PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2003-D4

PROVIDER –
Maple Crest Care Center

Provider No. 28-5149

vs.

INTERMEDIARY –
Mutual of Omaha Insurance Company

DATE OF DECISION-
November 7, 2002

Cost Reporting Periods Ended-
August 31, 1998

CASE NO. 01-0320

INDEX

Provider's Representative: Scott C. Jolley, CPA, Pinnacle Healthcare Consulting
Intermediary's Representative: Tom Bruce, Mutual of Omaha

The decision set forth below involves the Board's jurisdiction over two types of issues: a cost unclaimed on the cost report and a request to reclassify costs for which no audit adjustment was made by the Intermediary.

Background

This appeal was filed on November 15, 2000, from a Notice of Program Reimbursement dated May 19, 2000. The Provider identified 11 issues as the subject of dispute. The Provider did not identify any audit adjustments made by the Intermediary for any of the issues appealed.

The Intermediary originally challenged the Board's jurisdiction over the appeal, alleging that it had not been timely filed. However, the Board found that the appeal was filed on a timely basis. The Intermediary has now filed new jurisdictional objections and the Provider has filed its response.

The Provider's position paper identified the following nine issues which remain under appeal: (1) pharmacy consultation, (2) workers' compensation and unemployment insurance, (3) utilization review costs, (4) selected facility square footage statistics, (5) social service allocation statistic, (6) nursing administration allocation statistic, (7) classification of "pool" nursing costs, (8) allowable bad debts, and (9) classification of holiday, vacation and sick leave. In its position paper, the Provider acknowledged that it failed to claim bad debts on its cost report[1] and seeks to reclassify the remaining costs to different cost centers other than those it had elected when it filed its cost report.

Intermediary's Position

The Intermediary argues that the issues for appeal do not arise simply because, at some point, a provider may wish to record costs differently than it claimed them on its cost report. The Intermediary maintains that a provider's right to a hearing derives from an intermediary determination which is defined at 42 C.F.R. § 405.1801(a) as "a determination of the total amount of program reimbursement due the provider. . . following the close of the provider's cost reporting period." The Intermediary believes that it is implicit in 42 C.F.R. §§ 405.1801 and .1803 that there must be an identifiable adverse finding to request a Board hearing under 42 C.F.R. § 405.1841.

The Intermediary believes that the Provider, in hindsight, realized that it failed to maximize its reimbursement via the classification of certain costs, the representation of certain statistics and charges and the inclusion of bad debts. The Intermediary concludes that the Provider does not have a right to a hearing before the Board because the Intermediary did not make an adjustment and/or adverse finding to the costs in question.

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[1] Provider Position Paper, unnumbered pages, Issue 10-"the Provider failed to include its Medicare allowable bad debts on the subject cost report."

Provider's Position

The Provider cites Adams House Health Care v. Heckler, 837 F.2d 587 (9th Cir. 1987)[2] (Adams House) and Bethesda Hospital Association v. Bowen, 180 S.Ct. 1255 (1988) (Bethesda) for the proposition that once it has received a final determination with which it is dissatisfied, the amount in controversy is $10,000 or more and it filed a timely appeal, audit adjustments are not required for a valid appeal before the Board. The Provider states that it submitted its cost report in full compliance with the Intermediary's interpretation of the applicable program instructions and, as a result, the Intermediary made no audit adjustments. The Provider contends that it is now challenging the Intermediary's interpretation of the issues.

The Provider notes that the Court in Bethesda distinguishes providers who seek to circumvent the exhaustion requirements by first presenting claims to the Board. The Provider explains that it requested that the Intermediary reopen the cost report and the Intermediary denied the request.[3] The Provider believes that, in this case, it was correct to raise the challenge first with the Board.

In addition, the Provider contends that the Board has made a jurisdictional determination with regard to this appeal and the Intermediary should be precluded from raising another jurisdictional challenge. The Provider asserts the doctrine of double jeopardy is applicable. The Provider also argues that because the Intermediary did not issue its NPR within 12 months subsequent to filing, a jurisdictional challenge should be precluded.

Findings of Fact, Conclusions of Law and Discussion

Bad Debts Issue

The Board finds that it lacks jurisdiction over the bad debts issue because the Provider failed to claim bad debts on its cost report and, therefore, the issue is not a matter covered by the cost report as required by 42 U.S.C. § 1395oo(d). There was no statutory, regulatory or manual provision that precluded the Provider from claiming bad debts on its cost report. In fact, 42 C.F.R. § 413.80 establishes the requirements for claiming bad debts on a cost report. The Board finds that a hospital that does not seek reimbursement from the Intermediary for all costs for which it is entitled to be reimbursed cannot, on appeal to the Board, first ask for new costs. Little Company of Mary Hospital Health Care Centers v. Shalala, 24 F.3d 993 (7th Cir. 1994).

