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PRRB Jurisdiction

Interpretation and application of jurisdiction principles

By Kenneth R. Marcus

In the four decades since its enactment, the Medicare program has evolved from a cost-based reimbursement system to a prospective payment system. This evolution in payment methodology has not abated the appeals process. On the contrary, providers continue to file thousands of payment appeals annually with the Provider Reimbursement Review Board (PRRB), a five-person tribunal, one of which must be a certified public accountant, appointed by the Secretary of the Department of Health and Human Services (DHHS).

Several significant payment items, including bad debt, disproportionate share, and medical education, remain controversial. Moreover, in the wake of the decision of the United States Supreme Court in *Your Home Visiting Nurse Service v. Shalala*, 525 U.S. 440 (1999), the provider cannot rely on the re-opening process to resolve even the most ministerial disputes.

Your Home held that the decision whether to reopen is vested solely within the discretion of the fiscal intermediary. Because the provider does not have the right to appeal the fiscal intermediary's denial of a reopening request, numerous "protective appeals" are filed, many of which are ultimately settled without the need for a PRRB hearing and decision.

Absent PRRB jurisdiction, however, the provider will not succeed in achieving recovery, either through the formal appeals process or as a result of negotiation and settlement with the fiscal intermediary. Jurisdictional questions arise either from intermediary challenges or on the own motion of the PRRB.

In the author's experience, the substantive outcome of many cases turns on whether the PRRB asserts jurisdiction, because frequently there is no dispute regarding the substantive payment principle. Thus, it is imperative the provider and its representative have a sound understanding of fundamental PRRB jurisdiction principles, as well as a grasp of how these principles have been interpreted and applied in certain recurring factual contexts.

Sources of PRRB Jurisdiction

There are several sources that outline PRRB jurisdiction. The formal and informal authority governing the provider appeals process includes:

- The Medicare Act, 42 U.S.C. § 1395oo.
- The Medicare Regulations, 42 C.F.R. §§ 405.1801 et seq.¹

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- Chapter 29 of the Medicare Provider Reimbursement Manual (PRM).
- Provider Reimbursement Review Board Instructions effective May 5, 2000, as revised effective March 1, 2002. The instructions supersede many provisions of Chapter 29 of the PRM.² Regarding the instructions, the PRRB states:

The Board's instructions are intended to speak to the Board's internal operating procedures in that they give only an overview of the procedures in some respects. Accordingly, providers are encouraged to refer to the statute and regulations for a fuller discussion of the appeals procedures.³

- In January 2005, the PRRB issued for discussion and comment revised instructions, also posted to its Web site.⁴ The May 1, 2002, instructions remain in effect until the revised instructions are issued in final form.
- Periodically, the PRRB issues letters to a limited audience of intermediaries and select practitioners regarding changes in its policies and procedures.

Basic Jurisdictional Requirements

The Medicare Act, 42 U.S.C. § 139500(a), requires that a provider file a request for a hearing with the PRRB within 180 days of receipt of a final determination from the fiscal intermediary or the Centers for Medicare and Medicaid Services (CMS) and the amount in controversy must be at least \$10,000.⁵ Two or more providers appealing a common issue of law and fact may file a group appeal, in which event the amount in controversy must be at least \$50,000.⁶

The PRRB does not have authority to rule in a provider's favor in an appeal that challenges the Medicare Act, the Medicare Regulations, a CMS Ruling, or a Provider Reimbursement Manual Provision. In such an event, the provider may request that the PRRB grant "expedited judicial review" (EJR). If the PRRB grants the provider's request for EJR, the provider has the right to commence an action in federal court within 60 days of receipt of the PRRB letter granting EJR.⁷ The PRRB may also order EJR on its own motion.⁸

Final Determination Requirement

Clearly, the provider's receipt of a "final determination" is a prerequisite to PRRB jurisdiction. Typically, a notice of program reimbursement (NPR) is such a final determination. Alternatively, a decision by CMS, such as a Tax Equity and Fiscal

Responsibility Act (TEFRA) exception request, is a final determination subject to appeal. On occasion, however, whether an appealable final determination has been received is controversial.

Appendix A

Appendix A of a now superseded PRRB manual (circa 1990) identified the types of final determinations subject to PRRB appeal.⁹ For example, Appendix A provided that "[a] refusal by the intermediary to accept an amended cost report which is provided to the intermediary before the issuance of the NPR is appealable to the Board."

