PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D2

PROVIDER -Sacred Heart Medical Center
Spokane, Washington

Provider No. 50-0054

vs.

INTERMEDIARY -
Blue Cross and Blue Shield Association/
Blue Cross of Washington and Alaska

DATE OF HEARING-
September 16, 1998

Cost Reporting Period Ended -
December 31, 1987

CASE NO. 92-1027

INDEX

Page No.

Issue **2**

Statement of the Case and Procedural History **2**

Provider's Contentions **4**

Intermediary's Contentions **9**

Citation of Law, Regulations & Program Instructions **15**

Findings of Fact, Conclusions of Law and Discussion **18**

Decision and Order **19**

ISSUE:

Did the Intermediary properly include neonatal intensive care unit ("NICU") beds in the Provider's available bed count used for the indirect medical education ("IME") calculation?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Sacred Heart Medical Center ("Provider") is a general, acute care hospital located in Spokane, Washington. It filed its cost report for the calendar year ended December 31, 1987 ("1987") including the NICU beds that were used as part of the Provider's IME calculation and subsequent reimbursement. Blue Cross and Blue Shield of Washington and Alaska ("Intermediary") audited the Provider's cost report. It issued a Notice of Program Reimbursement ("NPR") which included audit adjustments to various costs and statistics used in calculating Medicare reimbursement. The Provider appealed some of the adjustments to the Provider Reimbursement Review Board ("Board"). The Provider's filing has met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The NICU bed issue in dispute results in a reduction in Medicare reimbursement of approximately $59,000. The following is a chronology of events and facts related to the NICU bed count.

1. March 31, 1988 -- The Provider filed its 1987 Medicare cost report with 552 total hospital beds reported on Worksheet S-3, Line 8.[1] This count included 18 nursery and 16 NICU beds which were separately reported on Line 7 and Line 4, respectively. The Provider used 534 (552 less 18) beds to determine the IME payment for the filed cost report. It excluded the 18 nursery beds and included the 16 NICU beds.[2]

2. January 10, 1990 -- The Provider submitted documentation on the bed count explaining that licensed, not available beds, had been reported.[3] It requested that available beds be used in the IME payment calculation.[4] The requested count of 446 also included 16 NICU beds.[5]

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[1] See Intermediary Exhibit 3, page 1.

[2] See Intermediary Exhibit 2.

[3] See Intermediary Exhibit 3, pages 2-3.

[4] See Intermediary Exhibit 3, page 3.

[5] See Intermediary Exhibit 3, page 4.

3. September 12, 1991 -- The Intermediary issued the Provider's NPR which determined an IME payment amount of $1,605,310.[6] The IME payment amount was based on a bed count of 452 which included 16 NICU beds.[7] The Intermediary failed to correct the bed count reported on Worksheet S-3. The differences between the "as filed" count of 534 and the "as finalized" count of 452 are due to unavailable beds or misclassified beds per the reconciliation between the Provider's documentation and the census report.[8] Both counts included 16 NICU beds.

4. March 9, 1992 -- The Provider filed a hearing request with the PRRB. The IME payment amount was appealed but only with respect to the resident count used in the payment calculation.[9] The inclusion of NICU beds in the IME bed count was not appealed.

5. April 22, 1992 -- The Provider requested a reopening of the 1987 cost report to correct the resident count used in the IME payment calculation. The inclusion of the NICU beds in the IME bed count was not identified as an issue.[10]

6. May 29, 1992 -- The list of issues was forwarded to the Intermediary. The inclusion of NICU beds in the IME bed count was not identified as an appeal issue.[11]

7. July 30, 1993 -- The Intermediary issued a Revised NPR to effect the new GME payment methodology. Reopening issues were also addressed. The Provider's reopening documentation reflected a .5 FTE increase in the resident count and the same bed count, determined at audit by the Intermediary, of 452 which included 16 NICU beds.[12] The Intermediary determined a revised IME adjustment of $1,633,663[13] using the audited bed count of 452.

8. January 20, 1994 -- The Provider filed an appeal request with the PRRB for the

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6 See Intermediary Exhibit 3, page 5.

7 See Intermediary Exhibit 3, page 6.

8 See Intermediary Exhibit 3, page 7-8.

9 See Intermediary Exhibit 3, page 9.

10 See Intermediary Exhibit 3, page 10.

11 See Intermediary Exhibit 3, pages 11-12.

12 See Intermediary Exhibit 3, page 13.

13 See Intermediary Exhibit 3, page 14.

> Revised NPR. This request was incorporated into the appeal of the original NPR. The revised list of issues was sent to the Intermediary March 3, 1994. It was to be inclusive of all issues, however, it did not identify the bed count used in the IME payment calculation as an appeal issue.[14]

9. March 15, 1995 -- The Provider added by letter the inclusion of the NICU beds in the bed count for determining the IME payment.