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[2] This decision was vacated by the Supreme Court at 108 Ct. 1569 (1988) and the Court remanded the case to the Ninth Circuit in light of the decision in Bethesda Hospital Association v. Bowen, 180 S.Ct. 1255 (1988). The decision issued on remand is Adams House Health Care v. Bowen 862 F.2d 1371 (9th Cir. 1988) which found that the Board has jurisdiction over issues for which the provider seeks full reimbursement under the Provider Reimbursement Manual (manual) provisions and later seeks additional reimbursement by challenging the validity of the manual provisions.

[3] An Intermediary's decision not to reopen a cost report cannot be reviewed by the Board. See Your Home Visiting Nurse Services, Inc. v. Shalala, 119 S.Ct. 930 (1999).

The statute and the regulation both contemplate an intermediary final determination as a prerequisite to Board jurisdiction. By failing to present a claim for reimbursement the Provider has failed to meet the threshold test for Board jurisdiction and has not exhausted its administrative remedy that could make later review unnecessary. See e.g. Aircraft and Diesel Equipment Corporation v. Hirsh, 331 S.Ct.752, 767-768 (1947) (exhaustion of administrative remedies requires pursuing them to their appropriate conclusion and awaiting the outcome), Janowski v. International Brotherhood of Teamsters, 673 F.2d 931,935 (7th Cir. 1982) (exhaustion is required where necessary to develop a factual record or take advantage of agency expertise).

The Issues of (1) Pharmacy Consultant Costs, (2) Workers' Compensation and Unemployment Insurance Costs, (3) Utilization Review Costs; (4) Square Footage Statistics (5) Social Service Allocation, (6) Nursing Administration Allocation Statistic, (7) Adjustment to Pool Nursing Compensation Expense and (8) Reclassification of Holiday, Vacation and Sick Leave Compensation Expense

The Board finds that it lacks jurisdiction over the remaining issues because they are not self-disallowed costs to which the decision in Bethesda applies. There was nothing in the statute, regulations or manual provisions that prevented the Provider from making the cost report elections in the manner it requested through the reopening request. In Bethesda, the Court noted that providers who fail to request from the intermediary all costs to which they are entitled stand on different ground than those who seek full reimbursement. Bethesda at 1259.

The facts of this case are analogous to those of Athens Community Hospital, Inc. v. Schweiker, 743 F.2d. 1 (D.C. Cir. 1984) (Athens II). In Athens II the providers did not include reimbursement for stock options or Federal income taxes. The providers sought to amend their cost reports and the intermediary denied this request through a denial of reopening. The Providers then sought to add the issue to a pending appeal. When discussing whether a provider could appeal any matter claimed on a cost report on one basis and then be allowed to recharacterize its cost and seek reimbursement on a totally different basis before Board, the Court stated that this kind of review would

> deprive [the PRRB] of the intermediary's analysis and conclusions and make the PRRB the tribunal of original jurisdiction, eliminating a tier of review, and [have the effect of] possibly substantially slowing the reimbursement process for other providers. This procedure would also render virtually meaningless the time limits for the filing of cost reports established by the Medicare regulations. Instead of requiring cost reports to be filed within three months, with a maximum extension of 30 days, the provider could file new cost claims for as long as its appeal as to any claim was pending before the PRRB.

Athens II at 7 citing Athens Community Hospital v. Schweiker, 989 F.2d. 989 at 997 (Athens I). The Court in Athens II found that for a "matter" to be "at issue" the intermediary must have resolved the issue adversely to an actual claim by a provider. Id.

The Provider's arguments that the Intermediary should be precluded from raising this jurisdictional challenge is without merit. Because jurisdiction refers to the Board's fundamental power to adjudicate the case, jurisdiction can never be forfeited or waived. Consequently, defects in subject matter jurisdiction require correction regardless of when they are raised. U.S. v. Cotton 122 S.Ct. 1781 (2002); Pennsylvania v. Union Gas Co., 109 S.Ct. 2273 (1989). The principle of double jeopardy applies to a second prosecution for substantially the same offense and has no application to these proceedings.

Decision and Order

The Board finds that it lacks jurisdiction over the appeal for the reasons set forth above. The Board hereby dismisses the case.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and .1877.

Board Members Participating

Suzanne Cochran, Esq.
Henry C. Wessman, Esq.
Stanley J. Sokolove, CPA
Gary B. Blodgett, DDS

DATE OF DECISION: November 7, 2002

FOR THE BOARD:

Suzanne Cochran, Esq.
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and .1877.