The PRRB instructions, which superseded the manual, do not contain such a listing. Depending upon when the appeal was filed, however, a provider may be able to rely on the listing.

Self-Disallowance

In the 1988 decision of *Bethesda Hospital Association v. Bowen*,¹⁰ the Supreme Court held that the PRRB has jurisdiction over an item that has been "self-disallowed." Self-disallowance means that a provider filed its cost report regarding a particular item in compliance with law, but under protest, with the intent of appealing the item.

Although there is no audit adjustment, the PRRB enjoys jurisdiction over a self-disallowed item. Regarding self-disallowance, the PRRB instructions provide as follows:

Where you are claiming a cost is self-disallowed, the hearing request must identify the specific law, regulation, CMS Ruling or manual instruction that precludes an intermediary from reimbursing the cost.¹¹

The PRRB instructions reflect a somewhat narrower scope of the self-disallowance principle than was originally recognized by the Supreme Court in *Bethesda*, which found that "once jurisdiction has been invoked" over a cost report under 42 U.S.C. § 139500(a), then § 139500(d) "sets forth the powers and duties of the Board."¹² The Court stated that the text of § 139500(d) "allows the Board . . . to review and revise a cost report with respect to matters not contested before the fiscal intermediary."¹³

According to the *Bethesda* Court, "[t]he 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

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The second and third CMS recommendations are somewhat intertwined, as both center on the issue of the definition of a hospital. Specifically, CMS notes significant concern regarding the application of the definition of hospital by orthopedic and surgical specialty centers. More precisely, CMS' concern is that such facilities are claiming the name hospital—and the related assigned and typically higher payment rates—while not fitting the definition.

Section 1861(e) of the Social Security Act defines “hospital” as an institution engaged, among other things, “primarily” in furnishing services to inpatients. The CMS study, however, revealed that orthopedic and surgical specialty hospitals primarily serve outpatients, as reflected in an average daily census of only five patients.

CMS plans to analyze data to assess whether these specialty orthopedic and surgical hospitals do indeed meet requirements to be defined as a hospital. CMS notes that some anecdotal evidence suggests that, in addition to orthopedic and surgical specialty hospitals, some cardiac care specialty hospitals also may not meet the definition of a hospital. CMS expects this analysis will take up to six months.

4. Review of procedures for approval for specialty hospitals' participation in Medicare.

CMS notes that, given the limited focus of specialty hospitals, it intends to review its procedures for approval of specialty hospitals to participate in

Medicare, to assure such facilities meet core requirements necessary for the health and safety of beneficiaries. To be approved for participation, a hospital must meet the statutory definition of a hospital, as well as the hospital conditions of participation. Hospitals also must meet, for example, federal civil rights requirements and advance directive requirements.

CMS' concern is whether specialty hospitals do indeed meet the definition of a hospital. In addition, CMS notes concern regarding how the Emergency Medical Treatment and Active Labor Act (EMTALA) should apply to specialty hospitals. To address this concern, CMS plans to revisit procedures by which applicant specialty hospitals are examined to ensure compliance with relevant standards. CMS also will instruct fiscal intermediaries to refrain from processing further participating applications from specialty hospitals until this review is completed and any indicated revisions are implemented.

CMS expects this review to occur during a six-month period. ■

Notes

1. See “Report to the Congress, Physician-Owned Specialty Hospitals,” MedPAC, March 2005.
2. See Testimony of Mark B. McClellan, MD, PhD, Administrator, Centers for Medicare and Medicaid Services, Before the House Committee on Energy and Commerce Hearing on Specialty Hospitals: Assessing Their Role in the Delivery of Quality Health Care, May 12, 2005.

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or expense was not expressly claimed.”¹⁴ Thus, *Bethesda* stands for the broad principle that the PRRB enjoys jurisdiction over any matter covered by the cost report.

The self-disallowance principle set forth in the PRRB instructions, however, represents a significant narrowing of *Bethesda*. The instructions adopt the decision in *Little Company of Mary Hospital & Health Care Centers v. Shalala*.¹⁵ *Little Company of Mary* narrowed the *Bethesda* ruling by holding that self-disallowance requires that there be a statute, regulation, or CMS ruling on point that makes reimbursement of an item unallowable.¹⁶

CMS also proposes to adopt this interpretation in the June 25, 2004, proposed rule. If the proposed rule is adopted, the provider would be required to file the cost report under protest regarding an item

which the provider believes may not be allowable or may not be in accordance with Medicare policy.¹⁷ Thus, under the PRRB instructions and the proposed rule, if there is no prohibition regarding payment for a particular item, then a self-disallowance would not give rise to PRRB jurisdiction.