10. The parties are contesting the issue both on legal and jurisdictional grounds.

The Provider is represented by Carol S. Gown, Esquire, of Bennett and Bigelow, P.S. The Intermediary is represented by Bernard M. Talbert, Esquire, of Blue Cross and Blue Shield Association.

PROVIDER'S CONTENTIONS:

LEGAL ARGUMENTS

The Provider contends that the regulations in effect throughout 1987 provided clear and specific instructions for determining the number of beds to be included in the available bed count. The regulations provided, in relevant part:

> [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, not including beds assigned to newborns, custodial care, and excluded distinct part hospital units, and dividing that number by the number of days in the cost reporting period.

42 C.F.R. § 412.118(b).

This regulation clearly excludes all beds assigned to newborns. It does not distinguish between newborn beds in routine areas (such as nursery) and newborn beds in intensive care areas (such as in an NICU). The text of the then effective regulation is plain and unambiguous on this point. The count of beds does not include any "beds assigned to newborns."

The Provider states that it is axiomatic that an administrative agency is bound by its own regulations. Pfizer, Inc. v. Heckler, 735 F.2d 1502, 1507 (D.C. Cir. 1984). Courts have specifically reiterated this principle in the context of Medicare cases. See, e.g. Charlotte Memorial Hospital v. Bowen, 665 F. Supp. 455, 458, 460 (W.D.N.C. 1987), aff'd, 860 F.2d 595 (4th Cir. 1988). The Secretary, therefore, is bound by the provisions of 42 C.F.R. §

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[14] See Intermediary Exhibit 3, page 15.

412.118(d) that were in effect during 1987. These provisions unequivocally exclude newborn beds (including NICU newborn beds) from the available bed count.

The Provider notes that the Secretary revised 42 C.F.R. § 412.105(b) (formerly § 412.118(b)) in subtle, but significant, ways effective October 1, 1994. The revised version of 42 C.F.R. § 412.105(b) states as follows:

> [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, not including nursery beds assigned to newborns that are not in intensive care areas, custodial care beds, and beds in excluded hospital units, and dividing that number by the number of days in the cost reporting period.

Id. (emphasis added).

The Secretary's revisions to this section, which specifically exclude newborn beds that are not in intensive care areas from the bed count, obviously are intended to include in the bed count those newborn beds that are in intensive care areas. As such, the 1994 revisions constitute a substantial change in the meaning of the regulation. The Provider does not challenge here the Secretary's authority to change regulations related to the methodology for counting available beds. The Provider asserts, however, that it would be unlawful and unconscionable for the Secretary's 1994 amendment of 42 C.F.R. § 412.105(b) to be applied retroactively to the Provider's 1987 cost report. See Bowen v. Georgetown Univ. Hospital, 488 U.S. 204, 208 (1988) (holding that the Secretary may not promulgate retroactive cost limits in the absence of express statutory authority for retroactive rulemaking).

The Provider notes that the Board has repeatedly addressed the issue of whether to include intensive care nursery ("ICN") beds in a provider's available bed count. In these cases, the Board consistently has held that the regulations in effect prior to September 1, 1994, require that ICN beds be excluded from the IME adjustment formula. See e.g., Humana Hospital University v. Blue Cross and Blue Shield Association/Blue Cross of Kentucky, PRRB Dec. No. 95-D15, January 4, 1995 ("Humana Hospital") Medicare & Medicaid Guide (CCH) ¶ 43,021, rev'd, HCFA Administrator, Feb. 21, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,140; Sioux Valley Hospital v. Blue Cross and Blue Shield of Iowa, ("Sioux Valley") PRRB Dec. No.92-D53,
August 26, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,747, rev'd, HCFA Administrator October 26, 1992, CCH ¶ 41,044, aff'd by oral opinion, No. 92-4200 (D.S.D. 1993), aff'd by unpublished opinion, Sioux Valley Hospital v. Shalala, 29 F.3d 628 (8th Cir. July 20, 1994).

The Provider observes that the facts and issues in the Humana Hospital and Sioux Valley cases closely parallel those of the present appeal. In Humana Hospital, the intermediary adjusted the provider's bed count to include ICN beds in the IME adjustment formula for the provider's 1987 fiscal year. The Board examined the regulations then in effect, including 42

C.F.R. § 412.118, and the Provider Reimbursement Manual ("PRM") provisions that became effective in 1988 and concluded that the intermediary's inclusion of ICN beds was improper.

The Provider also notes that although the Board has consistently held that the regulation in affect before the 1994 amendment required intensive care nursery beds to be excluded from the available bed count, the HCFA Administrator has taken the contrary position. The HCFA Administrator has repeatedly and erroneously reversed the decisions of the Board on this issue. To date, there appear to be no published judicial decisions concerning this issue. In one instance, a federal court has reviewed the HCFA Administrator's reversal of a Board decision on the ICN/NICU bed count issue. In Sioux Valley, the Eighth Circuit Court of Appeals affirmed by unpublished decision, an oral opinion of the district court, which in turn affirmed the HCFA Administrator's position. That opinion constitutes, at best, a mixed and tepid endorsement of the Secretary's position. The endorsement is mixed because the court flatly rejected one of the Secretary's principal bases for including ICN beds in the bed count. Specifically, the court stated that Provider Reimbursement Manual, HCFA Pub. 15-1 ("HCFA Pub. 15-1") § 2405.3G could not be applied retroactively. The court agreed with the Board that retroactive application of this guideline would be an improper and arbitrary act.

