PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2013-D39

PROVIDER –
St. Vincent Hospital & Health Center
Indianapolis, Indiana

Provider No.: 15-0084

Cost Reporting Period Ended -
June 30, 1999

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
Wisconsin Physicians Service

CASE NO.: 02-1590

INDEX

ISSUE:

Whether the Provider Reimbursement Review Board ("Board") has jurisdiction over Ambulatory Surgery Costs and Organ Acquisition Costs where the Intermediary made no audit adjustment to the cost report?

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act ("Act") to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & 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 ("FIs") and Medicare Administrative Contractors ("MACs"). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to the Medicare program.[3] Each 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").[4]

A provider dissatisfied with the intermediary's final determination of total reimbursement (*i.e.*, the NPR) may file an appeal with the Board provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[5]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

St. Vincent Hospital and Health Center ("Provider") is a Medicare certified acute care hospital located in Indianapolis, Indiana with a fiscal year ending on June 30. During the fiscal year ("FY") in dispute, FY 1999, National Government Services ("NGS"), Inc. was the Provider's designated intermediary responsible for finalizing the Provider's cost reports. In August, 2012, Wisconsin Physicians Service ("WPS") assumed the responsibility for the Provider and this appeal. NGS and WPS will be referred to collectively as the "Intermediary."

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[3] 42 C.F.R. § 413.20.
[4] 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835.

On March 27, 2002, the Provider filed a timely request for hearing before the Board based on the NPR for the FY 1999 cost report dated September 28, 2001. The Provider initially sought review of three issues in its appeal request: (1) Indirect Medical Education ("IME") Full Time Equivalent ("FTE") Count; (2) Ambulatory Surgery Costs; and (3) Organ Acquisition Costs.

The Provider later filed documents to add Issues 4, 5, and 6 to its appeal. Specifically, on September 20, 2004, the Provider filed documents to add two issues to the appeal: (4) DSH – Indiana Hospital Care for the Indigent Program Days; and (5) DSH – Medicare Crossover Days. On March 28, 2008, the Provider filed documents to add a final issue to the appeal: (6) Standardized Amount – Rural Floor. The Provider filed documents to transfer Issues 4 and 5 to group appeals on September 29, 2004[6] and transfer Issue 6 to a group appeal on March 28, 2008.[7]

The Provider withdrew Issue 1 involving the IME FTE Count on February 2, 2012, when it filed its preliminary position paper. The Board notes that, per the Provider's appeal request dated March 27, 2002, Issue 1 only involved a dispute with the IME FTE count and did not raise any similar issue specific to Direct Graduate Medical Education ("DGME") FTE counts. Accordingly, two issues remain in the appeal – Issue 2 involving Ambulatory Surgery Costs and Issue 3 involving Organ Acquisition Costs.

On May 25, 2012, the Intermediary filed a jurisdictional challenge with the Board regarding the two remaining issues (*i.e.*, Issues 2 and 3) because these items were paid as originally claimed on the cost report. On June 22, 2012, the Provider filed a reply brief to the Intermediary's challenge similarly addressing the two remaining issues raised in the appeal request (*i.e.*, Issue 2, and 3).

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that it did not make an adjustment to the Provider's cost report for Issues 2 and 3 which are the two remaining issues that were appealed in the instant controversy.[8] In support of this argument, the Intermediary relies on 42 C.F.R. § 405.1835 which states:

> The provider ... has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if ... [a]n intermediary determination has been made with respect to the provider.

The Intermediary maintains that this regulation limits the Provider's right to a hearing to the issues upon which it has made a final determination.

The Provider's appeal request identifies Issue 2 as "Ambulatory Surgery Reclassification as a Separate Cost Center (No Audit Adjustment Due to Prior Treatment by FI under PRM § 2304...)."[9] The Intermediary maintains that the Provider included ambulatory surgery costs in

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[6] The Provider transferred Issue 4 to PRRB Case No. 04-1657G and, on November 19, 2010, that group case was subsequently closed (*i.e.*, no more providers could be added to the group case without leave of the Board). The Provider transferred Issue 5 to PRRB Case No. 00-3795G and that group case has not yet closed.

