PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2011-D17

PROVIDER -
Charleston Area Medical Center

Provider No.: 51-0022

Cost Reporting Period Ended -
December 31, 2000

vs.

INTERMEDIARY –
Blue Cross and Blue Shield Association/
United Government Services

CASE NO.: 05-1761

INDEX

Issue:

Whether the provider has a right to a hearing on certain graduate medical education costs and kidney acquisition costs that were not claimed on the cost report.

Medicare Statutory and Regulatory Background:

The Medicare program was established to provide health insurance for the aged and disabled. 42 U.S.C. §§ 1395-1395cc. The Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. 42 U.S.C. § 1395h; 42 C.F.R. §§ 413.20 & 413.24.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the portion of those costs to be allocated to Medicare. 42 C.F.R. § 413.20. The costs may include direct and indirect costs related to graduate medical education (GME and IME), 42 U.S.C. §§ 1395ww(h), and costs related to the acquisition of organs, such as kidneys, for use in transplant and for donation to organ procurement organizations. Provider Reimbursement Manual, CMS Pub. 15-2 § 3625.4. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues a Notice of Program Reimbursement (NPR). 42 C.F.R. § 405.1803.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1839, a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the fiscal intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date of receipt of the final determination by the provider. The Board can affirm, modify, or reverse a final determination of the intermediary with respect to a cost report and has the power to make any other revisions on matters covered by the cost report that were not considered by the Intermediary in making its final determination. 42 U.S.C. § 1395oo(d).

Statement of the Case and Procedural History:

At issue in this appeal is a Notice of Program Reimbursement (NPR) dated December 28, 2004 for the Provider's fiscal year ending December 31, 2000. The appeal was timely filed and meets the amount in controversy requirement. The Provider's request for hearing specified eight issues and two more issues were subsequently added. All issues were either transferred to group appeals or withdrawn pursuant to an Administrative Resolution, except for the claim for three dental residents and acquisitions costs for twenty-two kidneys[1] which were not claimed on the

[1] The Provider failed to claim on the cost report acquisition costs of three kidneys that should have been allocated to Medicare as a result of misclassifying seven patients, and nineteen kidneys which had been given to organ procurement organizations.

cost report. The Intermediary then challenged jurisdiction on these two remaining issues.

Parties' Positions:

The Intermediary challenges jurisdiction over the graduate medical education costs and the kidney acquisition costs on the grounds that it made no adjustment on the NPR for these items because it made no adjustment and accepted the Provider's claim for these items as filed there is no determination from which the Provider can appeal; the Provider cannot be dissatisfied with the final determination.

The Provider argues that the Board has jurisdiction on the grounds that it raised both of these costs with the Intermediary during the audit of the cost report and before the Intermediary issued the NPR; therefore, the Intermediary's refusal to include the added cost is a final determination. The Provider further argues that the Intermediary's adjustment of other components of items that contain the costs puts the costs at issue. Also, the Intermediary has a duty to ensure that correct payment is made. In the alternative, the Provider argues that the Board should exercise its discretion to hear these issues pursuant to 42 U.S.C. § 1395oo(d).

Findings of Fact, Conclusions of Law, and Discussion:

After consideration of Medicare statutes, regulations, and guidelines, the parties' contentions, and the evidence in the record, the Board majority concludes that the Provider does not have a right under 42 U.S.C. § 1395oo(a) to a hearing and declines to hear the matter pursuant to its discretionary powers of review under 42 U.S.C. § 1395oo(d).

The costs at issue in this appeal are direct and indirect graduate medical education costs and kidney acquisition costs. On the cost report it filed with the Intermediary, the Provider failed to include three dental residents in its total resident count, nineteen kidneys it furnished to organ procurement organizations, and three kidneys due to patient misclassification. It is undisputed that these omissions were solely the fault of the Provider. After the Intermediary declined to reopen the cost report, the Provider appealed the issues to the Board.

A provider who has filed a timely cost report . . . may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if—

> (1) such provider
>
> > (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report . . .

42 U.S.C. § 1395oo(a).

42 U.S.C. § 1395oo(d) further provides that the Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to 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.

The Provider first argues that it has a right to a hearing under section 42 U.S.C. § 1395oo(a) because it raised the issues during the Intermediary's audit of the cost report and before the NPR was issued. It cites Athens Comm. Hosp., et al v. Schweicker, 743 F.2d 1 (D.C. Cir 1984) (Athens II) in support of its position. The providers in Athens II sought Board jurisdiction over certain stock option costs and federal income taxes that had been inadvertently omitted from the cost report and were reported to the intermediary after the NPRs had been issued. Id. at 4. The Court, invoking section 42 U.S.C. § 1395oo(d), held that the Board had jurisdiction over "cost issues raised by the provider prior to the intermediary's issuance of the NPR." Id. The Court determined that the Board did not have jurisdiction in that case however, because the costs were reported after the issuance of the NPR and "the Intermediary was never given the opportunity to make a final determination about them." Id. at 10.

Four years later, the Supreme Court examined the issue of Board jurisdiction over costs not claimed on the cost report in Bethesda Hosp. Ass'n v. Bowen, 485 U.S. 399 (1988). It held that the Board has jurisdiction over costs that were self-disallowed if the Intermediary would have been bound by a statute, regulation, or rule, to disallow the costs had they been claimed since any attempt to persuade the Intermediary to do otherwise would have been futile. But the Supreme Court drew a sharp line between these costs and costs omitted from the cost report because of inadvertence or negligence:

> [The providers in Bethesda] stand on different ground than do providers [. . .] who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.

Id. at 404-405.

Although the Supreme Court did not directly address whether inadvertently omitted costs give rise to a right to a Board hearing, other courts have examined the question. In doing so, they have demonstrated that the Supreme Court's discussion in Bethesda undercuts the Court of Appeals' broad holding in Athens II. The providers in Little Co. of Mary Hosp. v. Shalala, 24 F.3d 984 (7th Cir. 1994), failed to claim certain costs on their cost report due to the faulty design on their computer-based billing system and the Court, citing Bethesda, held that they did not have a right to a Board hearing with respect to those costs. See also MaineGeneral Medical Center v. Shalala, 205 F.3d 493 (1st Cir. 2000) (holding, in part, that a provider who mistakenly omitted Medicare bad debts from its cost report does not have a right under section 1395oo(a) to a Board hearing); Loma Linda Univ. Medical Center v. Leavitt, 492 F.3d 1065 (9th Cir. 2007) (declining to confer jurisdiction pursuant section 1395oo(a) over costs inadvertently omitted from the cost report); UMDNJ-Univ. Hosp. v. Leavitt, 539 F.Supp.2d 70, 76 (D.D.C. 2008) (citing HCFA Health Services of Oklahoma Inc. v. Shalala, 27 F. 3d 614, 621n.4 (D.C. Cir 1994) which stated that the holding in Athens II had been "undercut by Bethesda").

In Mercy Hosp. v Blue Cross and Blue Shield Ass'n & First Coast Serv. Options, PRRB Dec. No. 2010-D14, Mar. 11, 2010 the Board summarized these principles. In order for a provider to have a right to a Board hearing on a particular cost, that cost must have been included in the cost report unless it was self-disallowed pursuant to Bethesda or its progeny or its inclusion was impossible or unnecessary. In that decision the Board explained the practical difficulties in reviewing such unclaimed costs, particularly in determining if the cost was raised in time so that the intermediary could reasonably take it into account in making a final determination. The Board further examined the administrative burden involved in, particular the prospect that it would severely disrupt the intermediary's complex process of reviewing the adequacy, completeness, and accuracy of the cost report within the mandated deadlines.

The instant case does not meet the criteria set forth in Mercy. The costs at issue were not self-disallowed pursuant to Bethesda and their inclusion was not impossible or unnecessary. They were merely omitted. The Provider, therefore, does not have a right, under section 1395oo(a), to a Board hearing.

The Provider next argues that it has a right to a Board hearing under section 1395oo(a) because the Intermediary made adjustments to the resident count component of the medical education cost and the Provider Statistical and Reimbursement Report (PS&R). Those adjustments include the dental residents, which are a component of GME and IME, and the Medicare kidneys, which are a component of the PS&R, and hence the Provider asserts it has the right to appeal. It cites Blessing/St. Mary GME Group Appeal v. Blue Cross and Blue Shield Ass'n, PRRB Dec. No. 97-D57, Medicare & Medicaid Guide (CCH) ¶ 45,228 (May 5, 1997), aff'd by HCFA Administrator, Medicare & Medicaid Guide (CCH) ¶ 45,554 (July 7, 1997), in support of its position.

At issue in Blessing were subsidy payments to a medical school and an adjustment of certain stipends and related expenses that affected the Provider's Average Per Resident Amount (APRA) determination. Each of these costs were claimed on the appropriate cost report and then disallowed by the Intermediary in the Notice of Average Per Resident Amount (NAPRA). The Intermediary argued that the Board did not have jurisdiction because the only item that could be appealed is the base year determination used to calculate the GME costs and that the portions of the GME being challenged were not adjusted in the NAPRA. The Providers countered that these costs were first disallowed in the NAPRA and that they had not neglected to include them or self-disallow them. The Board agreed with the Providers, finding that it had jurisdiction over these costs because limiting the appeal to the base year determination would perpetuate the error in reimbursement related to the APRA and examining the costs was essential in determining reimbursement for that year and future years.

In its decision, the Board distinguished the situation in Blessing with the one found in a previous Board case, The Cleveland Clinic Foundation v. Blue Cross and Blue Shield Ass'n/Community Mutual Ins. Co., PRRB Dec. No. 94-D56, Medicare & Medicaid Guide (CCH) ¶ 42,593 (July 20, 1994), upon which the Intermediary had relied. In Cleveland Clinic, the Provider failed to claim on its cost report certain physician teaching and support expenses incurred by a related organization and the Intermediary disallowed them in calculating the Provider's APRA. The

Board found it had jurisdiction to properly calculate the APRA. Although the Board did not discuss jurisdiction in its Cleveland Clinic decision, its comment in the Blessing decision strongly suggests that it would not have found it had jurisdiction in Blessing if the costs had been omitted from the cost report.

Finally, the Provider argues that it has a right to a hearing under section 1395oo(a) because the Intermediary has a duty to ensure that reimbursement is calculated accurately. It claims that the result in Athens II follows this principle and that the audit process is not intended to be a "game of 'gotcha'." Provider's Reply in Opposition to Intermediary's Jurisdictional Objection at 12. The Board finds that calculating reimbursement accurately is in the best interests of Medicare and its beneficiaries and providers, but that goal must be balanced with the efficiency of the program. An open-ended opportunity to add costs to the cost report would unacceptably hinder the process of reimbursement. In light of each of these priorities, it is not unreasonable, subject to the guidelines outlined above, to require the Provider to claim on the cost report all costs to which it is entitled.

Although a provider does not have a right to a Board hearing with respect to a cost inadvertently omitted from a cost report, the case law also establishes that once the Board has jurisdiction over an appeal under section 1395oo(a), it has the discretion, pursuant to section 1395oo(d), to hear any other matter in the cost report, including unclaimed costs, MaineGeneral, 205 F.3d at 501-502; Loma Linda, 492 F.3d at 1073; UMDNJ, 539 F.Supp.2d at 77-78. In MaineGeneral, the Court stated:

> The choice is up to the Board. It can adopt a policy of hearing such claims or of refusing to hear them, or it can opt to decide on a case-by-case basis.

205 F.3d at 501. In the instant case, the Provider has a valid appeal under section 1395oo(a) for the Medicare/SSI percentage issue and the outlier payments issue.[2] Both of these issues were transferred to group cases, but because they constitute a jurisdictionally proper appeal before the Board, the Board has discretion, pursuant to section 1395oo(d), to hear and decide the issue in this appeal. The Board declines to do so, however.

Decision and Order:

The Board concludes that the Provider does not have a right to a hearing on the GME and IME issue and the kidney acquisition cost issue under 42 U.S.C. § 1395oo(a) and declines to hear the matter pursuant to its discretionary powers of review under 42 U.S.C. § 1395oo(d). Because these are the only issues left in the appeal, the Board hereby dismisses the appeal.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[2] All other issues except GME costs and kidney acquisitions costs were withdrawn.

Board Members Participating:

Suzanne Cochran, Esq.
Yvette C. Hayes (dissenting)
Keith E. Braganza, CPA
John Gary Bowers, CPA

For the Board:

Suzanne Cochran, Esq.
Chairman

DATE: January 6, 2011

Dissenting Opinion of Yvette C. Hayes

I respectfully dissent with the Board majority's decision that the Provider does not have a right to a hearing under 42 U.S.C. §1395oo (a) for any IME and DGME FTEs or Kidney Acquisition costs not claimed on its submitted cost report or for which the Intermediary did not agree to review at the time of audit; and the Board majority's decision declining to hear those matters under appeal pursuant to its discretionary powers of review under 42 U.S.C. §1395oo(d). Intermediary raised jurisdictional objection to the following two issues:

(1) Whether the Intermediary improperly reduced the Provider's number of resident full-time equivalent (FTEs) for Medicare direct graduate medical education and indirect medical education payments? (More specifically with respect to 3 dental residents representing 1.5 FTEs)

(2) Whether the Intermediary improperly computed the Provider's Medicare utilization for kidney acquisition costs?

Medicare payments for the direct costs of GME and the IME adjustment are based, in part, on the count of residents. The Intermediary audited the Provider's resident count and made a number of substantial adjustments.[3] During the course of the audit, the Provider determined that three (3) dental residents had been omitted from the resident count on the original submitted cost report. A package of written materials[4] relating to the 3 dental residents was hand-delivered to the auditor for the purpose of adding residents to the count for the FY 2000 cost report used to compute direct GME and IME payments. In addition, The Provider realized that the number of Total & Medicare kidneys on the original submitted cost report was incorrectly reported.[5] Medicare reimburses kidney transplant centers on a cost-reimbursement basis for kidney acquisition services. A kidney transplant center should count as "Medicare" kidneys those kidneys it transplants into Medicare patients and also any kidneys furnished to an Organ Procurement Organization (OPO).

At the pre-exit conference for the 2000 cost report, Provider inquired as to the status of counting the dental residents in the resident count for purposes of direct GME and IME payments in the settlement of the cost report. No definitive response noted. Again, at the exit conference, the Provider inquired about the status. Intermediary informed the Provider that the residents would not be counted in the settlement of the cost report, commenting further that the Intermediary would only make negative adjustments that were outside the scope of the audit if such matters came to the attention of Intermediary auditors.

[3] For example, Adjustment No. 207, reduced the number of unweighted residents for direct GME purposes from 127.92 to 96.80 FTEs and in Adjustment No. 208, reduced the resident count for IME from 127.92 to 97.29 FTEs. See Provider's Jurisdiction Brief.

[4] Included Medicare Remittance advices, patient account histories, and confirmation of the number of kidneys furnished by independent OPOs.

[5] There were errors in payor class for 7 patients transplanted at Charleston Area Medical Center (CAMC) which resulted in a net understatement of Medicare kidneys by 3 and 19 kidneys furnished to the OPO were omitted entirely from the cost report when they should have been included as Medicare kidneys and in the count of total kidneys. See Provider's Reply Brief at 4-5.

It is the Intermediary's position that there were no adjustments made to the cost report relating specifically to the dental residents and kidney acquisition cost statistics with respect to the two issues listed above.

It is the Provider's position that it clearly made a claim for both the additional dental residents and the kidney acquisition cost statistics at issue during the audit and well before issuance of the NPR. The Provider argues that it is well-established precedent[6] that a provider protects its appeal rights by making a claim for the cost or reimbursement prior to issuance of the NPR. In addition, the Provider claims with respect to the resident count, the Intermediary made extensive adjustments to its direct GME and IME reimbursement[7]. Further, the Board's jurisdiction is not premised on the existence of an identifiable adverse determination (e.g. an audit adjustment). Finally, there is no question that the Board had jurisdiction over the entire cost report by reason of the other six issues in the appeal for which there is no jurisdictional objection. Under §1395oo (d) the Board therefore can entertain other issue(s).

The Board's jurisdiction is established under 42 U.S.C. §1395oo (a). It provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in regulations may obtain a hearing with respect to such report by a Provider Reimbursement Review Board . . . if –
> (1) Such provider –
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report.
> (2) The amount in controversy is $10,000 or more, and
>
> (3) Such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(i).

The Board majority noted situations where "a provider simply neglects to include an item on the cost report for which it would be due reimbursement" separates this case from Bethesda Hospital Association v. Bowen, 485 U.S. 399 (1988), where the Supreme Court commented:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs* to which they are entitled under applicable rules.

[6] In Athens Community Hospital, Inc., et al. v. Schweiker, 743 F. 2d 1 (D.C. Cir. 1984) (Athens II)
[7] The Intermediary disallowed approximately 30 of the 120 resident [FTEs] claimed by the Provider.

Id. at 404-405. (emphasis added)

To the contrary, I find that the Provider did not simply neglect to include an item on the cost report. The IME/DGME reimbursement (of which the number of FTEs is just one component of determining the IME/DGME payment amounts) and Kidney acquisition costs (of which the number of kidneys is also just one component of determining the allowable costs) were claimed on the cost report and adjusted at audit, but the amount claimed is allegedly understated for the number of dental resident FTEs and the number of Medicare vs. non-Medicare kidneys inaccurately reflected therein.

In support of this position, the Supreme Court held that:

> The plain language of §1395oo (a) demonstrates that the Board had jurisdiction to . . . [t]here is no merit to the Secretary's contention that a provider's right to a hearing before the Board extends only to claims presented to a fiscal intermediary because the provider cannot be "dissatisfied" with the intermediary's decision to award the *amounts requested* in the provider's cost report. (emphasis added)

Bethesda at 399-400.

In addition, 42 U.S.C. §1395oo (d) states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to 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.

According to the Supreme Court, the language in 42 U.S.C. §1395oo (d) "allows the Board, once it obtains 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 prescribed 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." Bethesda, 485 U.S. at 406. In this case, there is no dispute that the IME/DGME FTE count or Kidney acquisition statistics in question were incurred within the period that is covered by the cost report, although not expressly claimed.

Although the Supreme Court has not had an opportunity to squarely address whether the Board has jurisdiction of an appeal of a cost [or reimbursement] unclaimed through inadvertence rather than futility, I find that the weight of authority holds that the once the Board has statutory jurisdiction pursuant to 42 U.S.C. §1395oo (a), it has the power to decide an issue that was not first raised before the intermediary under 1395oo (d), but that [the Board] is not required to do so. (MaineGeneral Medical Center v. Shalala, 205 F.3d 493 (1st Cir. 2000); Loma Linda Univ. Medical Center v. Leavitt, 492 F.3d 1065 (9th Cir. 2007); UMDNJ v. Leavitt, 539 F. Supp. 2d. 70

(D.D.C. 2008).

In Loma Linda Univ. Med. Ctr. v. Leavitt, 492 F.3d 1065 (9th Cir. 2007), the Ninth Circuit "joined" the First Circuit's view as expressed in MaineGeneral and St. Luke's and held that [the Provider] was "undoubtedly 'dissatisfied' with [the Intermediary's] final determination of the 'total program reimbursement due, *for it appealed*. Its appeal was on time and the amount [in dispute] exceeded the jurisdictional minimum." It found all threshold jurisdictional requirements were met "for a hearing that, according to the clear language of the [statute], was 'with respect to the cost report.' This being so, § 1395oo(d) kicked in." Id. at 1071. (emphasis added.) As the Supreme Court put it, §1395oo(d) "sets forth the powers and duties of the Board once its jurisdiction has been invoked." *Bethesda Hosp*., 485 U.S. at 405. Those powers and duties are to base its decision on the record, which is to include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board; "to affirm, modify or reverse a final determination "with respect to a cost report"; and to make other revisions "on matters covered by such cost report [8]. . . even though such matters were not considered by the intermediary in making such final determinations." Thus, § 1395oo (d) squarely allows the Board to modify a final determination based on evidence that was not considered by the intermediary, and to make revisions on a cost or expense incurred during the year being reported even though the cost wasn't claimed and the matter wasn't considered by the intermediary. Congress could not have intended an *absolute exhaustion rule* in the face of this explicit power. To the contrary, it found that the Congress spoke quite directly to the precise question and opted for Board discretion to go beyond the record adduced for, and considered by, the intermediary.

Id. (emphasis added)

I agree with the Loma Linda Court's reasoning that if Congress' intent was to *limit* the Board's review to just the matters adjusted[9] for by the intermediary or to just the evidence explicitly presented to, or considered by the intermediary at the time of its determination, it could have expressly done so. But, Congress did exactly the opposite, it gave the Board expanded powers to decide matters covered by a cost report that is properly before it and to address and revise as necessary any issue that may arise during the conduct of such hearing.

In MaineGeneral Medical Center v. Shalala, 205 F. 3d 493 (1st Cir. 2000), the First Circuit's advice or instructions to the Board on how to make the case for "refusing to hear inadvertently omitted claims" by establishing a "rule of consistency" was described as a rational approach in light of the fact that providers have the ability to request a reopening from its intermediary up to 3 years after NPR is issued. This rationale fails to acknowledge that the intermediary has complete discretion as to if it will or will not reopen a cost report, or that the intermediary could also adopt its own policy to not reopen for claims of omission and its decisions would be final with no administrative or judicial review. See Your Home Visiting Nurse Servs. Inc. v. Shalala, 119 S. Ct. 930, 933-934 (1999).

[8] A "matter covered by such cost report" 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 406; *Adams House Health Care v. Bowen*, 862 F.2d 1371, 1375 (9th Cir. 1988) (adopting the *Bethesda Hospital* definition).

[9] As described by the Secretary/CMS/FI as an "adverse audit adjustment."

As of the July 2009 update of the Board's rules and instructions, the Board had not established such a policy regarding unclaimed costs or reimbursement. The Board is currently deciding this matter on a case-by-case basis which means there is no final resolution to the question – whether the Board will hear an issue not first raised before the intermediary, even if it has the power to do so. At present, the decision to hear or not hear a provider's claim may vary depending on the very composition of Board members which would serve to undermine the principle of consistency the courts were cognizant of. The Board majority declined to exercise its discretionary authority because it found the circumstances in this case unpersuasive.

However, I would point out that the Ninth Circuit's view that the Board's jurisdiction is *discretionary* was more thoroughly explained as follows:

> What we did in [Adams House] was explain that the discretionary language in St. Luke's does not describe the Board's power to *accept* or *reject* appeals; rather, it describes the Board's options once an appeal is filed."[10] (Emphasis added)

The Loma Linda Court stated that it was guided by this construct in holding that once jurisdiction has been obtained over a cost report because of a provider's dissatisfaction with the intermediary's final determination of the total reimbursement amount due, the Board then has discretion to consider evidence that was not before the intermediary; to affirm, modify or reverse the final determination; and to revise matters covered in the cost report that the intermediary did not consider.

In UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008), the Court reached the same conclusion as the First and Ninth Circuits. The D.C. Circuit found that the plaintiff was clearly "dissatisfied" with the fiscal intermediary's determination of total reimbursement for it appealed multiple issues in each NPR on time and the amounts exceeded the jurisdictional minimum. At that point, the Board had jurisdiction for a hearing that according to the clear [and unambiguous] language of the statute, was with respect to the provider's cost reports for the years in question. Id. at 77.

The D.C. District Court was also not persuaded to interpret the statute to grant a hearing based upon a provider's expressed dissatisfaction with *individual* reimbursement determinations[11]

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[10] See *Adams House Health Care v. Bowen*, 862 F.2d 1371, 1375 (9th Circuit 1988) (Emphasis added). The court went further and held " [t]he Board has no discretion to reject an appeal, for as 42 U.S.C. §1395oo(a) provides,[a]ny provider of services which has filed a required cost report within the time specified in regulations *may* obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board. . . . The word "may" in the emphasized language connotes not contingency but entitlement. Id. at 1375-76.

[11] A final determination by the Intermediary does not indicate that all matters covered in such cost report were reviewed and or considered. When a provider's cost report is audited, a Report on Audit of Medicare Cost Report is usually included as a part of the Notice of Program Reimbursement. The language found in this report indicates its findings with respect to the items tested, and with respect to the items not tested, it commonly attests that nothing came to its attention that caused them to believe that the provider has not complied in all material respects with Medicare laws, regulations, and instructions. The Intermediary does not issue a separate and distinct determination for each and every aspect of the cost report.

when the plain language clearly predicates the Board's jurisdiction on a provider's dissatisfaction with the "amount of *total* program reimbursement." 42 U.S.C. §1395oo(a)(1)(A)(1). . . . As §1395oo(a) explicitly requires only dissatisfaction with the *total* amount of program reimbursement in order to obtain a hearing, and §1395oo(d) allows the Board to consider evidence not put before the intermediary and make modifications based upon that evidence, the Court [rejected] the Secretary's contention that Congress actually intended to impose an issue-specific exhaustion requirement to access administrative appellate review. There is no such limitation on the Board's jurisdiction or upon its power of review once jurisdiction is obtained. Id. at 77-78.

The D.C. District Court also agreed with the First and Ninth Circuit's view that the Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. The Court reasoned that this conclusion comports with the plain language of subsection (d) and found that Congress empowered the Board to make such modifications and allowed it to consider evidence not put before the fiscal intermediary, but did not require it to do so. I disagree with the Court's reasoning and observe that 42 U.S.C. §1395oo (d) does not expressly state or imply that the Board does not have to consider evidence not put before the fiscal intermediary. On the contrary it states in relevant part that "a decision by the Board *shall be* based upon the record made at such hearing, which *shall include* the evidence considered by the intermediary *and* such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is reviewed as a whole." (Emphasis added)

In support of its position that a provider preserves its right to appeal to the PRRB if it claims an item prior to issuance of the NPR, the Provider references the D.C. Circuit Court of Appeals holding in Athens Comm. Hosp. et al v. Schweiker, 743 F.2d 1 (D.C. Cir. 1984) (on rehearing) (Athens II). The Provider points out that the court's decision in Athens II reflects a thoughtful and thorough consideration of which "intermediary determinations" are appealable. The Court addressed the precise issue at hand – whether there is jurisdiction when an item is not claimed in the as-filed or submitted cost report but is claimed prior to the Intermediary issuing an NPR:

> We hold that the PRRB has jurisdiction over costs that are specifically claimed – meaning that the provider requested reimbursement in a timely manner – as well as those cost issues raised by a provider prior to the intermediary's issuance of the NPR. 743 F.2d at 5-6.

I find that the circuit and district court cases discussed above clearly conclude that, once the Board obtains jurisdiction under subsection (a), then subsection (d) sets forth the powers and duties of the Board [to decide a matter under appeal] not to refuse to accept and review any evidence not considered by Intermediary.

I respectfully dissent with my colleagues' reasoned and reasonable arguments, but we view the issues differently. I read 42 U.S.C. §1395oo (a) to permit use of the appeal process as a means for correcting an otherwise complete cost report. This view does not undermine the Secretary's regulatory framework for making corrections via reopening. I found no statutory or regulatory language that addresses cost report finality; however, I find support for my view in the agency's

guidance provided in the Provider Reimbursement Manual (PRM). See CMS Pub. 15, Part 1, Sections 2930 and 2931. (09/93)

In PRM §2930, which address the finality, reopening and correcting of intermediary and Board determinations and decisions, it states in part that "there must be a reasonable period of time within which to seek or make corrections wherever an error has been discovered. This section and the next discuss finality and set out the time limits (reopening periods) for making corrections of intermediary determinations.

PRM §2930.1 addresses when determinations and decisions become final as follows: "[f]or the purpose of the reopening and correction provisions of §2931. . . an intermediary's initial determination . . . becomes final and binding when the specific time limit for appealing such determination or decision expires. In addition, PRM §2930.1.A states in part that "an intermediary's initial determination (Notice of Amount of Program Reimbursement) becomes final and binding upon the expiration of 180 calendar days after the date of mailing of the notice, unless before that time the provider (entity) requests a hearing . . ."

Section 2930.1 goes on to say that determinations and decisions, otherwise final, may nevertheless be reopened and corrected when the specific requirements for reopening and correction set out in §2931 are met. Based on these provisions and other mechanisms in place to allow for amendments, revisions and/or corrections to previously submitted and/or settled cost reports, I find that the cost report as a whole is open to correction or amending until it is considered final and binding. The cost report is final and binding upon expiration of the 180 days from the date of issuance of the NPR, unless the provider has requested a hearing and its request is accepted. If the provider's request for a hearing is denied, then the cost report may still be reopened upon request if made within 3 years of the date of the NPR, with respect to the intermediary's findings on matters at issue. See 42 C.F.R. §405.1885(a).

In further support of the Provider's right to a Board hearing on the DGME/IME FTE count and Kidney Acquisition cost issues, I agree with the Provider's assertion that if the Board's jurisdiction over the other six issues in this appeal is undisputed, then clearly, the Board's jurisdiction over the Provider's cost report has been obtained; as a result, under 42 U.S.C. §1395oo(d) and the Supreme Court's ruling in Bethesda, the Board has the power to rule on and revise any other costs or expenses incurred during the period for which the cost report was filed even if such cost or expense was not expressly claimed.

The regulatory provisions to implement the statutory grant of authority are located at 42 C.F.R. §405.1835. According to §405.1835(a) (2004), the Provider has a right to a Board hearing about any matter designated in §405.1801(a)(1)[12], *if*:

[12] Section 405.1801(a)(1) defines what an *intermediary determination* means as: "with respect to a provider of services that has filed a cost report under §§413.20 and 413.24(f) of this chapter, the term means a determination of the amount of total reimbursement due the provider, pursuant to §405.1803 [written notice requirements] following the close of the provider's cost reporting period, for items and services furnished to beneficiaries for which reimbursement may be made on a reasonable cost basis under Medicare for the period covered by the cost report.

> (1) An intermediary determination has been made with respect to the provider; and
> (2) The provider has filed a written request for a hearing before the Board under the provisions described in §405.1841(a)(1); and
> (3) The amount in controversy (as determined in §405.1839(a)) is $10,000 or more.

42 CFR §405.1841(a)(1) addressing the general requirements of a request for Board hearing states:

> The request for a Board hearing must be filed in writing with the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider . . . Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. . . .

Again, all of the above requirements have been met, therefore, I find the provider has met all jurisdictional requirements of the statute and regulations and has a right to be heard on the merits.

In conclusion, I find that the Provider has met the jurisdictional requirements to a Board hearing under §1395oo (a) and it should be granted the right to be heard on the merits of its case. The Board's authority to decide the matter and the scope of its review is governed under §1395oo(d), this section does not convey discretion on the Board to refuse to hear an appeal or a matter at issue in an appeal, in effect cutting off a provider's statutorily given rights.

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Yvette C. Hayes