The Provider notes that the court adopted a highly deferential posture in reviewing the Secretary's interpretation of the regulations. Despite this high degree of deference, the court concluded that both the provider's and the Secretary's interpretation had merit. The court held, however, that under the deferential posture it had assumed, the court could not invalidate the Secretary's interpretation. Far from constituting a definitive endorsement of the Secretary's position, the Eighth Circuit's unpublished decision in Sioux Valley is an invitation to other courts to examine and decide whether the Secretary's interpretation of the regulations and manual provisions deserve the same high degree of deference accorded by the court in this case. The Board has repeatedly held that the regulations applicable during 1987 require a different interpretation; that the term, "not including beds assigned to newborns," means exactly what it says, without qualification or limitation. The Board should continue to reject attempts by intermediaries and the Secretary to retroactively modify this regulation and should continue to assert its position that ICN/NICU beds must be excluded from the available bed count in computing the IME adjustment factor.

The Provider further contends that HCFA Pub. 15-1 § 2405.3G cannot serve as the basis for the Intermediary to include the Provider's NICU beds in the available bed count for 1987. As demonstrated above, the regulations in effect during 1987 required that NICU beds be excluded from the available bed count for IME purposes. The Intermedairy's actions to the contrary, therefore, must be based upon some other authority, such as HCFA Pub. 15-1 § 2405.G, or they are without any legal authority whatsoever. However, the Intermediary may not legally rely upon that section as the basis for including the Provider's NICU beds in the available bed count for two reasons. First, it is inconsistent with the regulations in effect during 1987, and therefore is void and without effect during this period. Second, it was

issued in August 1988, long after the close of the Provider's 1987 cost reporting period and cannot apply retroactively to the earlier period.

The Provider observes that manual provisions are interpretive guidelines; they do not constitute substantive law. Courts have repeatedly held that where an interpretive guideline exceeds the purpose of or conflicts with the underlying statute or regulation, it is invalid under the Administrative Procedure Act ("APA"). See, e.g., National Medical Enterprises v. Bowen, 851 F.2d 291, 293 (9th Cir. 1988) (PRM interpretations that are inconsistent with regulations will not be enforced since the regulation and not the PRM has force of law); Creighton Omaha Regional Health Care Corp. v. Bowen, 822 F.2d 785, 789 (8th Cir. 1987) (interpretive manual provisions must be consistent with the underlying statutes or regulations, or they are without effect). Moreover, the Secretary may not promulgate regulations and then change their meanings through the issuance of "interpretations" or "clarifications" in the guidelines, unless the Secretary complies with the formal notice or comment procedures of the APA. Fairfax Nursing Center, Inc. v. Califano, 590 F.2d 1297, 1301 (4th Cir. 1979). Further, courts will refuse to defer to the Secretary's interpretations when they are inconsistent with the statute and regulations. Vista Hill Found., Inc. v. Heckler, 767 F. 2d 556, 559-60 (9th Cir. 1985).

JURISDICTIONAL ARGUMENTS

The Intermediary raised for the first time in its position paper an objection to the Board's jurisdiction over the issue of inclusion of NICU beds in the available bed count for IME purposes. For both substantive and procedural reasons, the Provider argues that the Board should reject this late attempt to raise a jurisdictional objection. The Intermediary apparently bases its jurisdictional objection on the premise that every issue included in an otherwise valid appeal must arise out of an audit adjustment. This premise is incorrect, and has been repeatedly rejected by the courts.

A. The Applicable Statute and Regulations Provide for Board Jurisdiction over All Issues In This Appeal.

The statutory provisions for Board appeals are set forth in 42 U.S.C. § 1395oo. Those provisions do not require an audit adjustment as a prerequisite to Board jurisdiction over a provider appeal. The statute provides that a hospital which is "dissatisfied with a final determination" by its fiscal intermediary or by the Secretary of the Department of Health and Human Services as to the amount of its reimbursement is entitled to a hearing before the Board. 42 U.S.C.
§ 1395oo(a)(1)(A). The term "intermediary determination" is defined in the regulations as either (1) "a determination of the amount of total reimbursement due the provider" with respect to items and services that may be reimbursed on a reasonable cost basis or (2) "

a determination of the total amount of payment due the hospital" pursuant to the prospective payment system. 42 C.F.R.
§§ 405.1801(a)(1) and (2). The regulations also provide:

> For purposes of appeal to the Provider Reimbursement Review Board, the term (intermediary determination) is synonymous with the phrases "intermediary's final determination" and "final determination of the Secretary," as those phrases are used in (42 U.S.C. § 1395oo(a)].

