CENTERS FOR MEDICARE AND MEDICAID SERVICES

Order of the Administrator

In the case of:	**Claim for:**
University of Missouri Health Care **Provider**	**Cost Reporting Period Ending: June 30, 2010**
vs.	**Case No. 14-1112**
Wisconsin Physician Services, Inc. **Medical Contractor**	**Review of:** **PRRB Dec. No. 2023-D31** **Dated: September 7, 2023**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period mandated in § 1878(f)(1) of the Social Security Act (Act), as amended (42 U.S.C. § 1395oo(f)). The Chronic Care Policy Group (CCPG), Center for Medicare (CM) requested that the Administrator review and clarify the Board's decision. The parties were notified of the Administrator's intention to review the Board's decision. The Center for Clinical Standards and Quality (CCSQ), Centers for Medicare and Medicaid Services, submitted comments. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue was whether CMS correctly refused to exclude the University of Missouri Psychiatric Center unit (MUPC) of the University of Missouri Health Care's (UMHC or Provider) from the inpatient prospective payment system (IPPS) for the cost reporting period ending June 30, 2010 (FY 2010), allowing it to be paid instead under the inpatient psychiatric facility prospective payment system (IPF-PPS).

The Board found that the CMS correctly refused to exclude the UMHC MUPC from the IPF-IPPS for FY 2010 and that the UMHC MUPC was properly paid under the IPPS for FY 2010.

SUMMARY OF COMMENTS

The Chronic Care Policy Group (CCPG) agreed with both the Board's exercise of jurisdiction over Provider's appeal of the removal of a protested item on its FY 2010 cost report related to CMS' determination to deny "excluded unit" status to its psychiatric unit for FY 2010 and the Board's determination that Provider was properly paid under the IPPS for FY 2010. However, CM disagreed with the limited scope of the conclusion set forth in the Board's decision. The decision should expressly state that the removal of the protested item on Provider's FY 2010 cost report was appropriate because Provider was not excluded from the IPPS for FY 2010. CM requested that the Administrator review and amend the Board's decision to include this reasoning.

In the subject appeal, CM stated that the question before the Board was purely factual: for the cost reporting period at issue, was Provider excluded from the IPPS or not? The Board correctly concluded that it was not, but unnecessarily addressed in its decision whether Provider should have been excluded from the IPPS. CM stated that CMS correctly denied Provider's request for exclusion from the IPPS (the Excluded Unit Determination), and the Board need not have ruled on that issue in the subject appeal. The Provider previously appealed the Excluded Unit Determination to the Departmental Appeals Board and then subsequently voluntarily withdrew that appeal. The Provider here attempted to secure for itself a second opportunity to appeal the Excluded Unit Determination through its appeal of the removal of a protested item on its FY 2010 cost report, claiming that the underlying Excluded Unit Determination was incorrect. It is CM's position that a provider's objection to a facially valid denial of exclusion from the IPPS cannot form the basis for an appeal of a cost report item. Therefore, CM requested that the Administrator exercise her right to review the Board's decision to clarify that the removal of the protested item on Provider's FY 2010 cost report was appropriate because Provider was not excluded from the IPPS for FY 2010. A provider may not use the PRRB appeals process to create additional procedural remedies.

CMS' Center for Clinical Standards and Quality submitted comments stating that the Board properly concluded that the psychiatric unit did not qualify for excluded IPPS status as it did not submit its completed request by the beginning of the fiscal year 2010 for the period it claimed excluded status. CCSQ also stated that the Board properly communicated that the timeline which discussed the information needed to make a determination. Since the necessary documents for the excluded status had not been provided until after the fiscal year had started, the psychiatric unit failed to qualify for excluded IPPS status.

BACKGROUND AND DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Background

The Provider is an acute care hospital located in Columbia, Missouri.[1] UMHC submitted its Medicare cost report for FY 2010, which included a protested item for the payment impact related to CMS' determination to deny the "excluded unit" status to its psychiatric unit.[2] The Medicare Contactor issued the Notice of Program Reimbursement for FY 2010 on June 6, 2013 removing the protested item, and UMHC subsequently filed its appeal with the PRRB on December 2, 2013.

