CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:	Claim for:
Saginaw General Hospital Provider	Cost Reimbursement Determination for Cost Reporting Period Ending: September 30, 1994
vs.	Review of: PRRB Decision 2004-D12
Blue Cross/Blue Shield Association/ United Government Services, LLC Intermediary	Dated: February 5, 2004

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 in §1878(f)(1) of the Social Security Act (Act). The parties were notified of the Administrator's intent to review the Board's decision and of their right to submit comments during the course of this review. No comments were submitted. Accordingly, the Board's decision is now before the Administrator for final agency review.

ISSUE AND BOARD'S DECISION

The issue on the merits was whether, for the purposes of allocation of administrative and general costs, the Part B physicians' compensation and related fringe benefits should be included in total expenses of the private physician practices.

As a preliminary matter, the Board found that it had jurisdiction over the Provider's appeal of this issue. The Board stated that the Provider's amended cost report, submitted before issuance of the Notice of Program Reimbursement (NPR) under appeal, was tantamount to an objection made by the Provider in its originally filed cost report. The original cost report included the Part B physician

compensation and related fringe benefits in the private physician practices cost center, while the amended cost report removed the Part B physician compensation and related fringe benefits from the private physician practices cost center. The Board concluded that the Provider could make a claim for an adjustment of the original report, as long as the Intermediary has not issued the NPR. The Board therefore concluded that it had jurisdiction to hear the disputed claim between the Provider and Intermediary.

On the merits, the Board held that the Provider cannot remove physician compensation and related fringe benefits from its established non-reimbursable cost center for the purposes of overhead allocation. The Board noted that physicians can offer three types of professional services to providers: physician services to providers (Part A); physician services to patients (Part B); and physician services that include non-reimbursable activities under either Part A or Part B, such as research. In this case, the Board found that the Provider had only physician services related to patients and the provider billed for physician services under Medicare Part B and was paid on a reasonable charge basis. The reasonable charge payment was designed to cover physician compensation as well as other overhead costs of physicians in their offices.

The Provider's premise that the physicians at issue were hospital-based was incorrect, as the physicians rendered professional services (i.e., Part B services) for the Provider's patients and the Provider employed the physicians. The Board found that including physician compensation in the non-reimbursable costs center as a basis to allocate administrative and general (A&G) costs (overhead) allows full overhead costs to be allocated to the physician offices and the remaining residual administrative costs to be allocated to the Provider. If physician compensation costs were removed from the allocation cost base, it would allocate additional overhead to the Provider and result in double payment for administrative costs, once through the physician charges and once through the Provider's cost report.

DISCUSSION

The entire record furnished by the Board has been examined, including all correspondence, position papers, and exhibits and subsequent submissions. After a review of the record, the Administrator finds that the Board did not have jurisdiction to hear the Provider's appeal.

The Medicare Act establishes an appeals procedure which provides for administrative review of final determinations of reimbursement to providers for

services rendered to Medicare beneficiaries.[1] The Medicare statute mandates that a Provider file with its fiscal intermediary a required cost report.[2] For the applicable cost year, 42 C.F.R 413.24(f) states in relevant part:

> For cost reporting purposes, the Medicare program requires each provider of services to submit periodic reports of its operations that generally cover a consecutive 12-month period of the provider's operations. Amended cost reports to revise cost report information that has been previously submitted by a provider may be permitted or required as determined by CMS. (Emphasis added.)

In addition, the regulation at 42 CFR 412.24(f)(2) (1994) explains that cost reports are "due on or before the last day of the third month following the close of the period covered by the report."

The Provider Reimbursement Manual §2931.2.A provides additional guidance regarding when cost reports may be permitted or required to be amended. That section states:

> Under limited circumstances, the program will accept an amended cost report. An amended cost report is one which is intended to revise information submitted on a cost report which has been previously filed by the provider.
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> A provider may file or an intermediary may require an amended cost report to:
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> 1. correct material errors detected subsequent to the filing of the original cost report,
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> 2. comply with the health insurance policies or regulations, or
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> 3. reflect the settlement of a contested liability
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> ….
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> Once a cost report is filed, the provider is bound by its elections. Except in 2 above, a provider may not file an amended cost report to avail itself of an option it did not originally elect. (Emphasis added)

Upon receipt of a provider's cost report, (or amended cost report where permitted), the Intermediary must, within a reasonable period of time, furnish the provider a

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[1] Section 1878(a) of the Act.
[2] Id. 42 C.F.R. §413.30(f)

Notice of Program Reimbursement or "NPR" reflecting the intermediary's determination of the total amount of reimbursement due the provider.[3]

A provider which is dissatisfied with the final determination of its fiscal intermediary may request a hearing before the Board if certain criteria are met. Under section 1878(a) of the Act, the Board's jurisdiction is limited to a provider's request for review of a "final determination" of the Intermediary or the Secretary for which the provider is "dissatisfied." That section states, in relevant part, that:

> 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 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…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 title for the period covered by such report….
> (2) the amount in controversy is $10,00 or more, and
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i)….

A "final determination" is not defined in the Act, but is defined in regulation 42 CFR §405.1801. Section 405.1801(a)(3) states that for purposes of appeal to the Board, "intermediary determination" is synonymous with "intermediary's final determination," and "final determination of the Secretary," as those latter two terms are used in section 1878(a) of the Act. Section 405.1801(a)(1) defines "intermediary determination," with respect to the cost reimbursement system, as:

> [A] determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 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.

Hence, an "intermediary's final determination," is represented by the Notice of Program Reimbursement or NPR which is issued after the close of the provider's cost reporting period and the provider's submission of a timely cost report.

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[3] 42 C.F.R. 405.1803.

Applying the law to the facts, the Administrator finds that the Board incorrectly concluded that it had jurisdiction to hear this issue. In this case, the Board accepted jurisdiction over an issue raised in an amended cost report, but not accepted or ruled upon by the Intermediary. The Board concluded that submission of an amended cost report before an intermediary had issued an NPR is tantamount to an objection made by the provider in its originally filed cost report.

In this case, the Provider filed a cost report for fiscal year ending (FYE) 9/30/94, and included Part B physician salary costs and related fringe benefit costs in a non-reimbursable cost center entitled "physician private offices." Prior to the Intermediary's issuance of the Provider's September 27, 1996 NPR for FYE 9/30/94, the Provider submitted an amended cost report in which the Provider offset the physician compensation against the total "physician private offices" costs. Subsequently, the Intermediary issued the September 27, 1996 NPR which accepted the physician's salary and benefit costs in the non-reimbursable cost center as it was claimed in the originally filed cost report (i.e., the cost report filed "within the time specified in regulations.")

The record shows that the Provider filed a Request for Board Hearing, dated March 21, 1997, pursuant to the September 27, 1996 NPR. The Provider's request for a hearing appealed the issue of "whether the Intermediary's failure to include[] the following issue[] from a refiled cost report mailed to them … prior to the Notice of Program Reimbursement date of September 27, 1996 are appropriate….To treat the salary and related benefits of the physicians associated with the private practice as a Part B offsettable cost[] in accordance with PRM-I Section 2328(E)."

In this case, the Administrator finds that the Intermediary's non-action with respect to the amended cost report is not a "final determination" within the meaning of Section 1878 of the Act. The meaning of "final determination,"[4] does not encompass the situation in which the Intermediary does not act on an amended cost report. Hence, the Board did not have jurisdiction over determining the appropriateness of the Intermediary's non-action with respect to the Provider's amended report.

In addition, the Board did not have jurisdiction over the substantive issue of the proper treatment of the Part B physician compensation costs. The Administrator finds that the Provider's appeal of this Part B physician allocation issue pursuant to the September 27, 1996 NPR, fails to meet the dissatisfaction requirement of Section 1878(a) of the Act. As noted, the Provider's originally submitted cost report did not make any offset for physician compensation costs to the non-

[4] 42 C.F.R.405.1801

reimbursable cost center, rather these costs were included in the filed cost report in the non-reimbursable cost center by the Provider.[5] Likewise, the Provider's September 27, 1996 NPR does not reflect an adjustment to this cost center for this purpose as the Intermediary accepted the Provider's original classification of costs in the non-reimbursable cost center.[6]

Under the statute, the Provider cannot demonstrate that it is dissatisfied with the intermediary's final determination reflected in this NPR, clearly issued pursuant to the originally filed cost report, by pointing to its filing of an amended cost report. The NPR under appeal was not issued pursuant to an audit of the amended cost report, but rather the original cost report. Moreover, as the Intermediary was not required to accept the amended cost report, no argument can be made that this NPR implicitly reflects a final determination on the amended cost report.

The Secretary's position has been that the jurisdictional requirement that a provider be "dissatisfied with a final determination of its fiscal intermediary" necessarily incorporates an exhaustion requirement. In other words, a provider's right to a hearing extends only to claims for reimbursement because a provider cannot be "dissatisfied" with the intermediary's determination to not award reimbursement for something that was never claimed on the cost report. In 1988, the Supreme Court decided Bethesda Hospital Ass'n v Bowen.[7] In Bethesda, the providers, following regulations, in effect, self disallowed malpractice costs in excess of those allowed by the regulation. The providers later filed a timely request for a Board hearing but the Board determined it was without jurisdiction to hear the providers' claims. The case eventually reached the Supreme Court. The Court held that the Board had jurisdiction over the claims stating:

> We agree that under subsection (a)(1)(A)(i) [of section 1878 of the Act], a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the fiscal intermediary. Providers know that, that under the statutory scheme, the fiscal intermediary is confined to the mere application of the Secretary's

[5] See Intermediary Exhibit 8.

[6] See Provider's March 21, 1997 Request for a Hearing with attached NPR dated September 27, 1996.

[7] 485 U.S. 399(1988).

> regulations, that the Intermediary is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the intermediary to do otherwise would be futile. 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.[8] (Emphasis added.)

In this case, as the Provider classified the physician compensation costs in the non-reimbursable cost center in its original cost report, it cannot demonstrate that it is dissatisfied with the Intermediary's final determination accepting the Provider's cost report as filed for that non-reimbursable cost center. Moreover, the Administrator notes that the Provider is not claiming it was foreclosed from offsetting the total non-reimbursable costs due to the Secretary's regulations. Thus, Board jurisdiction does not extend over that issue as a self-disallowed claim under Bethesda.

Therefore, the Administrator vacates the determination of the Board that it has jurisdiction to address the Provider's appeal in this case. [9]

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[8] Bethesda, supra, 485 U.S. at 405-406.

[9] The Administrator notes that, assuming arguendo there was Board jurisdiction over the substantive issue, the Board's analysis on the substantive portion of the case was correct. The Board held that the claimed physician compensation was properly included as part of a non-reimbursable physician offices cost center and part of the allocation basis used to distribute "administrative and general" costs.

DECISION

The Administrator vacates the decision of the Board on the foregoing grounds.

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

Date: 4/02/04

/s/
Leslie V. Norwalk, Esq.
Acting Deputy Administrator
Centers for Medicare & Medicaid Services