42 C.F.R. § 405.1801(a)(3).

Accordingly, under the plain language of the statute and of the regulations, the only prerequisite to Board jurisdiction is the existence of a "final determination" by the fiscal intermediary or the Secretary. If a provider is "dissatisfied" with that final determination, it has the right to obtain a hearing before the Board with respect to those portions of the determination with which it is dissatisfied. Neither the statute nor the regulations require an intermediary audit adjustment as a prerequisite to Board jurisdiction. All that is required is (1) an intermediary determination and (2) provider dissatisfaction with that determination.

In this case, the Intermediary issued an NPR for the Provider's 1987 cost report which included reimbursement for IME costs computed using an incorrect available bed count. The Provider was, for various reasons, dissatisfied with that determination, and filed a timely appeal with the Board. Pursuant to the rules, the Provider subsequently added to the appeal the issue of the inclusion of NICU beds in the available bed count for IME purposes. Under the statute and the regulations establishing the basis for Board jurisdiction, the origin of the Provider's dissatisfaction is irrelevant so long as there is an intermediary determination with which the Provider is dissatisfied. The Board, therefore, has jurisdiction over all issues raised by the Provider with respect to this cost report, regardless of whether the issues had their origin in an audit adjustment.

The Court of Appeals for the Ninth Circuit applied the Supreme Court's analysis in Bethesda Hospital v. Bowen, 485 U.S. 399 (1988) ("Bethesda") to a provider that filed its cost report in reliance upon Manual instructions (which it later challenged before the Board). In Adams House Health Care v. Bowen, 862 F.2d 1371, (9th Cir. 1988), ("Adams House") the court interpreted 42 U.S.C. § 1395oo(d), which addresses the Board's authority regarding matters "not considered by the intermediary" but "covered by [a] cost report." The court held:

> [I]t is no contradiction to say that a certain cost, though not explicitly raised before an intermediary, was covered by a cost report. The phrase "covered by a cost report" should be read broadly, in light of similar broad language elsewhere in the statute and regulations. See 42 U.S.C. § 1395oo(a) (provider may obtain a hearing "with respect to" a cost report if he is dissatisfied with th

> e intermediary's proposed reimbursement "for the period covered by such cost report");
>
> We believe that a cost is "covered by a cost report" if it was incurred within the period which is the subject of the report, even if it is not expressly claimed.

Id.

The reasoning of both the U.S. Supreme Court and the Court of Appeals for the Ninth Circuit, as expressed in these cases, does not require, as a predicate for Board jurisdiction, the existence of an audit adjustment for every issue that the provider has included in an appeal. Rather, once the Board has jurisdiction over a particular intermediary determination, it may review issues pertaining to costs that are covered by the cost report out of which the determination arises. In this case, it is undisputed that the Provider filed an appeal over which the Board properly had jurisdiction. The Provider settled certain issues included in the appeal and added to the appeal the issue of the Intermediary's inclusion of NICU beds in the available bed count. The addition of this issue in no way changes the jurisdictional validity of the underlying appeal. Consequently, the Board retains jurisdiction over all issues in this appeal.

B. The Intermediary Should Not Be Permitted to Raise Jurisdictional Objections At This Late Stage of the Appeal Process.

The Intermediary raises for the first time in its Final Position Paper an objection to the Board's jurisdiction over the issue of inclusion of NICU beds in the available bed count for IME purposes. As discussed above, this jurisdictional objection is without foundation. However, even if there were any merit to the Intermediary's assertions, the Board should reject the Intermediary's attempt to raise jurisdictional objections at this late stage of the appeal and should review and decide the issue on the record before it, as requested.

The Provider states that it properly added the available bed count issue to this appeal by letter to the Board dated March 15, 1995.[15] A copy of the letter was sent to the Intermediary at that time. The Intermediary had several months after receiving notice of the added issue to raise any jurisdictional issues related to the issue. Instead, the Intermediary failed to raise any jurisdictional concerns until June 16, 1995, less than two weeks before the deadline for submission of the parties final position papers in this appeal. The failure of the Intermediary to timely raise this jurisdictional issue should, by itself, cause the Board to reject this last minute attempt by the Intermediary to thwart this appeal. The Board should instead review and decide both of the issues on the merits.

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[15] See Intermediary Exhibit 1.

INTERMEDIARY'S CONTENTIONS:

LEGAL ARGUMENTS

The Intermediary contends that the regulation in effect during 1987 required inclusion of the NICU bed count. The Intermediary accepted the Provider's inclusion of the NICU beds in the bed count when determining the IME payment as modified by audit adjustment #71. The Provider's treatment and the Intermediary's treatment were consistent with the regulations in existence during 1987 concerning bed count. 42 C.F.R. 412.118 addresses the additional payment to hospitals for IME costs.

The term "newborn" is clearly defined at HCFA Pub. 15-2, § 1924.1:

> Newborn Inpatient Day -- Newborn inpatient days are the days that an infant occupies a newborn bed in the nursery.

