CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Select Specialty Hospital - Houston Heights **Provider** **vs.** **Mutual of Omaha Insurance Company** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 08/31/99** **Review of:** **PRRB Dec. No. 2005-D38** **Dated: May 10, 2005**

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), as amended (42 USC 1395oo(f)). Accordingly, the parties were notified of the Administrator's intention to review the Board's decision. Comments were received from CMS Center for Medicare Management (CMM), the Intermediary and the Provider. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

BACKGROUND

The Provider is a Medicare-certified long-term care hospital (LTCH) located in Houston, Texas. The Provider opened on September 1, 1994, and was certified by Medicare on March 1, 1995. The Provider submitted its first cost report as a LTCH for the period from March 1, 1995, through February 29, 1996, and another cost report for the period from March 1, 1996, through February 28, 1997. The Provider then filed a cost report covering the period from March 1, 1997 through August 31, 1997. This filing of a cost report for a six-month time period was the result of a change in the hospital's fiscal year-end (FYE). After a change in ownership, the Provider submitted a cost report for an 11 month period from September 1, 1997,

through July 31, 1998. The next cost report submitted by the Provider was for a 13-month period, from August 1, 1998, through August 31, 1999.

For the cost reporting period ending August 31, 1999, the Provider filed its cost report without claiming a continuous improvement bonus (CIB). The Provider did not complete or "populate" either line 58.01 or line 58.02 of Worksheet D-1, Part II of CMS form 2552-96.[1] Data contained on line 58.01—the expected cost line and 58.02—the trended cost line are used to compute the continuous improvement bonus (CIB). Unless data is input on both lines, no CIB computation can be computed on line 58.03. Thus, the Provider's as filed cost report also showed that the Provider made no claim for a CIB on line 58.03. The Intermediary audited the Provider's cost report and made an adjustment to line 58.01, the expected cost line. The Intermediary made no adjustment to line 58.02, the trended cost line. Since neither the Provider nor the Intermediary completed all of the lines necessary to make the calculation, the Provider did not receive a CIB.

ISSUE AND BOARD'S DECISION

The issue as stated by the Board is whether the Intermediary erred in denying the Provider a CIB for fiscal year ending August 31, 1999. However, a preliminary issue is whether the Board properly found jurisdiction over the CIB issue.

The Board majority found that it had jurisdiction over this case as the Intermediary made an adjustment to the expected cost line (line 58.01) on Worksheet D-1, Part II. The Board majority determined that, since there was no controlling authority which defined "full" with respect to cost reporting periods, a provider who kept costs below certain limits for at least 36 months could qualify for a CIB. Accordingly, the Board majority directed the Intermediary to use data from the Provider's cost reporting periods ending 2/28/96, 2/28/97, and the period between August 1, 1997 through July 31, 1998 to determine whether the Provider was eligible for the CIB.

One member of the Board dissented with the majority Board's opinion accepting jurisdiction over this case. The dissenting Board member argued that in order for the Board to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the Intermediary. The dissenting Board member argued that in order for a provider to be "dissatisfied" with a "final determination" of the Intermediary the provider either has to claim reimbursement for the items and services on its cost report or self-disallow the cost. The dissenting Board member concluded that since this case did not involve the exception situation described in

[1] Intermediary Exhibit I-13.

Bethesda, as the Provider was not challenging the validity of a statute, regulation or manual provision in which it would be futile to claim reimbursement the Provider failed to meet the "dissatisfaction" requirement of 42 U.S.C. §1395oo(a). Here, the Provider simply failed to claim the CIB. The fact that the Intermediary made an adjustment to the expected cost line in the CIB calculation did not give rise to jurisdiction.

SUMMARY OF COMMENTS

The Intermediary requested that the Administrator reverse the decision in this case The Intermediary submitted comments requesting that the Administrator reverse the Board's decision. The Intermediary contended that implicit throughout 42 C.F.R. §§ 405.1801 and 405.1803 is the rule that an identifiable adverse finding is necessary to request a Board hearing. Accordingly, since the Provider failed to claim the CIB on it cost report, and the CIB was not a self-disallowed cost to which the decision *Bethesda Hospital Ass'n v. Bowen*, 485 US. 399 (1988) applied, the Board lacked jurisdiction. The Intermediary also argued that the Provider should not be permitted to raise this issue for the first time before the Board. To support this position the Intermediary cited *Little Company of Mary Hospital Health Care Center v. Shala*, 24 F. 3d 993 (7th Cir. 1994) and *Maple Crest Care Center v. Mutual of Omaha Insurance Company*, Dec. No 2004-D4.