Failure to Claim an Allowable Cost

The self-disallowance principle does not extend, however, to circumstances where a provider fails to place a cost into controversy. Thus, the opposite of the self-disallowance situation is where the provider fails to claim payment for an allowable item.

The leading decision adjudicating this issue is *Maine General Medical Center v. Shalala*.¹⁸ In that case, the court held that the appeal was not barred by the statutory language of § 1395oo(a), but that “the Board has statutory jurisdiction to hear claims not first raised before the intermediary, but it may decline to do so as a matter of discretion.”¹⁹

The providers sought reimbursement for Medicare-related bad debts where the providers had not included the bad debts in the cost reports. The PRRB dismissed the bad debt issue for lack of jurisdiction. Relying on the *Bethesda* decision in which the Supreme Court defined a matter “covered by a cost report” as “a cost or expense that was incurred within the period in which the cost report was filed, even if such cost or expense was not expressly claimed,” the Maine General court concluded that the board has the statutory jurisdiction to decide an issue that was not first raised before the intermediary.

The court concluded, however, that the decision of whether or not to exercise such jurisdiction is within the PRRB’s discretion.²⁰ The court remanded to the PRRB with an order to exercise its discretion.

In one of the earliest reported decisions, *Somerset Rehabilitation, PC v. Blue Cross/Blue Shield Association*,²¹ the CMS Administrator upheld the PRRB’s dismissal of an appeal based on the fact that the provider failed to claim the cost item in controversy at the time it filed its cost report. The cost item would have been allowed had the provider claimed it. The PRRB has decided of number of such cases in recent years, with no apparent uniform result.²²

Audit Adjustment Requirement

The fiscal intermediary typically takes the position that an audit adjustment is a prerequisite for appealing an item. The PRRB has recognized, however, that an audit adjustment is not necessarily a prerequisite to its jurisdiction.

For example, in *Sacred Heart Medical Center, Spokane, WA*,²³ the PRRB held as follows regarding the right of a provider to appeal from an issue relating to neonatal intensive care unit beds for which there was no audit adjustment:

42 U.S.C. § 139500(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.²⁴

In that case, the PRRB held that it had jurisdiction over the provider’s appeal regarding an erroneous interest income offset for which there was no audit adjustment. The CMS Administrator vacated and remanded to the board for review of the NPR and the cost report, although the CMS Administrator did not dispute the reasoning of the board.²⁵

Appeal of Denied Cost Report Amendment

In contrast to a reopening request, which is filed after the NPR is issued, on occasion, a provider will submit a proposed cost report amendment before the NPR is issued. Recently, the PRRB has held that the fiscal intermediary’s denial of a proposed cost report amendment filed by the provider before issuance of the NPR conferred jurisdiction on the PRRB.²⁶

In *Saginaw General Hospital v. Blue Cross/Blue Shield Association*,²⁷ the CMS Administrator reversed the decision of the PRRB. In this reversal, the CMS Administrator asserted jurisdiction over the provider’s proposed amended cost report, finding that a “final determination” is an NPR and that the NPR did not set forth the requisite final determination regarding the Part B physician costs at issue.

These PRRB holdings are consistent with the long standing policy of the PRRB, as stated in the Appendix A of the superseded Manual discussed above. The PRRB, however, has not been consistent. For example, in *Extendicare Health Services v. United Government Services*,²⁸ the PRRB declined to assert jurisdiction over an amended cost report which corrected an error in which the provider had misclassified worker’s compensation and unemployment insurance in the employee benefits cost center instead of in the administrative and general cost center.

Appeal from an Amended NPR

When an amended NPR is issued, either as a result of a voluntary reopening or a provider’s successful appeal, another appeal right is triggered under 42 U.S.C. § 139500(a). At issue, however, is the scope of the provider’s appeal right from an amended NPR.

Blue Cross and Blue Shield Association, the PRRB, and CMS contend that an appeal from an amended NPR is limited to the scope of the amended NPR, *i.e.*, an issue which could have been appealed from the original NPR may not be appealed from an amended NPR. While perhaps the better view is that the provider should not have a second opportunity to appeal an item which could have been, but was not, appealed from the original NPR, the case law is not uniform.