Id.

Line 15 of Worksheet D-1, Part 1, of the Medicare cost report which reports total newborn days, is labeled "Total nursery days". These manual instructions specifically equate newborn with nursery and require that the newborn days reported on Worksheet D-1, Line 15 flow from Worksheet S-3, Line 7, column 6, which reports nursery days. The comparable data for beds on Worksheet S-3 is reported in column 1. Therefore the nursery beds on Worksheet S-3, Line 7, column 1, are the newborn beds.

The Intermediary further argues that nursery beds for program purposes are newborn beds and do not include the NICU beds, which qualify as special care unit ("SCU") beds in accordance with HCFA Pub. 15-1, Section 2202.7(l)(A)(4):

> NOTE: If a neonatal unit qualifies as an SCU, the days are considered SCU days rather than nursery days. . .

Id.

The Intermediary's reading of the instructions cited is that nursery beds means total newborn beds; NICU beds are not nursery beds; and therefore, NICU beds are not newborn beds. The Intermediary treated NICU beds similarly when determining the Provider's classification on the basis of bed size. HCFA Pub. 15-1, § 2510.5(A) defines bed size as used to classify hospitals:

> [f]or purposes of this section, a bed (either acute care or long term care) is defined as an adult or pediatric bed (exclusive of a newborn bed) maintained

> for lodging inpatients, including beds in intensive care units, coronary care units, and other special care inpatient hospital units.

Id.

This was the same definition of bed used for the IME bed count according to the discussion of 42 C.F.R. § 412.118. The final rule[16] for the above regulation provided that available beds, rather than beds at the beginning of the cost reporting period, be used for the IME bed count. Other than that difference, the bed count excluded newborn beds (42 C.F.R. § 412.118) and included special care unit beds (HCFA Pub. 15-1, § 2510.5(A)) for both classification purposes and IME bed count purposes.

Based on HCFA's discussion in 42 C.F.R. § 412.118 and at 50 FR 35679, the Intermediary disputes the Humana Hospital case contention that HCFA's bed count policy was not intended for IME purposes. The Intermediary also maintains that the meaning of newborn as defined by the manual instructions for other reimbursement purposes is indeed relevant to the IME issue. NICU meant acute special care, and nursery meant total newborn, for the purposes of:

1. classifying the providers for the disproportionate share hospital payments,

2. reimbursing pass through costs on Worksheet D, Part 1,

3. computing inpatient operating costs on Worksheet D-1, and

4. reimbursing non-approved resident training program costs on Worksheet D-2.

It would be inconsistent for the Intermediary to interpret newborn as nursery plus NICU only for the purpose of the IME bed count. It was reasonable for the Intermediary to treat nursery beds as total newborn beds for the purpose of applying 42 C.F.R. § 412.118 consistent with its treatment of nursery beds and days for other purposes.

The Intermediary contends that it properly determined after audit, a bed count of 452 for IME purposes in accordance with 42 C.F.R. § 412.118 by excluding 18 newborn beds and 109 excluded unit beds from an audited total of 579 beds based on the Provider's documentation.[17] The 18 newborn beds were from Worksheet S-3, Line 7, which reports newborn days and beds in accordance with HCFA Pub. 15-2, Section 1924.1. The NICU beds were treated as special care unit beds in accordance with HCFA Pub. 15-1, § 2202.7(l)(A)(4) and were properly included in the total hospital bed count in accordance with HCFA Pub. 15-1, § 2510.5(A).

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[16] See 50 Fed. Reg. 35679 (September 3, 1985).

[17] See Intermediary Exhibit 3, page 6.

The Intermediary argues that any other bed count determined by the Intermediary would have failed to comply with the hospital audit program in HCFA Pub. 13-4, § 4499. This section specifies that for teaching facilities, the program recognizes certain costs based on the bed count and requires that the Intermediary:

> [a]scertain that the bed count does not include nursery beds, excluded units and beds not currently in use.

Id.

Nursery beds are exactly what the Intermediary excluded from the bed count. The hospital audit program uses the term "nursery" beds, not newborn beds. This wording supports the Intermediary's position that the regulations treat nursery beds synonymously with total newborn beds. Compliance with the audit program, which requires that nursery beds be excluded, results in the same bed count as required by 42 C.F.R. § 412.118.