Finally, the Intermediary argued that, while the Board did not have jurisdiction the Provider also did not qualify for the CIB because the Provider did not meet the requirement of 42 C.F.R. §413.40(d) (5). Under this provision, a hospital must have been paid as a prospective payment excluded hospital for at least three full cost reporting periods prior to the applicable period. The Provider failed in this case because they only had filed two full cost reporting periods and two short period cost reports.

The Provider submitted comments requesting that the Administrator affirmed the Board's decision. The Provider argued that the Board correctly determined that it had jurisdiction over the appeal, because the Provider appealed the Intermediary's decision not to populate the trended cost line (line 58.02) of the cost report while adjusting the expected cost line (line 58.01). The Provider stated that the statue and the regulations allowed a provider to obtain a hearing before the Board if they were dissatisfied with the Intermediary's final determination as to the amount of total program reimbursement due. In this case, as the Provider was dissatisfied with the Intermediary's final determination, not to populate the trended cost line, jurisdiction was proper. The Provider also argued that the CIB cannot be denied when the Provider met the requirement for CIB through the submission of at least three complete cost reports, totaling more than 36 month, prior to the fiscal year at issue.

The Provider submitted four complete cost reports, totaling 41 months, and therefore argued they are eligible for the CIB for the cost report ending August 31, 1999.

CMM submitted comments requesting that the Administrator reverse the Board's decision. CMM agreed with the Intermediary's determination that the Board lacked jurisdiction because the Provider did not claim the CIB on its cost report and did not exhaust its administrative remedies. Thus, the Provider's appeal was premature. CMM also argued that the Provider was not eligible for CIB because they had not been paid as a PPS-excluded provider for three full cost reporting periods. CMM stated that the Board incorrectly interpreted the regulations providing for CIB and agreed with the Intermediary that the policy has always been that "full" cost reporting period means at least a 12-month cost reporting period.

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.

Section 1878(a) of the Act sets forth the requirements for Board jurisdiction. A provider may obtain a hearing before the Board with respect to its fiscal intermediary's determination of its cost report, *inter alia*, only if: The provider "is dissatisfied with a final determination of … of its fiscal intermediary … as to the amount of total program reimbursement due the provider" for care provided to Medicare beneficiaries for the period covered by the cost report; there is at least $10,000 in controversy; and the provider has filed a request for a Board hearing within 180 days of the intermediary's final determination.

With respect to the first criteria for Board jurisdiction, i.e., the dissatisfaction requirement, the Supreme Court in *Bethesda Hospital*, explained that the filing "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."[2] However, the Court recognized the distinction between a provider that self-disallowed a claim in conformity with a Medicare regulation which it intended to challenge before the Board, and a provider that failed to claim all reimbursement it was entitled to claim

[2] 485 U.S. 399, 404 (1988). The Supreme Court addressed the issue of "dissatisfaction" as set forth in §1878 of the Act. The provider in *Bethesda* "self disallowed" certain claims on the cost report submitted to its intermediary, in order to comply with a Medicare regulation that it intended to challenge before the Board.

in compliance with the law. With respect to the provider in *Bethesda*, the Court explained that:

> [P]etitioners stand on different grounds than do providers who bypass a clearly prescribed exhaustion requirement or who fail to request from the intermediary all costs to which they are entitled under the 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 present here….[3]

This language in *Bethesda* recognizes that a hospital that does not request reimbursement for all of the costs for which it is entitled to be reimbursed in its cost report, cannot then request such costs before the Board. In addition, significant to this case the Court in *Bethesda* noted that §1878(d) does not confer jurisdiction, but rather sets forth the Board's powers and duties after its jurisdiction has properly been invoked under §1878(a) of the Act.