For example, in *Edgewater Hospital, Inc. v. Bowen*,²⁹ the court held that the provider could appeal any issue from the amended NPR.³⁰ In *HCA Health Services of Oklahoma v. Shalala*,³¹ the court held that the appeal was limited to the scope of the amended NPR.

The PRRB instructions adopt a limited right to appeal to the scope of the amended NPR. As stated in the instructions:

The Board accepts jurisdiction over appeals from a revised Notice of Program Reimbursement (NPR) where the issue(s) in dispute were specifically adjusted by that revised NPR. The Board typically follows the courts by limiting the scope of such an appeal to only the revised issue(s).³²

Timing of Appeal Request

Of course, the best practice is to assure that the hearing request is received by the PRRB well within 180 days of the date of the final determination. On occasion, however, the hearing request is filed very close to the deadline, as in *Capeside Cove Good Samaritan Center (Siren, WI) v. Blue Cross/Blue Shield Association /Cahaba Government Benefit Administrators*.³³ The PRRB held that the appeal was timely filed where 180th day was a Sunday and the provider placed the appeal in the mail on Monday, as prescribed by 42 U.S.C. § 1395ii.

Review of the Medicare Act, the Medicare Regulations and the PRRB instructions reveals that these authorities provide slightly varying statements of the requirement for timely filing a hearing request. The varying statements regarding timely filing include:

- The Medicare Act, 42 U.S.C. § 1395oo(a)(1)(C)(3), provides that the provider must file “a request for a hearing within 180 days after notice of the intermediary’s final determination.”
- The Medicare Regulation, 42 C.F.R. § 405.1841 (a)(1), further clarifies the requirement as follows, by providing that the 180-day deadline begins with the date of the determination. The regulation 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 or, where notice of the determination was not timely rendered, within 180 days after the expiration of the period specified [for rendering the final determination.]”

- Finally, the PRRB instructions provide for a five-day mailing rule, as follows:

The Board presumes that you have received notice of your final determination within five days of the date of its issuance, unless you present evidence to rebut the presumed five-day period. You must mail your request no

later than close of business on the 180th calendar day after receipt of the determination in dispute. When the 180th day falls on a weekend, legal holiday, or any other day all or part of which is declared a nonwork day for federal employees, the Board considers your request to be timely if it is mailed on the first full workday thereafter. The Board’s receipt date is the day it stamps your hearing request “Received” or the date written as “received” on your certified mail return receipt.”³⁴

Additionally, the Medicare Regulations, 42 C.F.R. § 405.1841, provide for a good cause exception that permits a request to be filed within three years of the determination. As stated in the regulations:

A request for a Board hearing filed after the time limit prescribed in paragraph (a) of this section shall be dismissed by the Board, except that for good cause shown, the time limit may be extended. However, no such extension shall be granted by the Board if such request is filed more than 3 years after the date the notice of the intermediary’s determination is mailed to the provider.

The PRRB instructions make clear, however, that there is a high threshold for what constitutes “good cause” in this context. As noted in the instructions:

The Board will only consider a request for good cause if you submit an explanation with your initial hearing request showing that you had good cause for the late filing, and if the Board finds your explanation acceptable. The Board decides each case based on the factual circumstances presented. Examples of situations that the Board may consider acceptable are (1) unusual or unavoidable circumstances that demonstrate you could not have reasonably been expected to file timely; and (2) proof of involuntary destruction of or other damage to your records. If you request a hearing more than three years after issuance of the final determination in dispute, the Board cannot extend the time limit for filing the appeal.³⁵

At least one court has held that the good cause exception is not authorized by the Medicare Act. To date, however, CMS has not acquiesced to this holding.³⁶ The court stated:

Notwithstanding our normal deference to the responsible agency’s interpretation of a statute, we conclude that the [DHHS] Secretary exceeded the statutory scope of authority and therefore that the regulation allowing for a

good cause waiver of the 180-day filing deadline is invalid.

Exhaustion of Remedies

The formal authority governing PRRB procedure and appeals makes no explicit reference to an exhaustion of remedies requirement. Nonetheless, the PRRB has issued unpublished decisions holding that the PRRB lacks jurisdiction based on a failure to exhaust remedies.

Arguably, the PRRB has the authority to require an exhaustion of remedies requirement only if and when the DHHS Secretary or CMS duly promulgates a regulation prescribing such requirement. For example, in *Little Company of Mary Hospital and Health Care Centers v. Shalala*,³⁷ the exhaustion requirement was prescribed by regulation.³⁸

Similarly, in *Town and Country Nursing Home*,³⁹ the PRRB did not assert jurisdiction where a provider sought exception to RCL where CMS had not yet rendered a decision.