The Intermediary argues that it did not retroactively apply regulations as the basis for inclusion of the NICU beds in the IME bed count. The Intermediary is not basing its position on HCFA Pub. 15-1, § 2405.3(G) which clarified HCFA's treatment for NICU beds. However, as the Intermediary's determination of the IME payment was made after the issuance of this section, the Intermediary wishes to document that its treatment of NICU beds was established prior to the issuance date of August 1988. The Intermediary paid the Provider at the interim settlement of the 1986 cost report an additional payment for IME from what the Provider had claimed on the filed cost report. The Intermediary's determination of the payment used a bed count of 534 based on the 1985 audit results and the available bed count from the 1986 cost report Worksheet S-3 as filed. This bed count determined in May of 1987 by the auditor did not include the 18 newborn (nursery) beds but did include the 16 NICU beds. The bed count reflected the Provider's filed cost report Worksheet S-3, total hospital beds less nursery beds. The Intermediary's determination of the 1986 IME payment also used a bed count of 534.[18] The bed count was based on a review of the Provider's daily census report. The bed count determined on December 2, 1987, by the auditor did not include the 18 newborn beds but did include the 16 NICU beds.[19] This count was reviewed by the senior auditor on March 20, 1988, who made the notation by the excluded unit and newborn cost centers "don't count".[20] The reference given for the IME adjustment was 42 C.F.R. § 412.115(b) which refers to 42 C.F.R. § 412.118. The final bed count used by the Intermediary was in agreement with the Provider's filed cost report Worksheet S-3, total hospital bed count less nursery beds.

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[18] See Intermediary Exhibit 5, page 2.

[19] See Intermediary Exhibit 5, page 3.

[20] See Intermediary Exhibit 5, page 3.

JURISDICTIONAL ARGUMENTS

The Intermediary argues that this issue has not been identified as a reopening or appeals issue prior to the Provider's addition of the issue by the Provider's letter of March 15, 1995. 42 C.F.R.
§ 405.1841(a)(1) allows that prior to the commencement of a hearing, the provider may:

> identify in writing additional aspects of the intermediary's determination with which it is dissatisfied. . .

Id.

This issue was not included in the lists of issues previously submitted and has only just recently been added to the appeal. The Intermediary has, therefore, not had prior opportunity to raise jurisdictional objections to the Provider's inclusion of this issue in the appeal and is doing so in its position paper.

If the Board determines, after review of the facts and circumstances in this case and the position of the Intermediary presented above, that:

1. Program regulations in effect during 1987 clearly required the Intermediary and the Provider to exclude the NICU beds in the IME bed count, and

2. the Provider's inclusion of NICU beds in the count was therefore the result of an error, given the clarity of those regulations,

then, the Intermediary maintains that the Board lacks jurisdiction over this issue. The Intermediary contends that the Provider is not entitled to a Board hearing with respect to the costs at issue because:

1. there is no appealable determination as no audit adjustment was made and there was no self-disallowance by the Provider, and

2. the Provider's dissatisfaction was not due to a determination by the Intermediary.

No Audit Adjustment and No Self-Disallowed Costs

In order for a provider to obtain a Board hearing, the following condition as described in HCFA-Pub. 15-1, Section 2920(A)(1) must be met:

> [y]ou (provider) are dissatisfied with a final determination of the intermediary . . . (see Appendix A, Provider Reimbursement Review

> Board Jurisdiction, subsection B for a more detailed description of final determinations). . .

Id.

The issue identified by the Provider is the Intermediary's inclusion of the NICU beds in the bed count used to determine the IME payment. The Provider's bed count used to determine the IME payment on the filed cost report included 16 NICU beds. The Intermediary's bed count used to determine the IME payment on the finalized cost report included 16 NICU beds. Neither the treatment nor the number of the NICU beds was modified by the Intermediary's audit adjustment #71 to the IME payment amount. The change in the IME payment amount was not caused by the Intermediary's inclusion of NICU beds in the bed count. The Intermediary accepted the Provider's treatment of the NICU beds in the filed cost report. The change in the IME payment was due to differences in the resident count, the federal portion of the DRG plus outlier amount, and a reduction in total beds to reflect available beds. There was no difference between the number of licensed and available beds for the NICU beds.

The Intermediary further argues that there was also no self-disallowance of cost with respect to this issue if the Board maintains that the regulations in effect during 1987 clearly required the Intermediary to exclude NICU beds from the IME bed count. Reliance on such clear regulations would not result in the Provider's inclusion of the NICU beds in the IME bed count. Also, the Provider claims on page 5 of the draft preliminary position paper that it erroneously included the 16 NICU beds in the count of available beds on its as-filed cost report for 1987. Based on this statement, the Provider's inclusion of the NICU beds in the IME bed count was not because of reliance on Medicare regulations. Therefore, the Provider did not self-disallow the related cost.

The Intermediary argues that to reserve its right to appeal an issue, a provider must present a claim to the fiscal intermediary in its cost report unless such a claim would be futile. Without such a claim, a provider cannot be "dissatisfied" with an intermediary's determination to not reimburse items for which no reimbursement was claimed on a cost report. The Intermediary maintains that unless a provider is challenging the validity of a regulation, there must be a claim made by the provider in the cost report and an adjustment made by the intermediary to that claim in order for the provider to be "dissatisfied" with the intermediary's determination. Also, without such a claim, a provider has failed to pursue an available administrative remedy prior to appeal.

