PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
98-D94

PROVIDER -
Conemaugh Valley Memorial Hospital
Johnstown, Pennsylvania

Provider No. 39-0110

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of Western Pennsylvania

DATE OF HEARING-
August 14, 1998

Cost Reporting Period Ended -
June 30, 1992

CASE NO. 95-0100

INDEX

ISSUE:

Did the Intermediary use the proper bed count when computing the Provider's indirect medical education adjustment ("IMEA") for fiscal year 1992?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Conemaugh Valley Memorial Hospital ("Provider") is an acute care hospital located in Johnstown, Pennsylvania. Blue Cross of Western Pennsylvania ("Intermediary") audited the Provider's fiscal year ended ("FYE") June 30, 1992 cost report and issued a Notice of Program Reimbursement ("NPR") for that cost reporting period on April 12, 1994.[1] The Provider filed a timely appeal on October 7, 1994,[2] with the Provider Reimbursement Review Board ("Board") pursuant to 42 C.F.R. §§ 405.1835-.1841 and has met the jurisdictional requirements of those regulations. The Medicare reimbursement effect exceeded $10,000.

In the Provider's proposed list of issues, submitted on January 13, 1995,[3] three audit adjustments, unrelated to the IMEA, were challenged. On May 29, 1995, the Provider notified the Board that two of the issues had been administratively resolved and requested that an additional issue related to disproportionate share hospital adjustment be added.[4] On May 30, 1997, the Provider withdrew its challenge to the last of the initial three issues. In its final position paper, submitted August 29, 1997, the Provider raised the additional issue of the bed count used to compute the Provider's IMEA at issue in the instant case.

The IMEA is calculated by determining the ratio of resident full-time equivalents ("FTEs") to available beds. See 42 C.F.R. § 412.105(b). It states that "[f]or purposes of this section, the number of beds in a hospital is determined by counting the number of available bed days during the cost reporting period . . . and dividing that number by the number of days in the cost reporting period." Id. Thus, the use of a higher licensed bed count, rather than the lower available bed count, as the denominator of the above fraction would reduce a provider's IMEA payment.

The parties have entered into a detailed stipulation concerning the facts which are summarized below.[5]

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1 See Provider Exhibit 2.

2 See Provider Exhibit 3.

3 See Provider Exhibit 4.

4 See Provider Exhibit 8.

5 See Stipulation and Request to Proceed on the Record, July 28, 1998.

1. The Provider on Worksheet S-3, Part I of its as-filed cost report for FYE June 30, 1992, reported a total of 432 beds, including 20 newborn bassinets.[6]

2. The 432 beds reported represented the Provider's count of licensed beds for that cost reporting period.

3. The Intermediary employed the bed count as reported by the Provider, excluding the 20 newborn bassinets, in calculating the intern-to-bed ratio for purposes of the Provider's IMEA for FYE 1992.

4. As part of the as-filed cost report for FYE 1992, the Provider supplied an analysis of the square footage detail, identifying the activities occurring in various parts of the Provider's campus during that fiscal year.[7]

5. During the FYE 1992 audit, the Provider had available for review by the Intermediary, its internal statistical data for that cost reporting period.[8] That internal statistical data reports the Provider's active bed complement for the FYE 1992 was 372 beds, including 20 newborn bassinets.[9] The actual bed complement was also identified as the actual bed count.[10]

6. During the FYE 1992 audit, an Intermediary field auditor performed a walk-through of its campus and agreed that the available bed count was less than the licensed bed count.[11]

7. The Provider's risk manager, prepared a report detailing the variance between licensed beds for FYE 1992 and the actual bed count for that fiscal year. The report demonstrates that the Provider's actual bed count for FYE 1992 was 372, including 20 newborn bassinets.[12]

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6 See Provider Exhibit 32.

7 See Provider Exhibit 30.

8 See Provider Exhibit 31.

9 Id. at 1.

10 Id.

11 See Provider Position Paper at 22.

12 See Provider Exhibit 33.

8. The Provider and Intermediary agree and stipulate that, based on the square footage detail, internal statistical data, the compliance walk-through during the audit and risk manager's report, that the actual bed count for FYE 1992 was 372, including 20 newborn bassinets.

9. The Provider and Intermediary agree and stipulate that the actual bed count, excluding newborn bassinets, accurately represents the basis for calculating the number of available beds for purposes of calculating the Provider's IMEA. Thus, accurate calculation of the Provider's intern-to-bed ratio, for purposes of the IMEA for FYE 1992 would be based on 352 actually available beds, not 412 licensed beds.