Other examples of exhaustion requirements prescribed by regulation are as follows:

- 42 C.F.R. § 413.30 requires that a request for an exception to reasonable cost limits first be submitted to CMS, and that CMS must render a decision regarding such request, before the PRRB has jurisdiction over the request.
- 42 C.F.R. § 413.40 requires that a request for an exception, adjustment or exemption from the “TEFRA rate of increase ceiling” first must be submitted to CMS, and that CMS must render a decision regarding the request, before the PRRB has jurisdiction over the request.
- 42 C.F.R. § 412.302(c)(1)(v) provides that submitting a request for “obligated capital” under the Medicare capital prospective payment system is the prerequisite to an appeal before the PRRB.

In addition to exhaustion requirements prescribed by regulation, the Supreme Court has held that a provider’s attempt to bypass the PRRB and proceed directly to federal district court violates the exhaustion of remedies prescribed by 42 U.S.C. § 1395oo.⁴⁰

The PRRB has held that there is an exhaustion requirement where CMS has not promulgated a regulation requiring exhaustion. Notably, CMS has taken such a position in the context of the annual process for establishing the wage index, which involves sub-

mission of certain cost data, with a very tight deadline for submitting corrections to erroneous wage data. CMS takes the position that a provider’s failure to comply with the deadline for submitting a request for correction of wage data results in waiver of an appeal right before the PRRB. Although CMS has not promulgated a formal regulation set forth in the Code of Federal Regulations, as stated in the final rule for Medicare inpatient PPS for fiscal year (FY) 2005, CMS asserts that failure to file a timely wage data correction results in waiver of the appeal right. CMS states:

We created the processes described above to resolve all substantive wage index data correction disputes before we finalize the wage and occupational mix data for the FY 2005 payment rates. Accordingly, hospitals that did not meet the procedural deadlines set forth above will not be afforded a later opportunity to submit wage data corrections or to dispute the intermediary’s decision with respect to requested changes. Specifically, our policy is that hospitals that do not meet the procedural deadlines set forth above will not be permitted to challenge later, before the Provider Reimbursement Review Board, the failure of CMS to make a requested data revision.⁴¹

Similarly, in *United Hospitals Medical Center (Newark, New Jersey) v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of New Jersey*,⁴² the PRRB declined to assert jurisdiction over wage index related costs where the provider did not make a request to correct under the regulation 42 C.F.R. § 412.64. The PRRB also declined jurisdiction over Part B physician costs where the provider failed to submit time studies.

Perhaps illustrating a double standard, a court recently held that CMS is not required to exhaust remedies and may proceed directly to court to recover an overpayment.⁴³

Adding an Issue to a Pending Appeal

The Medicare Regulation, 42 C.F.R. § 405.1841(a), provides in pertinent part that “prior to the commencement of the hearing proceedings, the provider may identify in writing additional aspects of the intermediary’s determination with which it is dissatisfied and furnish any documentary evidence in support thereof.”

Consistent with the regulation, decisions of the PRRB hold that a provider has the right to add an issue to a pending appeal.⁴⁴ The intermediary generally disfavors this provision, however, which is seen as mechanism for adding to an appeal issues generated by consultants or lawyers. While perhaps there may be some truth in that perception, nonetheless, there is a legitimate interest in adding an issue to a pending appeal.

For example, a provider may not possess all of the facts or documentation with which to determine that a particular issue should be appealed within 180 days after the issuance of an NPR. The PRRB recognized this circumstance recently in the case of Mercy Hospital Anderson as a Participant in Blumberg Ribner 95-97 Medicaid Eligible Group (03-1344G) (March 5, 2004). In that case, the PRRB upheld the right of the provider to add to its appeal the disproportionate share (DSH) adjustment based on the sound reasoning that, when the provider initially filed its appeal, the provider did not possess the information with which to determine the need to appeal such issue.⁴⁵

Still another illustrative case is *Twin Rivers Regional Medical Center v. Blue Cross and Blue Shield Association/Premiera Blue Cross*.⁴⁶ In this decision, the CMS Administrator reversed the decision of the PRRB denying the provider's request to add to its appeal denial of a new provider exemption to the routine cost limits.