The Intermediary maintains that if a provider failed to properly claim a cost through its error or omission, the resulting dissatisfaction does not meet the threshold requirements of § 1878(a)(1)(A) of the Social Security Act. The Supreme Court held in Bethesda, that there are circumstances when the Board can take jurisdiction over items not expressly claimed by a provider in its cost report. It is clear from the Court's reasoning that a provider could be "dissatisfied" with how it was required by the regulations to file the cost report. In Bethesda,

the providers were challenging regulations. To file the cost reports with the disputed costs claimed would have been to no avail as the intermediary would be bound to disallow them. In that situation, the Secretary's view that the Board should decline jurisdiction unless providers first exhaust their administrative avenues short of appeal by contesting the issues in the filed cost reports would have made appeal of the issues impossible.

The Intermediary argues that the facts in this case are very different. As stated above, the Provider did not refrain from claiming reimbursement for the costs because of a regulation, nor is it contesting the validity of any regulation. The costs were not claimed as allowable costs due to the Provider's error. The Provider is not dissatisfied with the amount of reimbursement allowed by certain regulations, nor is it dissatisfied because of a determination by the Intermediary. The dissatisfaction derives from the Provider's erroneous inclusion of the 16 NICU beds in the count of available beds on its filed cost report. The Intermediary believes the exception created by Bethesda to the requirement that a provider claim a cost on its cost report prior to appeal is inapplicable to the instant case.

The Intermediary disagrees that under Bethesda all that is required for the Board to have jurisdiction is a provider's dissatisfaction with a determination. In Bethesda, the Court stated that a provider challenging a regulation would be on "different ground" than one who had simply failed to request reimbursement for certain costs. If all that is required is provider dissatisfaction under the plain language of Social Security Act, § 1878(a)(1)(A)(I), this distinction would not be relevant. However, the Court did make this distinction, which supports the Intermediary's interpretation of the Court's findings to mean that when a regulation is contested, an exception is created to the requirement that a provider claim a cost on its cost report. When no regulation is contested, a claim must be made and adjusted by the intermediary in order for the provider to have an intermediary determination with respect to that claim with which to be dissatisfied. In Bethesda, the Court addresses the dissatisfaction prerequisite and how it was met when regulations prevented the providers from claiming certain costs. In this case, the Provider failed to claim the costs through its own error and stands on different ground than the providers involved in Bethesda.

The Intermediary similarly believes that the findings of Adams House do not apply to the case being considered here. The court applied the reasoning used in Bethesda and it too made the distinction that the providers were not attempting to bypass an exhaustion requirement or had failed to claim reimbursement for certain costs. The providers were instead contesting Provider Reimbursement Manual rules.

The Intermediary maintains the circumstances and findings in Little Company of Mary Hospital and Health Care Centers, No. 92 C 7900 (N.D. 111. 1993) apply in this instant case because the Provider was not challenging a regulation. The court interpreted 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 to raise the issue for the first time on appeal under Section 1395oo(a).

Id.

The District Court interpreted the Supreme Court's reasoning to mean that there was definitely a distinction between providers circumventing prescribed exhaustion requirements or failing to claim a cost, and providers challenging a regulation. Only the latter qualify for the exception created by Bethesda, to the requirement that a cost must be claimed in an original cost report
before appealing. In the instant case, the Provider is not challenging a regulation.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1861(v)(1)(a)	-	Reasonable Cost
§ 1878(a)(1)(A)	-	Provider Reimbursement Review Board

2. Law - 42 U.S.C.:

§ 1395oo, et seq.	-	Provider Reimbursement Review Board

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

§ 405.1801(a) et seq.	-	Definitions
§§ 405.1835-.1841	-	Board Jurisdiction
§ 412.115(b)	-	Additional Payments -- IME
§ 412.118 (Redesignated as § 412.105) et seq., [previously § 405.477(d)(2)]	-	Determination of Indirect Medical Education Costs

4. Program Instructions - Intermediary Manual (HCFA Pub. 13-4):

§ 4499 et seq.	-	Hospital Audit Program -- Audit Steps

Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 2202.7(I)(A)(4)	-	Special Care Units -- Requirements to Qualify
§ 2405.3(G)	-	Adjustment for the Indirect Cost of Medical Education --Bed Size
§ 2510.5(A)	-	Bed Size Definition
§ 2920, et seq.	-	Right to Board Hearing

Provider Reimbursement Manual, Part II, HCFA Pub. 15-2:

§ 1924.1	-	Worksheet D- I -- Computation of Inpatient Operating Cost

5. Cases:

Adams House Health Care v. Bowen, 862 F.2d 1371 (9th Cir. 1988).
Bethesda Hospital v. Bowen, 485 U.S. 399 (1988).

Pfizer, Inc. v. Heckler, 735 F.2d 1502, 1507 (D.C. Cir. 1984).

Charlotte Memorial Hospital v. Bowen, 665 F. Supp. 455 (W.D.N.C. 1987), aff'd, 860 F.2d 595 (4th Cir. 1988).