[7] The Provider transferred Issue 6 to PRRB Case No. 07-1282G and that group case was subsequently closed on June 12, 2012.

[8] *See* Intermediary Exhibit I-1 (full adjustment report).

[9] Intermediary Exhibit I-2 at 2 (Provider's Appeal Request dated March 27, 2002).

the Operating Room cost center on the FY 1999 cost report and the Intermediary made no adjustment to this item.

While the Provider concedes that no adjustment was made in the current period under appeal, the Provider addressed the Intermediary's treatment of this issue in the prior period, stating:

> The [Intermediary] has combined the requested Ambulatory Surgery reclassification into a single cost center with other operating room functions through its reopening granted for FYE 6/30/98 and cited PRM § 2304 as authority. However, the Provider contends that this Ambulatory Surgery cost center should be separate as meeting the requirements of PRM § 2302.8, proper interpretation of PRM § 2304, and general cost accounting principles.[10]

Based on a review of the prior cost reporting period (*i.e.*, FY 1998) audit workpapers, in which the Intermediary proposed "to review expense groupings for reasonableness," various cost centers were identified as being new, deleted, or having a change in groupings between years.[11] Specifically, the Intermediary identified that cost center #7030 (Surgery-Ambulatory) had been grouped in the Operating Room cost center in prior years (FY 1997), but the Provider set up this department as a separate cost center in FY 1998.[12] Because of a mismatch of costs and revenues, the Intermediary proposed an audit adjustment to combine the cost centers in FY 1998.[13] The Intermediary states that the review of the FY 1998 cost report began on February 10, 2000, while the FY 1999 cost report had already been filed on November 30, 1999.[14] The Intermediary therefore concludes that, based on the difference in time periods, it is clear the Provider did not file its FY 1999 cost report to reflect the FY 1998 audit findings. The Intermediary further argues that the Provider did not file any protested amounts on its FY 1999 cost report.

Additionally, the Provider's appeal request identifies Issue 3 as "Organ Acquisition Costs Not Properly Included (No Audit Adjustment Due to Prior Treatment by FI through Pending Reopenings ...)."[15] The Intermediary notes that the Provider's position paper states: "Provider has been granted these pass-through costs via reopening for its FY 1997, FY 1998, and FY 2000 cost reports and requests the same treatment for the FY 1999 cost report under appeal herein."[16] In response, the Intermediary states that the revised NPRs for FYs 1997 and 1998 were issued on July 29, 2003 and, August 17, 2004 respectively. Both of these dates were within the three-year reopening period for the NPR for FY 1999. However, the Provider did not request a reopening for FY 1999 to address this issue.

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[10] *Id.*
[11] Intermediary Exhibit I-3 at 1.
[12] *Id.* at 2.
[13] *Id.*
[14] Intermediary Exhibit I-4.
[15] Provider's Appeal Request dated March 27, 2002 at 2.
[16] Provider Final Position Paper at 3.

As such, the Intermediary submits that the Provider had ample opportunity to request a reopening for similar handling for the FY 1999 cost report. Also, the Provider did not file any protested amounts on its FY 1999 cost report.

The Intermediary concludes that it did not make an adjustment to the cost report for either Issues 2 or 3 involving Ambulatory Surgery and the Organ Acquisition costs respectively. Therefore, the Intermediary has not made a determination with respect to the Provider for the two remaining issues under appeal. Since these are the last two issues remaining in the appeal, the Intermediary requests that the Board dismiss this case.

PROVIDER'S CONTENTIONS:

The Provider contends that there is no discretionary element in the jurisdictional requirement. The language of the Medicare statute at 42 U.S.C. § 1395oo(a) contains three main jurisdictional requirements for a provider to obtain the right to an appeal. First, a provider must be dissatisfied with a final determination of the intermediary as to the total amount of reimbursement. Second, the amount in controversy must be $10,000 or more for an individual appeal. Finally, a provider must request a hearing within 180 days of receiving notice of the intermediary's final determination. The Provider states that a second provision of the statute at § 1395oo(d) discusses the Board's powers and duties with respect to decision making, but does not give the Board the ability to deny a provider the right to appeal if the three jurisdictional requirements in § 1395oo(a) have been met.