Appeal of a Denied Reopening Request

The PRRB instructions adopt, and the PRRB consistently follows, the Supreme Court decision in *Your Home*. The decision states:

The Board does not have jurisdiction over an intermediary's refusal to reopen a cost report.⁴⁷

In light of this decision, a provider is well advised to identify and timely appeal items, rather than relying on the reopening process.

Reinstatement of Incomplete Administrative Resolution

The PRRB instructions provide that a provider has the right to request reinstatement within 180 days of the date of the PRRB's letter acknowledging receipt of a withdrawal in the event an administrative resolution is not completed. The instructions state:

If you fail to receive payment according to a settlement agreement, you may, within 180 days of the date of the Board's letter granting your withdrawal request and closing your appeal, request that your appeal be reinstated. Your reinstatement request must specifically explain why you want reinstatement and the issues you want reinstated. The Board will then consider your reinstatement request.⁴⁸

If there are unresolved issues which are decided by the PRRB and proceed to higher levels of appeal when the provider requests reinstatement, however, the PRRB likely will decline to reinstate because it no longer possesses jurisdiction over the case.⁴⁹ The CMS Administrator held that the PRRB had jurisdic-

tion over the provider's request for reinstatement of a case where the intermediary had not completed the administrative resolution. Note that, upon remand, the PRRB did not assert jurisdiction, and the case ultimately was settled only after the provider commenced an action in federal court and CMS agreed to implement the administrative resolution.

Recently, the fiscal intermediary has been reluctant to implement a partial administrative resolution, and has required that the PRRB appeal, and any CMS Administrator review, be completed before implementation of the administrative resolution. The PRRB instructions do not provide for this eventuality. One approach is to enter into and file a stipulation with the PRRB together with a request that the PRRB decision adopt the stipulated administrative resolution. Presumably, the provider then would have the right to appeal the failure of the intermediary to complete the administrative resolution.

Other recent reported decisions of the PRRB involve settlements. In *Home Care PRN v. Blue Cross and Blue Shield Association/Associated Hospital Services*,⁵⁰ the PRRB denied jurisdiction in dispute over identity of proper payee in a settlement agreement. In *Florida Convalescent Centers 97 Therapy Management Fee Group v. BlueCross BlueShield Association/First Coast Service Options, Inc.*,⁵¹ the PRRB declined to assert jurisdiction where the original providers and the intermediary achieved an administrative resolution. The intermediary did not pay the providers under the administrative settlement, but applied the payment to amounts owed to Medicare by the bankrupt successors.

Jurisdictional Issues and Practice Before PRRB

Although there are numerous reported administrative and judicial decisions presenting jurisdictional and procedural issues, until quite recently, the PRRB did not publish its jurisdictional decisions. The rationale articulated by the PRRB was that there is not unanimity among members of the PRRB regarding such decisions and that the composition of the PRRB membership changes over time.

Furthermore, in litigation, CMS vigorously opposes discovery which seeks to obtain copies of such unpublished decisions. As a result, the provider and practitioner community is challenged to research this important area of the law because most PRRB jurisdictional decisions are not published.

One approach to gain a sense of the jurisdictional decisions is to review CMS Administrator decisions, which are reported periodically in American Health Lawyers Association's Health Law Digest under the

topic "PRRB Decisions." The summary provides a review of all PRRB jurisdictional decisions which are either reviewed by the CMS Administrator or regarding which the CMS Administrator declines review.

It should also be recognized that the PRRB may decide a jurisdictional issue without notice to the provider and with no opportunity for the parties to brief the issue before the PRRB. In the event the provider appeals the decision to court, there may be less than an adequate record for judicial review, thus licensing legal counsel for the DHHS secretary to proffer its interpretation of the basis for the PRRB's decision. Thus, if the provider believes that there may be a jurisdictional issue, upon filing the hearing request, it is prudent to identify the issue to the PRRB, to fully brief the provider's position regarding the issue, and to request that the PRRB conduct a hearing regarding the issue.

Until recently, in litigation the DHHS secretary contended that a jurisdiction decision of the PRRB was "discretionary" and thus not subject to judicial review. The courts have rejected the notion that certain procedural decisions of the PRRB are "discretionary" and thus not subject to judicial review.⁵² These courts, however, upheld the basis for the dismissal.