Bowen v. Georgetown Univ. Hospital, 488 U.S. 199 (1988).

Humana Hospital University v. Blue Cross and Blue Shield Association/Blue Cross of Kentucky, PRRB Dec. No. 95-D15, January 4, 1995, Medicare & Medicaid Guide (CCH) ¶ 43,021.

Sioux Valley Hospital v. Blue Cross and Blue Shield of Iowa, PRRB Dec. No.92-D53, August 26, 1992, Medicare and Medicaid Guide (CCH) ¶ 40,747, rev'd, HCFA Administrator October 26, 1992, CCH ¶ 41,044, aff'd by oral opinion, No. 92-4200 (D.S.D. 1993), aff'd by unpublished opinion.

Sioux Valley Hospital v. Shalala, 29 F.3d 628 (8th Cir. July 20, 1994).

National Medical Enterprises v. Bowen, 851 F.2d 291 (9th Cir. 1988).

Creighton Omaha Regional Health Care Corp. v. Bowen, 822 F.2d 785 (8th Cir.

1987).

Fairfax Nursing Center, Inc. v. Califano, 590 F.2d 1297 (4th Cir. 1979).

Vista Hill Found., Inc. v. Heckler, 767 F. 2d 556 (9th Cir. 1985).

Little Company of Mary Hospital and Health Care Centers v. Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 98-D1, (October 21, 1997), Medicare and Medicaid Guide (CCH) ¶ 45,739, rev'd in part, HCFA Adm. Dec. (December 22, 1997), Medicare and Medicaid Guide (CCH) ¶ 46,053.

Kern Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D42, June 13, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,467.

Hahnemann University Hospital v. Shalala, No. 96-5191, 1997 WL 362672, at *1 (D.C. Cir. May 5) (per curiam).

6. Other:

50 Fed. Reg. 35679 (Sept. 3, 1985).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the facts, parties contentions, and evidence presented, finds and concludes that: (1) the Board has jurisdiction to hear this issue and (2) the Intermediary's inclusion of neonatal intensive care unit (NICU) beds in the indirect medical education (IME) calculation was proper.

In reviewing the record to determine if the Board has jurisdiction over the disputed issue, the Board notes that the NICU beds were included in the Provider's bed count and used in the IME reimbursement calculation. 42 U.S.C. § 1395oo(d) allows the Board to consider matters which a provider disputes on a cost report. It does not refer or require that an audit adjustment occur. Since the Provider included the disputed statistic (NICU beds) on the cost report, it may appeal the issue to the Board. Thus, the Board accepts jurisdiction over this issue. Further, 42 C.F.R.
§ 405.1841(a) allows a provider additional items with which it is dissatisfied. The Provider's filing a letter on March 14, 1995, requesting the NICU bed count as an additional appeal item meets this requirement.

Regarding the inclusion/exclusion of the NICU beds in the IME adjustment, the Board notes that the issue in this case has been brought before it many times in the past. The Board finds that its original position opposing the inclusion of NICU beds in the IME adjustment

calculation was predicated on the Board's literal interpretation of 42 C.F.R. § 412.118(b). See Kern Medical Center v. Blue Cross and Blue Shield Association/Blue Cross of California, PRRB Dec. No. 95-D42, June 13, 1995, Medicare and Medicaid Guide (CCH) ¶ 43,467. This subsection, states in part:

> Determination of number of beds. For purposes of this section, the number of beds in a hospital is determined by counting the number of available beds days during the cost reporting period, not including beds assigned to newborns, custodial care, and excluded distince part hospital units, and dividing that number by the number of days in the cost reporting period.

42 C.F.R. § 412.118(b). (emphasis added).

The Board takes judicial notice of two U.S. circuit court decisions on the same issue as presented in the instant case. See Sioux Valley Hospital v. Shalala, 29 F.3d 628 (8th Cir. July 20, 1994) and Hahnemann University Hospital v. Shalala, No. 96-5191, 1997 WL 362672, at *1 (D.C. Cir. May 5) (per curiam). These two circuit court decisions put forth an interpretation of the issue in this case different from earlier Board decisions and different from the Board majority's most recent decision in Little Company of Mary Hospital and Health Care Centers v. Blue Cross and Blue Shield of Illinois, PRRB Dec. No. 98-D1, (October 21, 1997), Medicare and Medicaid Guide (CCH) ¶ 45,739, rev'd in part, HCFA Adm. Dec. (December 22, 1997), Medicare and Medicaid Guide (CCH) ¶ 46,053.

The Board finds the circuit courts' decisions persuasive, and therefore gives deference to the circuit courts' decisions in their interpretation of the regulations regarding the inclusion of NICU beds in the IME calculation.

DECISION AND ORDER:

The Provider properly appealed the NICU unit beds to the Board. The Intermediary properly included NICU beds in the IME calculation. The Intermediary's action is affirmed.

Board Members Participating:

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

Date of Decision: October 16, 1998

FOR THE BOARD:

Irvin W. Kues
Chairman