The Provider argues that the language of the statute is clear and unambiguous, and that the Provider meets all three jurisdictional requirements. While the timeliness and amount in controversy requirements are not disputed here, the Provider states it is dissatisfied as to the total amount of program reimbursement it received.

The Provider also asserts that, pursuant to 42 U.S.C. § 1395oo(d), the Board has the power to consider the items not submitted with its cost report or at audit. However, this provision does not give the Board the discretion to decide whether to accept jurisdiction on an appeal when all the jurisdictional elements of § 1395oo(a) have been met. The Provider continues that it is relatively clear from the structure of the statute that Congress had no intention of giving the Board any discretion related to the jurisdictional element of dissatisfaction. Rather, had Congress actually intended to provide the Board with discretion when addressing the Provider's right to an appeal, it most certainly would have done so with clear, unambiguous language in the statute. Instead, Congress imposed a general requirement of dissatisfaction as to the total amount of program reimbursement. The Provider concludes that the only discretionary language found anywhere in the statute is with respect to the Board's powers and duties once jurisdiction is established.

The Provider argues that the dissatisfaction element has been interpreted in many cases, and that it is evident from the case law and the statute that a provider should obtain a hearing if it is dissatisfied with the intermediary's final determination of the amount of total reimbursement. The Provider asserts there is no requirement that it must be dissatisfied as to the amount of reimbursement on each claim.[17] Pointing to *Bethesda Hospital Association v. Bowen*

[17] *See Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F. 3d 1065, 1070-71 (9th Cir. 2007) [hereinafter *Loma Linda*].

("*Bethesda*"),[18] the Provider further suggests that the U.S. Supreme Court held that providers are able to claim dissatisfaction, within the meaning of the statute, without incorporating their challenge in the cost reports filed with their Intermediary. Effectively, the Provider contends that *Bethesda* allows a provider to claim dissatisfaction and receive a hearing even on claims that were not presented to the Intermediary.

The Provider further notes that the dictum in *Bethesda* spawned a split in the circuit courts relating to situations where a regulation predetermines a disallowance and those situations in which the provider simply neglects to include an item on the cost report.[19] The Provider submits that, to date, the Supreme Court has not had an opportunity to squarely address whether the Board has jurisdiction over an appeal of a cost unclaimed through inadvertence rather than futility. The Provider opines that, although the contrast drawn in *Bethesda* has a hint of suggestion to it, the Court's dictum stops short of compelling the conclusion that a provider can never claim dissatisfaction unless it has included an allowable claim in a cost report. Rather, the Provider argues that, at most, the Court suggests that failing to do so "might well establish" satisfaction. In support of this position, the Provider cites the *Bethesda* Court:

> 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.[20]

The Provider contends that, despite this language, DHHS appears to have adopted its own interpretation of the *Bethesda* decision.[21] However, the Provider points out that the majority of courts that have looked at this issue have interpreted *Bethesda's* dicta as allowing jurisdiction over costs not reported in the cost report. Specifically, the Provider notes that two out of the three United States Courts of Appeal that have looked at the issue presented in this case, as well as the D.C. District Court, have interpreted *Bethesda* in the Provider's favor, allowing jurisdiction over specific claims not included in the filed cost report.[22] The Provider also suggests that, even if the two classifications discussed in *Bethesda* are authoritative, they do not apply to this situation because the Provider did not neglect to include the cost.

The Provider states that, in connection with Issue 2, it did in fact claim Ambulatory Surgery costs on the cost report, noting it included those costs in the Operating Room cost center. The Provider explains that, following the submission of the FY 1999 cost report, the Provider refiled its prior period (FY 1998) cost report to set up the Ambulatory Surgery costs as a separate cost center,[23] and that it sought to continue that treatment in the FY 1999 cost report. The Provider asserts that it should not be punished with denial of the right to appeal for attempting to follow the pertinent regulation and cost reporting guidelines when filing its cost report and then later