Conclusion

A firm understanding of PRRB jurisdictional principles is as important to successfully pursuing an appeal as is knowledge of the underlying substantive payment principles at stake. This area of the law continues to evolve, as witnessed by the recently proposed revised PRRB instructions and the proposed revised regulations. ■

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Notes

1. On June 25, 2004, CMS proposed a significant amendment to the applicable regulations governing PRRB appeals. 69 *Fed. Reg.* 35715. To date, such regulations have not been promulgated in final form. See *Dennis Barry's Reimbursement Advisor*, Vol. 19, No. 12, p. 3.
2. On June 25, 2004, CMS proposed a significant amendment to the applicable regulations governing PRRB appeals. 69 *Fed. Reg.* 35715. To date, such regulations have not been promulgated in final form. See *Dennis Barry's Reimbursement Advisor*, Vol. 19, No. 12, p. 3.
3. Provider Reimbursement Review Board Instructions posted on the PRRB Web site: <http://www.cms.hhs.gov/providers/prrb/inst2002.pdf>.
4. Instructions, I. Revised PRRB instructions posted at http://www.cms.hhs.gov/providers/prrb/Revised_PRRB_RULES.pdf.
5. In the event the amount in controversy is at least \$1,000 but less than \$10,000, the provider is entitled to a hearing before the intermediary. See also 42 C.F.R. § 405.1835.
6. 42 U.S.C. § 1395oo(b). See also 42 C.F.R. § 405.1837, 405.1839(b).
7. 42 U.S.C. § 1395oo(f)(1).
8. See also, 42 C.F.R. § 405.1842.
9. See MEDICARE AND MEDICAID GUIDE (CCH) ¶7719G.
10. 485 U.S. 399 (1988).
11. See, e.g., *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988), *Adams House Health Care v. Bowen*, 862 F.2d 1371 (9th Cir. 1988), *Little Company of Mary v. Shalala*, 24 F.3d 984 (7th Cir. 1994). (B.I.A.5.)
12. 485 U.S. at 405; accord, *French Hosp.*, 89 F.3d at 1418, n.9.
13. 485 U.S. at 406.
14. *Id.*
15. 24 F.3d 984 (7th Cir. 1994).
16. *Id.* at 993.
17. See proposed 42 C.F.R. § 405.1835(a)(1)(ii).
18. 205 F.3d 493 (1st Cir. 2000).
19. *Id.* at 500.
20. *Id.* at 497.
21. HCFA Administrator Decision (Aug. 16, 1990) MEDICARE AND MEDICAID GUIDE (CCH) ¶ 38,661.
22. See, e.g., *Maple Crest Care Center v. Mutual of Omaha Insurance Company*, PRRB Dec. No. 2003-D4, Case No. 01-0320 (Nov. 7, 2002), MEDICARE AND MEDICAID GUIDE (CCH) ¶ 80,42 (PRRB declined to assert jurisdiction over a bad debt claim not filed in the provider's cost report); *Hemet Valley Medical Center v. Blue Cross Blue Shield/Blue Cross of California*, CMS Administrator Decision (Jan. 19, 2001), MEDICARE AND MEDICAID GUIDE (CCH) ¶ 80,644 (PRRB did not have jurisdiction where provider failed to claim bad debt costs; the CMS Administrator reversed the decision of the PRRB in favor of the provider, reported MEDICARE AND MEDICAID GUIDE (CCH) ¶ 80,635); *Mayo Regional Hospital Dover-Foxcroft ME v. Blue Cross Blue Shield Association/Associated Hospital Service of Maine*, PRRB Dec. No. 2002-D15 (March 27, 2002) (PRRB asserted jurisdiction over the provider's claim for Medicare cross-over bad debt payment that the provider inadvertently omitted from its cost report, in reliance on the decision in *Maine General Medical Center v. Shalala*, 205 F.3d 493 (1st Cir. 2000), which held that it was within the discretion of the PRRB whether to assert jurisdiction.)
23. PRRB Dec. No. 99-D2, MEDICARE AND MEDICAID GUIDE (CCH) ¶ 80,085.
24. Affirmed by CMS. CMS Administrator Decision (Dec. 21, 1998), MEDICARE AND MEDICAID GUIDE (CCH) ¶ 80,154. See also *Loma Linda University (Loma Linda, Cal.) v. Blue Cross and Blue Shield Association/Blue Cross of California*, PRRB Dec. No. 98-D99 (Sep. 18, 1998), MEDICARE AND MEDICAID GUIDE (CCH) ¶ 80,076, *rev'g* CMS Adm't Dec. reported at ¶ 81,176.
25. *Loma Linda University (Loma Linda, Cal.) v. Blue Cross and Blue Shield Association/Blue Cross of California*, HCFA Administrator Decision (Nov. 17, 1998), MEDICARE AND MEDICAID GUIDE (CCH) ¶ 80,136.