The Intermediary questioned the Board's jurisdiction to hear the bed count issue. On July 24, 1998, the Board ruled that it had jurisdiction.

The Provider was represented by David W. Thomas, Esquire, of Nash and Co. The Intermediary was represented by Bernard M. Talbert, Esquire, of the Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that the Board has jurisdiction to hear the bed count issue. The Provider asserts that an incorrect bed count was used in the calculation and that the Intermediary should have discovered and corrected the error.

The Provider points out that the Board exists to supply providers with a due process "hearing with respect to [the provider's] cost report." 42 U.S.C. § 1395oo(a). In accordance with this broad scope of subject matter jurisdiction, the Board has "the power to affirm, modify or reverse a final determination of the fiscal intermediary with respect to a cost report and make any other revisions on matters covered by such cost report (including revisions adverse to the [provider of services) even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. § 1395oo(d) (emphasis added). Thus, the plain language of the statute establishes that the Provider need not raise this issue with the Intermediary as a prerequisite to Board review.

The Provider notes that HCFA and the intermediaries have argued that for Board jurisdiction to exist, the provider must have raised the issue with the intermediary prior to the issuance of the original NPR for a given year. HCFA and the intermediaries claim that under 42 U.S.C. § 1395oo(a)(1)(I) a provider must be dissatisfied with a final determination of the intermediary and thus if a provider does not raise a claim on the cost report they have "self-disallowed" that claim and cannot obtain Board review. See, e.g., Athens Community Hospital, Inc. v. Schweiker, 743 F.2d 1, 5-10 (D.C. Cir. 1984). Under this theory, 42 U.S.C. § 1395oo(d) was limited to revisions "necessary to accommodate other PRRB revisions of

other matters that were claimed by the provider, adversely by the intermediary, and then contested by the provider to the PRRB." Id. at 9. The Provider indicates that there was a split in the circuits on this issue and that in Bethesda Hospital et al. v. Bowen, 108 S. Ct. 1255, 1258 (1988) ("Bethesda"), the self-disallowance theory was rejected as a "strained interpretation . . . [that] is inconsistent with the express language of the statute." The Supreme Court first ruled that it would have been futile for the provider to present a challenge to the regulation to the intermediary. Id. at 1259. However, it also expressed an alternative basis for its rejection of self-disallowance, i.e. 42 U.S.C. § 1395oo(d). It stated that:

> [s]ection 1395oo(d), which sets forth the powers and duties of the Board once its jurisdiction has been invoked, explicitly provides that in making its decision whether to affirm, modify or reverse the intermediary's decision, the Board can "make any other revisions on matters covered by the cost report . . even though such matters were not considered by the intermediary in making such determination." This language allows the Board, once it has obtained jurisdiction pursuant to subsection (a), to review and revise a cost report with respect to matters not contested before the fiscal intermediary. The only limitation proscribed by Congress is that the matter must have been "covered by such cost report," that is, a cost or expense that was incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed.

Id. at 1259 (emphasis added, footnote omitted).

The D. C. Circuit court has noted that once the Board obtains jurisdiction by virtue of a request for review filed within 180 days of the original NPR, "anything in the original cost report is fair game for a challenge by virtue of subsection (d)." HCA Health Services of Oklahoma v. Shalala, 27 F.3d 614, 617 (1994). The Provider asserts that since the Supreme Court considered 42 U.S.C. § 1395oo(d) an alternate ground, it cannot merely be considered "obiter dictum." Woods v. Interstate Realty Co., 69 S.Ct. 1235, 1237 (1949). Since the Supreme Court has ruled that the issue need only be covered by the cost report in question and the bed count issue meets that requirement the Board has jurisdiction to review that claim.