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[18] 485 U.S. 399 (1988).
[19] *Id.* at 401.
[20] *Id.* at 399-400.
[21] *See* 73 Fed. Reg. 30190, 30194-205 (May 23, 2008).
[22] *See Loma Linda*, 492 F.3d 1065; *MaineGeneral Med. Ctr. v. Shalala* 205 F.3d 493 (1st Cir. 2000); *UMDNJ-Univ. Hosp. v. Leavitt*, 539 F. Supp. 2d 70 (D.D.C. 2008), *appeal dismissed sub nom, UMDNJ-Univ. Hosp. v. Johnson*, 2009 WL 412888 (Feb. 5, 2009). *But see Little Company of Mary Hosp. v. Shalala*, 24 F.3d 984 (7th Cir. 1994).
[23] Despite the Provider's change in treatment of Ambulatory Surgery costs in FY 1998, the Intermediary reclassified the Ambulatory Surgery costs back to the Operating Room cost center at audit. *See* Intermediary Exhibit I-3 at 2.

attempting to allocate the costs to a more appropriate cost center. The Provider further advises that its actions were in accordance with 42 C.F.R. § 405.1835(a)(1), which confers the right to an appeal when:

> [T]the provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either – (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment *that it believes to be in accordance with Medicare policy* ...[24]

Additionally, the Provider maintains that, in connection with Issue 3, the Organ Acquisition costs were not discovered to be eligible for pass-through status until after the FY 1999 cost report was filed, when the costs were allowed via reopening for prior cost report years. The Provider states that it did not include Organ Acquisition costs on its FY 1999 cost report because it did not believe it was eligible to include those costs.[25] Noting the uncertainty, the Provider argues that the Board should not dismiss its appeal, as the Provider consciously attempted to file a cost report in accordance with the regulations and cost reporting guidance at the time it filed the cost report. The Provider asserts that it became dissatisfied with its filing once it discovered the regulations supported the inclusion of the Organ Acquisition costs it now seeks to include.

The Provider argues that it is not required to protest appeal items for a FY 1999 cost report. The Provider states that the Board regulations were revised in 2008,[26] and contends that, in order to preserve its appeal rights under the 2008 revisions, a provider must either claim an item on its cost report where it is seeking reimbursement that it believes to be in accordance with Medicare policy, or self-disallow the item where it is seeking reimbursement that it believes may not be in accordance with Medicare policy by adding the item as a "protest amount" on its cost report.[27] The Provider suggests that, by adopting this policy, DHHS recognized that the language in *Bethesda* created a discrepancy. However, the Provider argues that this change in policy was not even proposed until the spring of 2008 and is only effective for cost reports ending on or after December 31, 2008.[28] Because there was no clear policy as to the treatment of self-disallowed costs prior to 2008, the Provider believes that *Bethesda* should control, which permits providers to claim dissatisfaction within the meaning of the statute, without necessarily incorporating their challenge in the cost reports filed with their intermediary.

The Provider concludes, that once a provider has met the jurisdictional requirements in § 1395oo(a) and been granted the right to be heard, the Board's authority to decide the matter and scope of review is governed under § 1395oo(d). Here, the Provider argues that it meets the

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[24] 42 C.F.R. § 405.1835(a)(1)(i) (emphasis added).

[25] The Provider asserts that its situation in this case is also analogous to the multiple Board jurisdictional decisions regarding the inclusion of "Medicaid eligible" days for purposes of Disproportionate Share Hospital ("DSH") reimbursement. These decisions involve situations where providers claimed certain Medicaid eligible days on the as-filed cost report and then appealed to the Board claiming dissatisfaction as to the total amount of reimbursement in order to add additional Medicaid eligible days (above the number of days claimed on the as-filed cost report) to the provider's Medicaid fraction. *See, e.g., Rome Mem'l Hosp. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2005-D42 (Apr. 6, 2005), *vacated,* CMS Administrator (July 25, 2005).

[26] *See* 73 Fed. Reg. at 30194-30205. *See also* 42 C.F.R. § 405.1835(a)(1)(ii).

[27] 42 C.F.R. § 405.1811(a)(1).

[28] *See* 42 C.F.R. § 405.1811(a). *See also* 73 Fed. Reg. at 30194-30205.

dissatisfaction element for jurisdictional purposes because it filed a cost report in accordance with what it believed was an accurate representation of Ambulatory Surgery costs and Organ Acquisition costs based on the respective regulations. Only after filing its cost report and learning the regulations could support moving the Ambulatory Surgery costs to its own cost center and could support a claim for Organ Acquisition costs[29], did the Provider become dissatisfied as to the total amount of program reimbursement it received. Finally, the Provider states that the Board does have the power to consider these issues, and the Board does not have the power to deny the provider its right to appeal when all the jurisdictional elements have been met.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered the Medicare law, program instructions, the evidence presented and the parties' contentions. Set forth below are the Board's findings and conclusions.

The Board finds that the Provider does not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the distinct remaining issues of Ambulatory Surgery Costs and Organ Acquisition Costs. The Provider received reimbursement for the items and services claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear these matters under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d).

The crux of this dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which provides in relevant part:

> (a) 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 under 42 U.S.C. § 1395oo(d) to make a determination over all matters covered by the cost report. Specifically, § 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)

[29] The merits of these claims are not addressed as part of the jurisdictional analysis herein.

> even though such matters were not considered by the intermediary in making such final determination.

The operation of the jurisdictional gateway established by 42 U.S.C § 1395oo(a) was addressed by the Supreme Court in the seminal Medicare case of *Bethesda Hospital Association v. Bowen*.[30] The narrow facts of the *Bethesda* controversy dealt with the self-disallowed apportionment of malpractice insurance costs.[31] The provider failed to claim the cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 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.*[32]

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.[33]

While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost that was unclaimed through inadvertence rather than futility, other appellate courts have. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.[34]

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Co. of Mary Hosp. v. Shalala* ("*Little Co. I*"),[35] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal

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[30] *Bethesda,* 485 U.S. 399 (1988).
[31] *Id.* at 401-402.
[32] *Id.* at 404 (emphasis added).
[33] *Id.* at 404-405 (emphasis added).
[34] *See supra* note 22
[35] 24 F.3d 984 (7th Cir. 1994).

intermediary, which establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[36]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[37] In *Little Co.II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[38] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[39]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[40] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[41]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[42] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[43] 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 intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later

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[36] *Little Co. I,* 24 F.3d at 992.
[37] *Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999).
[38] *Little Co. II,* 165 F.3d at 1165.
[39] *Id.*
[40] 73 Fed. Reg. at 30196.
[41] 73 Fed. Reg. at 30203.
[42] *See Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).
[43] 492 F.3d 1065 (9th Cir. 2007).

discovered its interest error, the provider added the interest expense issue to its pending appeal. The Ninth Circuit Court 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.*[44]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[45] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[46] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[47] which were decisions issued in 2000 and 1987 respectively.[48]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[49] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 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."[50]

The First Circuit in *MaineGeneral* then found 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 First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims

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[44] *Id.* at 1068 (emphasis added).
[45] *See* 73 Fed. Reg. at 30197.
[46] 205 F.3d 493 (1st Cir. 2000).
[47] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[48] *See Loma Linda,* 492 F.3d at 1068.
[49] *St. Luke's,* 810 F.2d at 332.
[50] *Id.* at 327-328 (emphasis in original).

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."[51] Similarly, in *St. Luke's*, the First Circuit 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.[52] Although the First Circuit in *MaineGeneral* analyzed appeal rights on an "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence, or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[53]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.*, unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[54] 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 an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

> 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. This conclusion comports with the plain language of subsection (d), ...[55]

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[56]

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion,

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[51] *MaineGeneral*, 205 F.3d at 501.
[52] *St. Luke's*, 810 F.2d at 327.
[53] *MaineGeneral*, 205 F.3d at 501.
[54] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].
[55] *Id.* at 79.
[56] *Id.*at 77.

which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[57] However, the Provider is located in the Seventh Circuit and, as such, *Little Cnty. I* and *Little Cnty. II* apply to this appeal and serve as controlling precedent for the Board.[58]

42 U.S.C. § 1395oo(a) dictates that, to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the intermediary. Thus, it follows that a provider must have claimed reimbursement for items and services for the intermediary to make a "final determination" regarding such items and services.

In this instant case, the Provider failed to claim the Ambulatory Surgery costs involved in Issue 2 as a distinct cost center on its cost report as filed with the Intermediary. The Provider suggests that it attempted to follow the regulation and guidelines in good faith in its initial allocation of

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[57] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

[58] While the Provider argues that the holdings of the Ninth and First circuits are supportive of its position, it fails to acknowledge that the decisions in *Little Co. I* and *Little Co. II* are binding precedent. The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, CMS Administrator Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009) (stating "as the *Alahambra* [*Hosp. v. Thompson*, 259 F.3d 1071 (9th Cir. 2001)] case is binding in the circuit in which the Providers are entitled to seek judicial review, the Administrator hereby affirms the Board's decision . . . with respect to the LDRP days. The Board's decision is affirmed only on the limited ground that there is binding law in the Ninth Circuit . . . . The decision does not affect the Secretary's ability to continue to defend this issue in other circuits . . . ."); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, CMS Administrator Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008) (stating that "[i]n the absence of a controlling decision by the Supreme Court, the respective courts of appeals express the law of the circuit" with citation to *Hyatt v. Heckler*, 807 F.2d 376, 379 (4th Cir. 1986)). Further, the Board notes that, while the Provider could appeal the Board's decision in the D.C. District Court, the D.C. Circuit has not yet reviewed and ruled on this issue. *See Jordan Hosp. v. Blue Cross Blue Shield Ass'n.* CMS Administrator Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007) (stating with respect to a provider located in Massachusetts that "under § 1878(f)(1), the District of Columbia is the judicial district in which this Provider may file suit and, thus, *St. Elizabeth's* [*Med. Ctr. of Boston v. Thompson*, 396 F.3d 1228 (D.C. Cir. 2005)] is binding case law here"). Accordingly, the Board applies the law of the Seventh Circuit as controlling precedent.

the Ambulatory Surgery costs, but now wishes to claim reimbursement in an alternate manner which it posits is permissible by regulation. Likewise, the Provider failed to claim the Organ Acquisition costs involved in Issue 3 on its cost report, indicating that it initially self-disallowed these costs due to the uncertainty as to the eligibility to receive reimbursement for those costs under the regulations at the time the cost report was filed. Thus, the Board finds that Issues 2 and 3 involve unclaimed costs as the Provider is not asserting futility (*e.g.*, a law, regulation, CMS Ruling, or manual provision actually precludes reimbursement) but rather that it mistakenly believed inclusion of the costs would have been futile.

Although Issue 1 involving the IME FTE Count was withdrawn, it was one of the three original issues that were included in the appeal request filed with the Board. As the Board has determined that the other 2 original issues (*i.e.*, Issues 2 and 3) were not ones by which the Provider could establish a proper appeal before the Board, the Board must look at the remaining issue that was part of the original appeal, Issue 1, to determine whether the appeal as it was filed was proper in the first instance. The Board notes that the Provider also characterized this issue in terms of unclaimed costs, stating that the "Provider believes that the Board has the power to consider the FTEs that were not submitted with its cost report or at audit."[59] Based on this admission and the record before it, the Board concludes that, similar to Issues 2 and 3, Issue 1 involves unclaimed costs.

The errors and omissions for all three issues initially raised in the appeal (*i.e.,* Issues 1, 2 and 3) were due solely to the Provider's negligence in understanding the Medicare regulations governing the reimbursement of such costs on the Medicare cost report. Only in hindsight did the Provider determine that it could (and should) have claimed these costs, thereby potentially increasing the amount of reimbursement. However, uncertainty as to the interpretation of a regulation does not necessarily make a claim for reimbursement futile. Rather, this case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[60]

As previously noted, the Seventh Circuit decisions in *Little Co. I* and *Little Co. II* are controlling precedent in this case. Since none of the original three issues give the Board jurisdiction under subsection (a) pursuant to this controlling precedent, the Board cannot exercise its discretion under subsection (d) to make any other revisions on matters covered by the cost report. Since no issues remain open, the Board dismisses the Provider's appeal and closes the case.

A byproduct of the Board finding that there is no jurisdiction over the three issues that were part of the original appeal request is the status of the three supplemental issues that were later added to and subsequently transferred from the current appeal (*i.e.*, Issues 4, 5, and 6). Since the jurisdictional requirements for a valid appeal (*i.e.*, dissatisfaction with the final determination of the intermediary under 42 U.S.C. § 1395oo(a)) were not met when the case was filed, there was no valid appeal to which to attach these remaining three issues (*i.e.*, Issues 4, 5, and 6). In addition, appeal of these supplemental issues was not within the 180-day appeal period and could

[59] Provider's Reply Brief to Fiscal Intermediary's Jurisdictional Challenge at 2.
[60] *Bethesda*, 485 U.S. at 404-405.

not independently meet the timely filing requirements of a stand-alone appeal.[61] Consequently, the Board dismisses these additional issues (*i.e.*, Issues 4, 5, and 6) as invalid and denies the transfers of these issues to the group appeals.[62]

Even if the Seventh Circuit decisions were not controlling precedent, the Board would reach the same result. The Board notes that this appears to be the first case to come before the Board where the provider's original appeal request only pertained to issues or claims involving unclaimed costs.[63] As previously noted, the Board generally has interpreted 42 U.S.C. § 1395oo(a) as the gateway to establishing Board jurisdiction to hear an appeal and requiring a provider to establish a right to appeal on a claim-by-claim or issue-specific basis. Accordingly, the Board finds that only when the provider has established jurisdiction under § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other claims not considered by the intermediary (*e.g.*, unclaimed costs).[64] Further, the Board again notes that it has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeal of other issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs.[65] As the three original issues to the appeal involved unclaimed costs (*i.e.*, Issues 1, 2, and 3), the Board would have found that the Provider's original appeal request failed to establish gateway jurisdiction under § 1395oo(a) because the original appeal request only pertained to three issues involving unclaimed costs and failed to include an appeal of a final determination on an issue or claim (*i.e.*, a claim or issue that the Intermediary had reviewed and then adjusted to the Provider's detriment on the NPR).[66]

DECISION AND ORDER:

The Board concludes that, pursuant to *Little Co. I* and *Little Co. II*, the Provider does not have a right under 42 U.S.C. § 1395oo(a) to appeal the NPR dated September 28, 2001 for FY 1999 and, hereby, dismisses the case in its entirety.

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[61] The date of the NPR that gave rise to this appeal occurred on September 28, 2001. The Provider added the issues to the appeal on September 29, 2004, and March 28, 2008.

[62] Two of the three supplemental issues were transferred to group cases which are currently closed. *See supra* notes 6 and 7. Accordingly, Issue 5: DSH Medicare Crossover Days, currently contained in PRRB Case No. 00-3795G, is the only active issue generated from this appeal.

[63] Further the Board notes that none of the decisions in *MaineGeneral*, *St. Luke's*, *Loma Linda*, and *UMDMJ* involved this specific fact scenario before the Board, even though these decisions may have addressed the fact scenario directly or through dicta and may have reached a different legal conclusion than the Board regarding the fact scenario. Specifically, each of these cases involved situations where the providers had appealed multiple issues and only one of these issues involved unclaimed costs. *See MaineGeneral*, 205 F.3d at 495; *St. Luke's* 810 F.2d at 327: *Loma Linda* 492 F.3d at 1069; *UMDNJ* 539 F. Supp. 2d at 72.

[64] *See supra* note 57 and accompanying text.

[65] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010). This would not be a case in which the Board would deviate from this practice.

[66] This includes any issue that the Provider later attempted to add (*i.e.*, Issues 4, 5 and 6). A provider's right to add issues is not absolute but rather the addition of issues is dependent upon a proper and valid appeal in the first instance under § 1395oo(a). The Board in reviewing jurisdiction has determined that there was not a proper and valid appeal in the first instance under § 1395oo(a).

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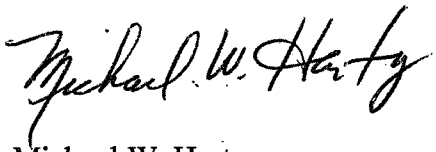

Michael W. Harty
Chairman

DATE: SEP 13 2013