26. *St. Mary's Medical Center (Saginaw, Michigan) v. United Government Services and Blue Cross Blue Shield Association*, Dec. No. 2005-D6 (Nov. 23, 2004), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 81,258, *rev'd*, CMS Administrator Decision (Feb. 16, 2005), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 81,294.
27. PRRB Dec. No. 2004-D12, CMS Administrator Decision (Apr. 2, 2004), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 81,176.
28. PRRB Dec. No. 2003-D13, Case Nos. 96-0618G, 96-0619G, and 96-0620G (Jan. 28, 2003), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 80,964.
29. 857 F.2d 1123 (7th Cir. 1988).
30. *See also Minnesota Hospital Association v. Bowen*, 703 F. Supp. 780 (D. Minn. 1988).
31. 27 F.3d 614 (D.C. Cir. 1994).
32. Section B.I.a.3. *See also Anaheim Memorial Hospital v. Shalala*, 130 F.3d 845 (9th Cir. 1997).
33. *Capeside Cove Good Samaritan Center (Siren, Wisc.) v. Blue Cross Blue Shield Assoc.*, PRRB Dec. No. 2005-7, Case No. 00-0374 (Nov. 23, 2005), *MEDICARE & MEDICAID GUIDE (CCH)* ¶ 81,259.
34. Instructions B.I©.
35. Instructions, B.I.(a)(2).
36. *See Alacare Home Health Services, Inc. v. Bowen*, 891 F.2d 850 (11th Cir. 1990).
37. 24 F.3d 984 (7th Cir. 1994).
38. 42 C.F.R. § 412.60(d).
39. CMS Administrator Decision (Apr. 20, 1998), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 80,399.
40. *Shalala v. Illinois Council on Long Term Care*, 120 S. Ct. 1084 (2000). *See also Palisades General Hospital v. Shalala*, No. 98-1281 (D.D.C. 1999), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 300,157.
41. *See W.A. Foote Memorial Hospital v. Shalala*, No. 99-CV-75202-DT (E.D. Mich. 2001), *see also Palisades General Hospital v. Thompson*, No. 99-1230 (D.D.C. 2003). 69 Fed. Reg. 28270.
42. PRRB Dec. No. 2000-D23, (March 2, 2000) *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 80,399.
43. *United States v. Lahey Clinic Hospital, Inc.*, 2005 WL 268048 (1st Cir. 2005).
44. *See, e.g., Little Company of Mary Hospital and Health Care Centers*, PRRB Dec. No. 97-D29, *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 45,080, *rev'd*, *Little Company of Mary*, 165 F.3d 1162 (7th Cir. 1999).
45. *See Dennis Barry's Reimbursement Advisor*, Vol. 19, No. 11, p. 10. *See also Ingham Regional Medical Center v. United Government Services*, PRRB Dec. No. 2003-D14 (Jan. 30, 2003), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 80,965, CMS Adm'r Dec. (Mar. 19, 2003) (PRRB held that provider had the right to add DSH issue upon reinstatement of withdrawn appeal when intermediary did not comply with settlement agreement; CMS Adm'r declined review). *See also Dennis Barry's Reimbursement Advisor*, Vol. 18, No. 8, p. 9.
46. CMS Administrator Decision (May 29, 2002), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 80,881.
47. *See* 42 C.F.R. § 405.1885(c) and *Your Home Visiting Nurse Service v. Shalala*, 525 U.S. 440 (1999). Instructions B.I (a) (4).
48. Instructions, C.XIII (a).
49. *See, e.g., Hurley Medical Center v. Blue Cross and Blue Shield Association/Health Care Service Association*, CMS Administrator Decision (Jan. 8, 1999), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 80,156.
50. PRRB Dec. No. 2004-D1, Case Nos. 01-1470, 01-1539G, 01-1534G (Oct. 14, 2003), *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 81,053.
51. PRRB Dec. No. 2004-D45, Case No. 00-2151G (cost reporting period ending 12/31/97), Sept. 30, 2004, *MEDICARE AND MEDICAID GUIDE (CCH)* ¶ 81,251.
52. *See, e.g., Inova Alexandria Hospital v. Shalala*, No. 00-1409 (4th Cir. 2001); *UHI d/b/a/University Hospital v. Thompson*, No. 99-4418 (6th Cir. 2001).

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