The Provider assert that HCFA and the intermediaries have attempted to limit Bethesda, supra, to instances where it would be futile to present the issue to the intermediary. See Little Company of Mary Hospital Health Care Centers v. Blue Cross and Blue Shield Association/Blue Cross of Illinois, HCFA Administrator, April 4, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,233; Bon Secours Heartland Home Health Agency v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Maryland, HCFA Administrator, August 23, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,690, at 37,336; and Somerset Rehabilitation P.C. v. Blue Cross and Blue Shield Association, HCFA Administrator, August 16, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,661. The Provider acknowledges that the Seventh Circuit accepted this limitation in Little Company of Mary Hospital and Health

Centers v. Shalala, 24 F.3d 983 (7th Cir. 1994) but indicates that this decision did not consider the effect of 42 U.S.C. § 1395oo(d) and its implications on the self-disallowance theory. It also noted that another appeal process not availed by that provider existed and that no similar process applies to IMEA payments. The Provider asserts that 42 U.S.C. § 1395oo(d) as interpreted by Bethesda and acknowledge by HCA, supra, stands for the proposition that once a provider properly invokes Board jurisdiction any issue covered by the cost report may be presented to the Board for review. The Provider notes that it properly raised the bed count issue prior to the Board hearing as required by 42 C.F.R. § 405.1841(a)(1).

The Provider also asserts that the Intermediary had an obligation to discover and correct cost reporting errors even if they are favorable to the provider. See 42 C.F.R. § 421.100(c).[13]

Finally, as noted in the stipulation above, the Provider assert that the proper figure that should have been used to calculate its IMEA was 352 available beds and not the 412 licensed beds erroneously reported.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that the Medicare rules provide that available beds should have been reported by the Provider. In the instant case, the Provider made the error not to do so. The Intermediary asserts that this error is not a self-disallowed cost under the rule in Bethesda, supra, and therefore, it cannot add this issue to the appeal because there was no audit adjustment.

Medicare regulation at 42 C.F.R. § 412.105(b) provides that in computing the IMEA adjustment, the number of available bed days is utilized. A hospital reports the number of beds available for use during the cost reporting period on Worksheet S-3 of its cost report. The cost report instructions for reporting the number of bed days available state as follows:

> Enter the total number of bed days available. Bed days are computed by multiplying the number of beds (excluding newborn which are not in intensive care areas, custodial beds, and beds in excluded units) available throughout the period by the number of days in the reporting period. If there is an increase or decrease in the number of beds available during the period, the number of beds available for each part of the cost reporting period is multiplied by the number of days for which that number of beds was available.

HCFA Pub. 15-2 § 2406.1 - Worksheet S-3, Part I - Hospital and Hospital Health Care Complex Statistical Data.

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[13] See also Tr. from PRRB Case No. 91-2673, at 1834, Provider Exhibit 28.

Thus, the instructions for completion of the cost report contemplate that beds for which a provider is licensed and which are otherwise eligible for use in the count of beds for IMEA purposes in accordance with 42 C.F.R. § 412.105(b) may not be available throughout the cost reporting period due to temporary closures, renovations, required maintenance, etc. Under those circumstances, "the number of beds available for each part of the cost reporting period is multiplied by the number of days for which that number of beds was available."[14]

As previously noted in the stipulations above, the Provider reported 432 licensed beds instead of the 372 available beds that should have been reported and that the Provider IMEA should have used 352 available beds with the removal of 20 newborn bassinets. The Intermediary indicates that it relied upon the instructions for completing the Medicare cost report and indicates that it was the Provider's responsibility to properly report available beds.

The Intermediary contends that the Provider's argument is an untimely request for reopening, over which PRRB jurisdiction is lacking. See 42 C.F.R. § 405.1885. See also St. Vincent Health Center v. Shalala., No. 92-373 Erie, (W.D. of Pa. Dec. 22, 1995), aff'd, No. 96-3050, (3rd Cir. August 16, 1996); Good Samaritan Regional Medical Center et al. v. Shalala, et al., No. 95-6224, (2nd Cir. June 12, 1996); and Your Home Visiting Nurse Services, Inc. v. Shalala, No. 96-5525, (6th Cir. December 22, 1997). Accordingly, the Board should also dismiss this issue from the current appeal.

The Provider cites the U.S. Supreme Court's decision in Bethesda, supra, as relevant to a finding that the Board should accept jurisdiction over the Provider's failure to report properly an accurate count of available bed days in connection with the IMEA adjustment on its as-filed cost report. Bethesda, however, does not stand for the proposition that a self-disallowance may be added to an appeal anytime a provider wishes.