In this case, the record shows that for the cost reporting period ending August 31, 1999, the Provider filed its cost report without claiming a (CIB) (i.e., the Provider did not complete line 58.01, line 58.02 or line 58.03 of Worksheet D-1, Part II of CMS Form 2552-96). The record further shows that the Intermediary audited the Provider's cost report and made an adjustment to line 58.01, the expected cost line. The Intermediary made no adjustments to line 58.02, the trended cost line, or 58.03 the computation of the CIB. Consequently, no CIB was calculated. A Notice of Program Reimbursement (NPR) was issued on February 28, 2002 and the Provider request for a hearing before the Board, was filed on August 22, 2002, seeking review of the Intermediary's decision not to "populate the trended costs on Worksheet D-1, line 58.01. The Provider requested that the board "populate Worksheet D-1, line 58.01, so the CIB calculation can be completed." The Board majority found that it had jurisdiction over this case as the Intermediary made an adjustment to the expected cost line (line 58.01) on Worksheet D-1, Part II.

Applying the law to the facts in this case, the Administrator finds that the Provider failed to meet the statutory "dissatisfaction" requirement. The statute and the regulation contemplate an Intermediary final determination as a prerequisite to Board jurisdiction. Even if the Provider thought it was prohibited from making such a claim, it could have filed a protested amount. Instead, it appears the Provider's failure to do so was oversight. By failing to present a claim for reimbursement the

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[3] *Id.*

Provider failed to meet the threshold test for Board jurisdiction and has not exhausted its administrative remedy.[4]

Even assuming *arguendo* that the Board properly accepted jurisdiction in this case, the Administrator also finds that the Provider did not otherwise qualify for a CIB.[5] In order for a provider to be eligible for a CIB, a provider must have received payment as a PPS-exempt hospital for at least three full cost reporting periods prior to the current period cost report. Thus, the issue raised on the substance of the Provider's present claim before the Board for a CIB is whether the Provider received payment as a PPS-exempt hospital for "at least 3 full cost reporting periods" prior to the cost reporting period ending August 31, 1999.

Neither the statute, nor the regulation defines "full cost reporting period." However, the Administrator finds that the term 12-month cost reporting period and full 12-month cost reporting period are used interchangeably. For example, for cost reporting purposes, Medicare requires submission of annual reports covering a 12-month period of operation based on the provider's accounting year.[6] Therefore, the use of the term "full" cost reporting period means a 12 month cost reporting period.

In addition, the Administrator finds that there are several provisions under TEFRA that uses the term "full" as a 12-month cost reporting period. For example, 42 C.F.R. §412.30(a) discusses the requirement that a decrease in bed capacity in a rehabilitation unit "must remain in effect for a least a full 12-month cost reporting period…." The regulation at 42 C.F.R. 412.30(b) (4) states "if a hospital that has not previously participated in the Medicare program seeks exclusion of a rehabilitation unit, it may designate certain beds as a new rehabilitation unit for the first full 12-month cost reporting period…."[7] The Administrator also notes that 42 C.F.R. §

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[4] The Administrator notes that the Program has in place methods for correcting cost reporting errors so that providers are not without remedy. Pursuant to the regulations at 42 C.F.R. 405.1885(a), a provider may request a reopening of its cost report from the Intermediary to correct errors on the cost report. However, in this case, the three year period during which to request a reopening ended on February 22, 2005. Moreover, the Administrator notes that had the error discovered after filing of the cost report but prior to the issuance of the NPR, the Provider could have requested permission from its Intermediary to file and amended cost report. See §2931.2 of the Provider Reimbursement Manual. Thus, there were mechanisms in place in the regulations which the Provider could have used to correct the cost reporting error in this case.

[5] Section 1886(b) (2) (B) of the Act and 42 C.F.R. §413.40(d) (5).

[6] CMS Publication 15-II, §102.

[7] *See also* 42 C.F.R. §§412.23(b) (2) and (b) (8).

413.40 (b)(1) which governs the CIB describes the base period for the target amount (not at issue in this appeal) as a cost reporting period of at least 12 months. It then defines a short cost reporting period as "fewer than 12 months." Thus, based on the above guidance the Administrator concludes that the use of the term "full cost reporting period" means a cost reporting period of 12 or more months. In the instant case, the Administrator finds that the Provider filed two full cost reporting periods (3/1/95—2/29/96 and 3/1/96—2/28/97) and two short cost reporting periods (3/1/97—8/31/97 and 9/1/97—7/31/98) and thus did not qualify for a CIB under 42 C.F.R. § 413.40(d)(5).

DECISION

The decision of the Board is reversed consistent with the foregoing opinion.

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

Date: 7/11/05

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