Pursuant to CN 14-1112, the Joint Stipulations of Facts, dated May 21, 2021, exhibits P-1 through P-14 set forth the following facts in the record: On April 3, 2009, the Curators of the University of Missouri approved a plan under which UMHC would open and operate a unit providing comprehensive and clinically integrated inpatient psychiatric services.[3] On April 16, 2009, UMHC submitted to the CMS Regional Office, and copied WPS, a CMS-855A requesting to expand its services to include an exempt psychiatric unit, to be known as University of Missouri Psychiatric Center, or MUPC, effective at the beginning of the cost reporting period on July 1, 2009. This CMS Form 855A is a Medicare enrollment application.[4] WPS recommended that the CMS-855A application be accepted and forwarded it to the CMS Regional Office and the State Survey Office for review on June 17, 2009.[5] Later, on June 30, 2009, UMHC sent its self-attestation to the Missouri Department of Health and Senior Services ("DHSS"), the survey agency for the state. DHSS requested additional information from UMHC, on that same day.[6] Several emails between UMHC and DHSS were sent dated June 30, 2009, July 10, 2009, and July 31, 2009, and UMHC responded to the request for additional information needed on August 5, 2009.[7]

On October 2, 2009, the Administrator of the Section for Health Standards and Licensure of DHSS wrote to the Division of Survey and Certification at DHHS, supporting the request for exclusion from IPPS made by UMHC for MUPC for FYE 06/30/2010, effective July 1, 2009. However, the [Medicare Contractor] alleged that this same document indicated that the timeline needed for the application had not been followed.[8] A series of emails followed as on January 8, 2010, the Executive Director of MUPC wrote to the regional Director of DHHS, asking for her assistance in obtaining a response to the exclusion request for MUPC for FYE 06/30/2010. On January 12, 2010, the letter was acknowledged as received, and on February 9, 2010, a letter was sent back to MUPC stating that the exclusion request was still under consideration.[9] On March 5, 2010, CMS denied UMHC's CMS-855A, stating in its letter that UMHC had failed to comply with the requirements under the following regulations: 42 C.F.R. §§ 412.22, 412.25, and 412.27. CMS also stated in the letter that a request for an exception to these requirements was also denied.[10] UMHC subsequently filed its cost report for the reporting period beginning July 1, 2009 and ending June 30, 2010 under

[1] Medicare Contractor's Final Position Paper, March 4, 2021, at page 1.
[2] PRRB Decision, 2023-D31, dated September 7, 2023, at page 5.
[3] See the Joint Stipulations of Facts, dated May 21, 2021, Exhibit P-1.
[4] *Id.* at Exhibit P-2.
[5] *Id.* at Exhibit P-3.
[6] *Id.* at Exhibit P-4 and P-5.
[7] *Id.* at Exhibit P-5.
[8] *Id.* at Exhibit P-6.
[9] *Id.* at Exhibit P-7 through P-9.
[10] *Id.* at Exhibit P-10.

protest.[11] WPS issued its Notice of Program Reimbursement for UMHC's hospitals and clinics on June 6, 2013.[12] UMHC alleges that the amount of reimbursement given to UMHC for FYE 06/30/2010 was $861,884 less than it would have been if CMS had not denied the exclusion of UMHC's psychiatric unit from the IPPS and instead included it in IPF-PPS.[13] On May 21, 2010, CMS approved the exclusion of MUPC from IPPS for FYE 06/30/2011.[14]

UMHC is now appealing the Medicare Contractor's removal of the protested item on its FY 2010 cost report relating to CMS' determination to deny the exclusion of its psychiatric unit.[15] Pursuant to the Excluded Unit Determination that CMS issued denying UMHC's request that its psychiatric unit be excluded from IPPS for FY 2009, CMS explained that "the information submitted to support the psychiatric unit's exclusion from IPPS did not meet the regulations specified at 42 C.F.R. §§ 412.22, 412.25, and 412.27" and that "a request for exception to these requirements is also denied based on review by CMS's Regional Office and Central Office."[16]

The March 5, 2010 Letter was from the CMS Midwestern Consortium, Division of Survey and Certification, with the letter signed by the CMS Branch Manager of Survey, Certification and Enforcement, CMS Kansas City Regional Office. The Letter stated that:

> We regret to inform you that we are unable to exclude the hospital's psychiatric unit from the inpatient prospective payment system (IPPS) effective at the start of your cost report period, July 1, 2009. After a thorough review, we have concluded that the information submitted to support the psychiatric unit's exclusion from IPPS did not meet the regulations specified at 42 C.F.R. §412.22, §412.25, and §412.27, A request for an exception to these requirements is also denied based on review by CMS's Regional Office and Central Office.
>
> If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 C.F.R. § 498.40, et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to:
> Department of Health and Human Services
> Departmental Appeals Board
> Civil Remedies Division

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[11] *Id.* at Exhibit P-11.
[12] *Id.* at Exhibit P-13.
[13] It should be noted that the MAC could not verify this alleged amount.
[14] *Id.* at Exhibit P-14
[15] All Providers of service participating in the Medicare program are required to submit information to achieve settlement of costs relating to health care services rendered to Medicare beneficiaries. The regulation at 42 C.F.R. §413.20 requires providers to file cost reports on an annual basis, with cost reporting periods based on the provider's accounting year. Providers are permitted to dispute regulatory or policy interpretations by filing cost reports under protest. The PRM Section 115 describes the process a provider must follow to file its cost report under protest. The PRM informs very clearly that protests are non-allowable items. In this case, the Provider included a protested amount for the issue at hand.
[16] *See* the Excluded Unit Determination letter, dated March 5, 2010, at Exhibit P-10.

Attention: Oliver A. Potts, Chief
330 Independence Avenue, S.W.
Cohen Building, Room G-644
Washington, D.C. 20201
A copy of your request for a hearing must be sent to your State Agency and the following offices:

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

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

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

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

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

- a completed, signed and dated Psychiatric Unit Criteria Work Sheet (CMS-437),
- medical record protocols to verify that each patient receives a psychiatric evaluation within 60 hours of admission; that each patient has a comprehensive treatment plan; that progress notes are routinely recorded; and that each patient has a discharge plan and a discharge summary, and
- a description of the type and number of clinical staff, including a qualified medical director of inpatient psychiatric services and a qualified director of psychiatric nursing services, registered nurses, licensed practical nurses, and mental health workers to provide care necessary under their patients' active treatment plans.[17]

The record indicates that UMHC appealed the Excluded Unit Determination to the Department of Health and Human Services' Departmental Appeals Board (DAB) in April of 2010.[18]

[17] *See* Provider Exhibit P-10.
[18] *See* the Provider's Final Position Paper, dated February 23, 2021, at 9-10.

The DAB assigned Docket No. C-10-676, and as part of that DAB Docket, CMS filed a Motion to Dismiss, pursuant to the DAB's governing regulations at 42 C.F.R. Part 498.[19] UMHC subsequently withdrew its DAB appeal.[20] The Provider, conceded in its Final Position Paper, that it failed to exhaust its administrative remedies by obtaining a ruling from the DAB on the motion for dismissal.[21]

The UMHC submitted its FY 2010 cost report to the Medicare Contractor, and maintained that its psychiatric unit met the criteria to be excluded from the IPPS at the beginning of the cost reporting period, even if its application to be excluded was then still under review at that point of time.[22] Accordingly, the Medicare Contractor issued the Notice of Program Reimbursement for FY 2010, on June 6, 2013, which removed the protested amount.[23] On December 2, 2013, UMHC filed this appeal with the Board. UMHC and the Medicare Contractor exchanged Preliminary Position Papers on August 28, 2014, and December 12, 2014, respectively. On September 23, 2014, the Medicare Contractor filed a jurisdictional challenge, and on April 16, 2020, the Board issued its jurisdictional determination stating that it had "jurisdiction under 42 U.S.C. §1395oo(a)."

Jurisdiction

The Board found that for this appeal. the Provider did not appeal the March 5, 2010 Excluded Unit Determination, but rather appealed the NPR issued by the Medicare Contractor for FY 2010. UMHC's appeal of the NPR issued by the Medicare Contractor for FY 2010, contested the disallowance of an item on its cost report which was filed under protest, pursuant to 42 C.F.R. § 1835 (a)(1)(ii)(2008). The Board determined that the basis of the appeal the UMHC's dissatisfaction with the Excluded Unit Determination that had been issued almost four years earlier on March 5, 2010.

The Board did not reach the issue as to whether the Excluded Unit Determination itself was an appealable final determination, but rather the Board found that it had jurisdiction under section 1878(a) of the Social Security Act [42 U.S.C §1395oo(a)] over UMHC's appeal from its NPR to challenge the disallowance of the protested item and the related cost report items associated with the $861,884 reimbursement impact.[24] The Provider's dissatisfaction with the removal of the protested item stems ultimately from its dissatisfaction with the Excluded Unit Determination, and accordingly, the Board addressed the merits of the Excluded Unit Determination and its impact on the FY 2010 cost report.

The Administrator finds that the Board jurisdiction is limited to a finding that the removal of the protested item on Provider's FY 2010 cost report was appropriate because Provider was not excluded from the IPPS for FY 2010. In addition, the Provider may not seek a secondary route for appealing the Excluded Unit Determination through the PRRB. The Excluded Unit Determination included the instructions directing appeals to the DAB and was issued by the CMS survey and

[19] *See* Medicare Contractor's Jurisdictional Challenge, dated September 17, 2014, Jurisdictional Exhibit I-1, at 5.
[20] *See* the Provider's Final Position Paper, at 10.
[21] *Id*.
[22] *See* Board's Jurisdictional Decision, dated April 16, 2020, at page 2.
[23] *See* Notice of Program Reimbursement, dated June 6, 2013.
[24] *See* Board's Jurisdictional Decision at 2.

certification Division with the Missouri Survey and Certification included in the matter. The Departmental Appeals Board provides impartial, independent review of disputed decisions in a wide range of Department programs under more than 60 statutory provisions. The DAB generally issues the final decision for the Department, which may then be appealed. The record indicates that UMHC did appeal the Excluded Unit Determination to the DAB, however, it later abandoned and withdrew that appeal without obtaining a decision or ruling from the DAB.[25] As a result, no direct ruling or decision by the DAB was made, and UMHC ultimately abandoned its appeal rights. Thus, the Excluded Unit Determination became the final determination of the agency.

However, CMS granted appeals rights to the DAB for this psychiatric excluded unit determination.[26] The letter does not specify the authority under which it is granted. The DAB has issued decisions rejecting jurisdiction in certain circumstances. However, the DAB does accept jurisdiction when requested by CMS. In addition, where the DAB has rejected jurisdiction, it was based on a finding that the determination under review is strictly a reimbursement issue.[27] CMS providing an appeal route to the DAB is not inconsistent with an issue being more like determinations involving coverage and certification, and not a purely reimbursement impact. Conversely, the PRRB has historically rejected jurisdiction where coverage or certification issues are involved.

In *Highland District Hospital vs. Secretary of Health and Human Services*, 676 F.2d 230 (5th Cir. 1982), (HCFA Ruling 83-1) a hospital sought judicial review of a decision by the PRRB that it lacked jurisdiction to review a determination by hospitals' fiscal intermediary disallowing certain cost reimbursements requested by the hospital The Court of Appeals held that a determination by a fiscal intermediary, that Medicare payment could not be made on behalf of Medicare-eligible patients who received acute care services in the hospitals skilled nursing facility, involved questions of coverage, and thus, the PRRB was without jurisdiction to hear the hospital's appeal, citing §§ 1812(a)(1), 1861(b), 1862, 1878(a, g). *Id.* at 235. The Court recognized that: "neither the statute nor the regulations employ or define the term "coverage" in delineating PRRB jurisdiction. The legislative history, while making it clear that questions of coverage are outside the PRRB review process, does not define what is or is not a coverage question." *Id.* at 235. The Court further noted that:

> In *Mount Sinai Hospital of Greater Miami, Inc. v. Weinberger*, *supra*, the Fifth Circuit defined "coverage" questions as those issues framed by §§ 1395d [section 1812 of the Social Security Act] and 1395y.[Section 1862 of the Social Security Act] 517 F.2d at 335….A "coverage" issue thus is involved where the question is

[25] The record did not include a copy of the dismissal. The Provider in its Final Position Paper at 10, acknowledged it failed to exhaust its administrative remedies by obtaining a ruling from the DAB.

[26] CMS provider status determinations which the PRRB has historically reviewed, (e.g., SCH, MDH) would have no impact on beneficiaries' benefits nor do they involve decisions involving certification and survey.

[27] The DAB has recognized that HHS/CMS has requested the DAB hear certain appeals, without relying on specific regulatory or statutory authority to do so. CMS has also promulgated regulations in order to ensure the DAB jurisdiction (e.g., in establishing enrollment date is an appealable initial determination.) In prior cases involving excluded unit determinations, the DAB focused on whether the matter was a reimbursement issue and whether there was a new provider agreement issued.

> whether services rendered fall within the scope of benefits defined by § 1395d {Section 1812] or are excluded by §1395y.[Section 1862]
> Id. at 235.