In Little Company Hospital and Health Care Centers v. Blue Cross and Blue Shield Association/ Blue Cross Blue Shield of Illinois, PRRB Dec. No. 97-D29, February 4, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,080, rev'd (on other issue) and vacated (on jurisdiction issue) HCFA Administrator, April 4, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,233, the Board held that it had jurisdiction over the issue of a providers loss on the sale of land, despite the fact that the loss was not claimed on the provider's cost report, and, as in this appeal involving the Provider's as filed count of available bed days, no adjustment was made by the intermediary. In accepting jurisdiction over the loss on sale issue, the PRRB held as follows:

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[14] The above instructions are for hospital cost report, Form HCFA-2552-89, applicable to cost reporting periods beginning on or after January 1, 1989, and therefore apply to the fiscal year under appeal. However, similar instructions were also in effect for the prior version of the cost report, Form HCFA-2552-85. See Intermediary Exhibit 12, Worksheet S-3 instructions for the HCFA--2552-85.

> Based on the regulations, evidence and parties' arguments, the Board rules that it has jurisdiction over the investment loss issue. The regulation at 42 C.F.R. § 405.1841(a) permits a provider to add an additional item to an existing appeal if it is submitted in writing along with appropriate documentary evidence prior to a hearing. The Provider has fulfilled this requirement.

Id., Medicare and Medicaid Guide (CCH) ¶ 45,080, at 52,877.

In vacating the Board's acceptance of jurisdiction over the loss on sale issue, the HCFA Administrator, in a succinct explanation of the relevance of Bethesda to self-disallowed or omitted costs, ruled as follows:

> Under § 1878(a) of the Act, the Board's jurisdiction is limited to requests for review of "final determination[s]" of the Intermediary or the Secretary for which the provider is "dissatisfied." Generally, for a provider to demonstrate dissatisfaction with the reimbursement reflected on the notice of program reimbursement (NPR), the provider must have requested reimbursement for all costs to which it is entitled under the applicable rules. Thus, a provider who fails to claim a cost on a cost report, not because of binding law or Policy, but because of error, does not meet the dissatisfaction requirement necessary for Board jurisdiction.
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> . . . .
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> Because the Provider did not claim the loss on its cost report for FYE 06/30/88, the Intermediary never had cause to make a final determination on that loss. Therefore, as the Provider cannot demonstrate "dissatisfaction" within the meaning of the statute, the Board has no jurisdiction over the issue of the amount of reimbursement resulting from that loss.
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> The Administrator also finds the Provider's reliance on Bethesda Hospital erroneous, for in that case, the providers successfully argued that it would have been improper to submit a claim for reimbursement in a manner clearly prohibited by the regulations, and that it was proper to raise the issue in the first instance to the Board. Thus, Bethesda is distinguishable from the instant case, where the Provider failed to include the loss on the sale of land in the course of not following Medicare law in its treatment of its loss on the advance refunding of debt.
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> Indeed, the distinction between a provider who seeks to bypass the intermediary in order to challenge a regulation, and a provider who self-disallows an item on a cost report and later files for a Board hearing alleging that it is entitled to reimbursement "under applicable rules," was recently noted

> in Little Company of Mary Hospital and Health Care Centers. The Court read Bethesda to mean that "only where a petitioner can demonstrate that a challenge made to a fiscal intermediary in the first instance would have been futile will that petitioner be permitted the issue for the first time on appeal under [section 1878(a)]."

Id., Medicare and Medicaid Guide (CCH) ¶ 45,233, at 53,755-7 (emphasis added).

The Administrator's decision was affirmed by the district court. Little Company of Mary Hospital and Health Care Center v. Shalala, No. 97-C-4107 (N.D. Il., E.D. February 19, 1998). The same reasoning is applicable to the available beds issue in this appeal. The Provider failed to claim the appropriate number of available bed days on its as-filed cost report in accordance with the applicable cost report instructions. This is not an issue where it would have been futile for the Provider to claim available bed days. The Provider's self-disallowance was not because of binding law or policy, but because of its failure to follow those instructions, a failure for which it now seeks to blame the Intermediary.

With respect to the number of available bed days issue for purposes of computing the Provider's IMEA adjustment, that issue is a self-disallowance to which the provisions of Bethesda similarly do not apply. The Provider was not barred by a Medicare policy from claiming a lower number of available bed days compared to its as-filed number. To the contrary, the Provider failed to follow the Health Care Financing Administration's cost report instructions when it filed its cost report. The Intermediary made no determination regarding the number of available bed days. It simply reclassified the number of psychiatric unit beds along with the associated Provider reported number of available bed days. The Intermediary's reclassification of psychiatric unit beds to the adults and pediatrics cost center is not under appeal. The Provider's new issue of licensed versus available bed days is an untimely request for reopening over which Board jurisdiction is lacking. It, too, should be dismissed by the Board.

