settled cost report.

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. . . .
> (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), where the Supreme Court commented:

[13] For its FYE January 31, 2006 (prior cost reporting period), the Provider reported 100 Adults & Pediatrics beds and zero (0) beds for the Rehab sup-provider unit. The intermediary adjusted available beds to reflect 83 Adults & Pediatrics beds and 15 Rehab unit beds (The 17-bed Rehab unit was closed on December 31, 2005 and beds were prorated to reflect that it was open for 6 out of 7 months of the period ended 1/31/2006). The NPR was issued on August 24, 2007 – less than 4 months before the NPR for FYE 6/30/2006 was issued on December 13, 2007.

> 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 IME reimbursement was claimed on the cost report but the amount claimed was allegedly understated based on the number of available beds being inaccurately reflected. The Provider did make a request to its Intermediary to correct the error but was denied via reopening; it then subsequently added the issue to its jurisdictionally proper pending appeal from its original cost report.

In support of this position, the Supreme Court held that:

> The plain language of §1395oo (a) demonstrates that the Board had jurisdiction to [consider a provider's challenge to a regulation of the Secretary]. There is 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. (emphasis added)

Bethesda at 399-400.

In addition, 42 U.S.C. §1395oo (d) states in relevant part:

> 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.

According to the Supreme court, the language in 42 U.S.C. §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. 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, 485 U.S. at 406. In this case, there is no dispute that the matter at issue – IME bed count – was incurred within the period that is covered by the cost report although not expressly claimed.

Although the Supreme Court has not had an opportunity to squarely address whether the Board has jurisdiction of an appeal of 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).

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 [14]. . . 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

[14] 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).

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[15] 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 Provider emphasized this by stating that the First Circuit points out in St. Luke's, the Congressional history relating to the statutory grant of PRRB authority supports this interpretation of the statute. The House committee report states that the Board may "affirm, modify, or reverse the fiscal intermediary's determination, including revisions which are adverse to the provider and revisions involving matters not considered by the intermediary; and that Board decisions "would have to be based on the record made at [the] hearing [before the Board], which may include any evidence submitted by the Department . . .[as well as] the evidence or record considered by the intermediary…[The] Board may find in whole or in part for the provider or the Government (including a finding based upon evidence before it that the provider owes sums in addition to the amount raised in the appeal.)" See St. Luke's, 810 F.2d at 328 (citing H. Rep. No. 231,92d Cong., 2d Sess., reprinted in 1972 U.S.C.C.A.N. 4989, 5094-95, 5309).

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. [16]

Id. at 1072.

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

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

[16] 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).

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 Maine General'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.[17]

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 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,[18] 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.

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,

[17] 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.

[18] The Intermediary denied the Provider's request for reopening on May 29, 2008.

> "it describes the Board's options once an appeal is filed."[19]
> (Emphasis added)

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.

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. 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[20] 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. (citations omitted)

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[19] 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.

[20] 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.

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:

> "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 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].

In further support of the Provider's right to a Board hearing on the IME bed count issue, I agree with the Provider's assertion that if the Board's jurisdiction over the first three issues originally in this appeal[21] is undisputed, then clearly, the Board's jurisdiction over the Provider's FYE 6/30/2006 cost report has been obtained; as a result, under 42 U.S.C. §1395oo(d) and the Supreme Court's ruling in Bethesda, the Board has the power to rule on and revise any other costs or expenses incurred during the period for which the cost report was filed even if such cost or expense was not expressly claimed.

To address the Intermediary's argument that an audit adjustment is a prerequisite under 42 C.F.R.§§ 405.1801 and 405.1803 for requesting a hearing before the board under 42 C.F.R. §405.1841(a) the following is offered:

According to the Medicare regulations at 42 CFR §405.1835(a), the Provider has a right to a hearing before the Board about any matter designated in §405.1801(a)(1).

Section 405.1801(a)(1) defines what an *intermediary determination* means as follows:

> With respect to a provider of services that has filed a cost report under §§413.20 and 413.24(f) of this chapter, the term means *a determination of the amount of total reimbursement due the provider*, pursuant to §405.1803 [written notice requirements of an NPR] following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report. (Emphasis added)

[21] See Provider's Jurisdictional Brief, Exhibit 2 – Request for Hearing dated April 16, 2008. The following issues were requested: DSH – Labor and Delivery Days; DSH – SSI Ratio; Bad Debt. All these issues were subsequently transferred to group appeals.

42 CFR §405.1835(a) further states that, a provider has a right to a Board hearing *if*:

> (1) An intermediary determination has been made with respect to the provider; and
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and
> (3) The amount in controversy (as determined in §405.1839(a)) is $10,000 or more.

42 CFR §405.1841(a)(1) addresses the general requirements of a request for Board hearing as follows:

> The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider . . . Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. . . .

All of the above requirements have been met, therefore, I find the provider has met all jurisdictional requirements of the statute and regulations and has a right to be heard on the merits of its case.

I agree with the Provider's conclusion that the Intermediary's challenge based on "no determination" is factually and legally without basis. Furthermore, the case law relied upon by the Intermediary in this challenge is factually dissimilar to the case at hand and has been implicitly overruled by more recent case law.

Furthermore, I agree with the Provider's assertion that reaching an accurate determination of Medicare reimbursement due the Provider is the goal of the Medicare program. This goal stems from Congress' stated statutory objective that the Medicare regulations ensure that:

> the necessary costs of efficiently delivering covered services to individuals covered by the [Medicare program] will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by [the Medicare program]," and that such regulations shall "provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

42 U.S.C. §1395x(v)(1)(A)

This goal is plainly stated in guidance provided in the CMS Pub. 100-6, Chapter 8 – Medicare Financial Management Manual (June 12, 2009) which 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 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 . . .

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

In summary, I find that even if the Provider mistakenly claimed 100 Adults & Pediatrics beds for IME purposes, as it did in prior period ended 1/31/2006, it is the Intermediary's responsibility to correct such an error. The Intermediary has stated that it performed its duty and reviewed the provider's claim as reported and found it acceptable as filed. The Provider's contends the Intermediary's determination is inaccurate. Only by examining the merits of the Provider's claim can it be established whether the IME bed count as reported/submitted is accurately reflected.

In conclusion, I find that the Board has jurisdiction over the IME bed count issue pursuant to 42 U.S.C. §1395oo (a) and the Board's authority to decide the IME bed count issue and the scope of its review is governed under §1395oo (d). This case should not be dismissed.

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Yvette Hayes