Section 1861(u) of the social Security Act defines "Provider of Services" and pursuant to section 1861 of the Act, the term, "Psychiatric Hospital", is separately defined (while referencing (e) which defines a "Hospital"), which also includes psychiatric distinct part units. 42 CFR 412, Subpart N, provides payment for inpatient psychiatric treatment when provided to a patient in psychiatric hospitals, and distinct part psychiatric units of acute care. IPFs are certified under Medicare as inpatient psychiatric hospitals, which means, an institution that is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill patients, maintains clinical records necessary to determine the degree and intensity of the treatment provided to the mentally ill patient, and meets staffing requirements sufficient to carry out active programs of treatment for individuals who are furnished care in the institution. A distinct part psychiatric unit may also be certified if it meets the clinical record and staffing requirements in 42 CFR 412.27. Notably, the IPF PPS does not change the basic criteria for a hospital or hospital unit to be classified as a psychiatric hospital or psychiatric unit that is excluded from the hospital prospective payment systems under §1886(d) and §1886(g) of the Act, nor does it revise the survey and certification procedures applicable to entities seeking this classification. [28]

In addition, section 1812. [42 U.S.C. 1395d] of the Act sets forth the scope of benefits, which includes benefits for inpatient hospital services at (a) and inpatient psychiatric hospital services at (c) with a limitation on the number of lifetime days. However, the 190-day lifetime limitation does not apply to a certified psychiatric distinct part unit.[29] Consistent with the definition of IPFs, in accordance with 42 CFR 412.27(c), for all IPFs, a provisional or admitting diagnosis must be made on every patient at the time of admission and must include the diagnosis of comorbid conditions as well as the psychiatric diagnosis. Distinct part psychiatric units of acute care hospitals are required to admit only those patients whose admission to the unit is required for active treatment, of an intensity that can be provided appropriately only in an inpatient hospital setting, of a psychiatric principal diagnosis that is listed in the International Classification of Diseases, Tenth Revision, Clinical Modification. As a condition for Medicare payment, all admissions to IPFs must be certified and recertified by a physician.

While a determination to exclude a unit as a psychiatric unit means the payment system under which it will be paid is impacted, the determination to exclude the unit is a survey and certification determination. The IPF PPS does not change the applicable survey and certification procedures. From the certification of the provider, likewise, flows, among other things, the admission criteria, whether a service is medically necessary, and the scope of benefits.

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[28] Medicare Benefit Policy Manual Chapter 2 - Inpatient Psychiatric Hospital Services, " Chapter 2 Inpatient Psychiatric Hospital Services Section 10.3.

[29] "See Medicare Benefit Policy Manual", Chapter 2 - Inpatient Psychiatric Hospital Services. ("80 - Benefit Limits in Psychiatric Hospitals The psychiatric benefit application (190 days) applies to freestanding psychiatric hospitals per 42 CFR 409.62. The 190-lifetime limitation does not apply to certified psychiatric distinct part units. Section 409.62 states, "There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any beneficiary. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual.")

As the courts have recognized, a coverage question in the context of PRRB jurisdiction is not defined. However, "coverage" is implicated by virtue of issues related to a certification determination of an entity under section 1861 of the Act and the related benefits to which a beneficiary is entitled under section 1812 of the Act,.[30] Whether this matter at issue here is more aligned with a coverage question under HCFA Ruling 83-1, as opposed to a reimbursement-only issue, was not briefed in this case. However, that the CMS granted appeal route of the Psychiatric Excluded Unit Determination was via the DAB is not inconsistent with the fact that the determination is one of survey and certification, which is generally outside the PRRB jurisdiction, for some of the same reasons set forth in HCFA ruling 83-1 and related cases.

Accordingly, the Administrator clarifies that the case is limited to review of the removal of the protested item on the UMHC's FY 2010 cost report and whether it was appropriate because UMHC was not excluded from the IPPS for FY 2010. The Administrator finds that a provider may not use the PRRB appeals process to create additional procedural remedies.

[30] *See* Medicare Benefit Policy Manual, Chapter 4 – Inpatient Psychiatric Benefit Days Reduction and Lifetime Limitation, Rev. 1, 10-01-03.

DECISION

The Administrator modifies the decision of the Board in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: November 3, 2023

/s/
Jonathan Blum
Principal Deputy Administrator
Centers for Medicare & Medicaid Services