CITATIONS OF LAWS, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Laws - 42 U.S.C.:

§ 1395x(v)(1)(A)	-	Reasonable Cost
§ 1395oo et seq.	-	Provider Reimbursement Review Board

2. Regulations - 42 C.F.R.:

§ 405.1835	-	Right to a Board Hearing

§ 405.1841	-	Time, Place, Form, and Content of Request for Board Hearing
§ 412.105(b)	-	Special Treatment: Hospitals that Incur Indirect Costs for Graduate Medical Education Programs: Determination of Number of Beds
§ 413.9	-	Cost Related to Patient Care
§ 421.100(c)	-	Intermediary Functions: Provider Audits

3. Program Instructions - Provider Reimbursement Manual, Part II (HCFA Pub. 15-2):

§ 2406.1	-	Worksheet S-3, Part I - Hospital and Hospital Health Care Complex Statistical Data

4. Cases:

Athens Community Hospital, Inc. v. Schweiker, 743 F.2d 1 (D.C. Cir. 1984).

Bethesda Hospital et al. v. Bowen, 108 S. Ct. 1255 (1988).

Bon Secours Heartland Home Health Agency v. Blue Cross and Blue Shield Association/ Blue Cross and Blue Shield of Maryland, HCFA Administrator, August 23, 1993, Medicare and Medicaid Guide (CCH) ¶ 41,690.

Good Samaritan Regional Medical Center et al. v. Shalala, et al., No. 95-6224, (2nd Cir. June 12, 1996).

HCA Health Services of Oklahoma v. Shalala, 27 F.3d 614 (1994).

Little Company Hospital and Health Care Centers v. Blue Cross and Blue Shield Association/Blue Cross Blue Shield of Illinois, PRRB Dec. No. 97-D29, February 4, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,080, rev'd (on other issue) and vacated (on jurisdiction issue) HCFA Administrator, April 4, 1997, Medicare and Medicaid Guide (CCH) ¶ 45,233, aff'd, Little Company of Mary Hospital and Health Care Center v. Shalala, No. 97-C-4107 (N.D. Il., E.D. February 19, 1998).

Little Company of Mary Hospital and Health Centers v. Shalala, 24 F.3d 983 (7th Cir. 1994).

St. Vincent Health Center v. Shalala., No. 92-373 Erie, (W.D. of Pa. Dec. 22, 1995), aff'd, No. 96-3050, (3rd Cir. August 16, 1996).

Somerset Rehabilitation P.C. v. Blue Cross and Blue Shield Association, HCFA Administrator, August 16, 1990, Medicare and Medicaid Guide (CCH) ¶ 38,661.

Woods v. Interstate Realty Co., 69 S.Ct. 1235 (1949).

Your Home Visiting Nurse Services, Inc. v. Shalala, No. 96-5525, (6th Cir. December 22, 1997).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties' contentions, evidence presented in the record, finds and concludes as follows:

The Board notes that the Provider filed a proper appeal with the Board within 180 days of the original NPR, pursuant to 42 C.F.R. § 405.1835, and therefore the Board has jurisdiction over the Provider's FYE 1992 cost report. The Board notes that the number of beds was reported on the cost report and that the correct number of beds is an issue subject to Board review by virtue of 42 U.S.C. § 1395oo(d). The Board also notes that the Provider properly added this issue prior to the Board hearing pursuant to 42 C.F.R. § 405.1841(a)(1).

The Board finds that the Provider erroneously reported its licensed beds, instead of its available beds, on its FYE 1992 cost report. The Board finds that the Intermediary acknowledged the error but did not correct it and therefore used the incorrect bed count in calculating the Provider's IMEA. The Board notes that the parties have stipulated that the incorrect number of beds was used to calculate the Provider IMEA. The Board believes that errors such as these can result in both over and underpayment to the Provider and that they should be corrected when raised during a properly filed appeal before the Board. See 42 U.S.C. § 1395oo(d) and Bethesda, supra.

DECISION AND ORDER:

The Board finds that the bed count used to calculate the Provider IMEA was incorrect. The Board directs the Intermediary to recalculate the Provider's IMEA using the correct bed count as stipulated by the parties.

Board Members Participating:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin Hoover, Jr., Esq.
Charles R. Barker

: September 15, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman