# A Funny Thing Happened on the Way to the PRRB: The Amended Cost Reporting and Appeal Rules

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Most headlines regarding the Federal Fiscal Year 2016 Outpatient Prospective Payment System (OPPS) Final Rule trumpeted the latest revisions to the "Two Midnight Rule."[1] Overlooked by most commentators, however, was the ticking time bomb largely unrelated to the OPPS that was appended at the end of the 311-page document: final rules significantly amending the Medicare Part A cost reporting and appeals process.[2] The amended cost reporting and appeal rules are effective for, and apply to, cost reporting periods beginning on or after January 1, 2016. This article reviews the historical context, discusses the amended rules, and concludes with commentary on the revisions.

## From *Bethesda* to "Gotcha": The Ever Narrowing Scope of the Part A Appeals Process

A Medicare participating provider is required to annually file a detailed cost report, which the Centers for Medicare & Medicaid Services (CMS) contractor (previously called the intermediary but now called the Medicare Administrative Contractor (MAC)) audits and issues to the provider as a notice of program reimbursement (NPR). Although cost reimbursement has all but disappeared, this process continues.

The Medicare Act did not initially include a Part A appeals process for a provider of services.[3] Thus, the provider had no right to appeal the audit as stated in the NPR. In 1972, Congress enacted a statute establishing an administrative and judicial appeals process for Part A Medicare reimbursement.[4] The statute established the right of hospitals and other providers to appeal reimbursement determinations to the Provider Reimbursement Review Board (PRRB or Board). The PRRB is "composed of five members appointed by the Secretary . . . . Two of such members shall be representative of providers of services. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and at least one of them shall be a certified public accountant."[5]

The statute provided that a hospital or other provider had the right to a hearing before the PRRB regarding its cost report if the provider is dissatisfied with the final determination of payment, the amount in controversy is $10,000 (or $50,000 for a group appeal), and the appeal is filed within 180 days of the date of the determination.[6] These three statutory requirements are deceptively simple; in fact, the interpretation and application of each has been litigated. In particular, from the outset a tension has existed regarding the principal subject of this article: the "dissatisfaction" requirement. As stated by CMS in the November 13, 2015 OPPS final rule, "providers have challenged our interpretation of the statutory dissatisfaction provision in litigation spanning more than 30 years."[7]

As early as 1979, the PRRB recognized its inherent authority to review any matter covered by a cost report: "the Board has the power to make any other modifications on matters covered by such cost report, even though such matters were not considered in the Intermediary's determination."[8] CMS contended, however, that the PRRB lacked jurisdiction over any claim for any costs that a hospital had not "self-disallowed"—i.e., costs the provider did not claim on its cost report because it was not entitled to reimbursement for such costs under existing regulations. Thus, CMS argued that an audit adjustment on the cost

report was mandatory to meet the dissatisfaction requirement, even if a provider filed its cost report consistent with a regulation that the provider subsequently challenged on appeal, i.e., even if claiming the cost would have been futile.

The conflicting interpretations of the PRRB and CMS regarding "dissatisfaction" ultimately reached the Supreme Court in the landmark 1988 decision in B*ethesda Hosp. Assn. v Bowen (Bethesda).*[9] In *Bethesda*, the Court rejected the argument that to challenge a regulation it was necessary for a provider to reference the challenge in its cost report. This decision was widely interpreted as meaning that a provider had the right to appeal any matter covered by the cost report, regardless of whether the provider claimed it or whether there was an audit adjustment.

In the ensuing 28 years, the *Bethesda* doctrine has gradually eroded, with CMS and the PRRB continuing to require a specific adjustment to demonstrate "dissatisfaction." Most notably, as part of a 2008 major amendment of the regulations governing PRRB appeals procedure, a prerequisite to self-disallowance for appeals of cost reporting periods beginning on or after December 31, 2008 is the requirement that a provider "present" a self-disallowed issue as a protested item in the cost report.[10]

CMS amended 42 C.F.R. § 405.1835(a)(1)(ii) to provide in relevant part that:

> Effective with cost reporting periods that end on or after December 31, 2008, **self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy** (for example, if the intermediary lacks the discretion to award the reimbursement the provider seeks for item(s)).

(Emphasis added) (the Presentment Requirement).[11]

The PRRB and the MAC have relied on the Presentment Requirement to challenge jurisdiction in numerous appeals. Hence, without regard to the substantive merits of a provider's claim, the PRRB and the MAC have played "gotcha" if the provider fails to satisfy the Presentment Requirement. As discussed below, apparently out of a concern about continued litigation contesting the validity of the Presentment Requirement, CMS decided "to eliminate an appropriate cost report claim as a requirement for Board jurisdiction."[12] But as the reader will see CMS has not in fact eliminated the Presentment Requirement. Rather, CMS has merely shifted this requirement to the new cost report rule, 42. C.F.R. § 413.24(j), which the PRRB now must review under the amended appeals rule, 42 C.F.R. § 405.1873. Thus, CMS has converted the Presentment Requirement from a PRRB jurisdictional requirement to a substantive reimbursement requirement:

> [W]e are eliminating our longstanding interpretation of the statutory dissatisfaction requirement for Board jurisdiction over appeals of a timely final contractor or Secretary determination, an interpretation that required the provider to establish its dissatisfaction by submitting an appropriate cost report claim. Under . . . this final rule, we are making an appropriate cost report claim a general substantive requirement for Medicare payment.[13]

To add to the confusion, CMS has further explained: "We did not propose shifting the dissatisfaction requirement from a Board jurisdiction requirement to a cost reporting requirement, and we are not adopting such provisions in this final rule."[14]

## The Amended Cost Reporting Regulation: "Claim or Explain"

CMS has added a new paragraph (j) to the regulation at 42 C.F.R. § 413.24, which for the first time provides that the contents of the cost report establish a substantive reimbursement requirement for an appropriate cost report claim and which, as discussed below, requires the PRRB to review the cost report as a substantive reimbursement requirement as opposed to a jurisdictional requirement.

Paragraph (1) of this rule requires the provider either to: "[c]laim[ ] full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy" or "[s]elf-disallow[ ] the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the Contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item) . . . ."[15] Thus, CMS has not eliminated the Presentment Requirement. Rather, CMS in effect has transferred the Presentment Requirement from the appeal rules, where it had jurisdictional significance, to the cost reporting rules, where it has substantive payment significance.

Under the new cost reporting rule, the provider must "claim or explain," i.e., if the provider does not claim payment for an

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item, the provider must self-disallow. Paragraph (2) specifies the procedural requirements for a self-disallowed claim by requiring the provider to "[i]nclude an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report" and "[a]ttach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item."[16]

Paragraph (3) establishes that whether a cost report claim is appropriate "must be determined by reference to the cost report that the provider submits originally to, and was accepted by, the contractor for such period" unless the provider submits and the MAC accepts an amended cost report.[17] Finally, "[i]f the contractor reopens either the final contractor determination for the provider's cost reporting period . . . or a revised final contractor determination for such period and the contractor adjusts the provider's cost report with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the most recent revised final contractor determination for such period."

Paragraph (4) sets forth the reimbursement effect of the provider's claim by establishing three options for the MAC.[18] First, the MAC must allow reimbursement "[i]f the contractor determines that the provider's cost report included an appropriate claim for a specific item . . . and that all the other substantive reimbursement requirements for the specific item are also satisfied . . . ." Second, the MAC must make an appropriate adjustment "[i]f the contractor determines that the provider made an appropriate cost report claim for a specific item but the contractor disagrees with material aspects of the provider's claim . . . ." Finally, [i]f the contractor determines that the provider did not make an appropriate cost report claim for a specific item, the final contractor determination must not include any reimbursement for the specific item, *regardless of whether the other substantive reimbursement requirements for the specific item are or are not satisfied*." (Emphasis added.)

Finally, Paragraph (5) provides that if "any party" (presumably the MAC, but, notably, not the PRRB) "questions whether the provider's cost report included an appropriate claim for the specific item under appeal" then the "reviewing entity" (i.e., either the PRRB or the MAC for appeals with Medicare impacts of less than $10,000) "must follow the procedures prescribed in § 405.1873 (i.e., the amended PRRB appeals regulation if the appeal is filed with the PRRB) or the procedures set forth in § 405.1832 (i.e., the amended appeals regulation if the appeal was filed initially with the contractor)."[19] Significantly, the reviewing entity's determination must be based on the provider's compliance with the cost reporting requirements of new Section 413.24(j):

> The reviewing entity must follow the procedures set forth in paragraph (j)(3) of this section in determining whether the provider's cost report included an appropriate claim for the specific item under appeal. The reviewing entity may permit reimbursement for the specific item under appeal solely to the extent authorized by § 405.1873(f) of this chapter (if the appeal was filed originally with the Board) or by § 405.1832(f) of this chapter (if the appeal was filed initially with the contractor).

This provision evidences, again, that CMS has transferred the Presentment Requirement from the appeal rules to the cost reporting rules where it has become a condition of payment.

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## The Amended Appeals Rule

The rules were amended for PRRB appeals and for appeals alleging a Medicare impact of less than $10,000 that may be appealed before the MAC.[20] Most readers are unlikely to have an interest or participate in contractor appeals and, therefore, this article's focus is the amended rules for appeals before the PRRB—specifically, amended rule 42 C.F.R.§ 405.1835, the new rule 42 C.F.R. § 405.1873 entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim," and the amended rule regarding CMS Administrator review of a PRRB decision, 42 C.F.R. § 405.1875(a)(2)(v), which mirrors the amended cost report and appeals rules.

***Section 405.1835***

First, CMS amended 42 C.F.R. § 405.1835 by deleting the Presentment Requirement as a jurisdictional matter. In doing so, CMS explained as follows:

> Thus, because we would require an appropriate cost report claim in proposed § 413.24(j), it is reasonable to eliminate the Board jurisdiction requirement in existing §§ 405.1835(a)(1) and 405.1840(b)(3) of an appropriate cost report claim. We note that once this amendment to the Board appeals regulations becomes effective, this proposal will facilitate an orderly end to any litigation

regarding the Board jurisdiction requirement of an appropriate cost report claim.[21]

***Section 405.1873***

Next, CMS promulgated an entirely new section, 42 C.F.R. § 405.1873, which prescribes in exacting detail the PRRB's review of whether the provider complied with the requirements of Section 413.24(j). Notably, and in stark contrast to current practice, the PRRB's findings of fact and law *will not be the bases for dismissing the provider's claim*. Rather, upon issuing its findings to the parties, the PRRB is required to issue one of four types of decisions, as discussed below.

The amended appeal rules complement the new cost reporting rule, Section 413.24(j). Thus, if a provider self-disallows an item, the provider's appeal request must include "an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item."[22]

The reader is well advised to carefully review this new rule, as well as the CMS *Federal Register* preamble commentary.[23] Lest there be any doubt, Section 405.1873 begins by cross-referencing the new cost reporting rule Section 413.25(j): "In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter)."[24] Moreover, the new rule mirrors Section 413.24(j)(5) by providing that if "any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section."[25] In the event a party, likely the MAC, raises such a question, the PRRB is required to "give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal."[26] Those accustomed to receiving the MAC's jurisdictional check list should be prepared to receive a Section 413.24(j) cost report check list. The PRRB "must follow the procedures set forth in § 413.24(j)(3) of this chapter for determining whether the provider's cost report included an appropriate claim for the specific item under appeal."[27]

Although the Medicare Act and regulations confer broad authority on the PRRB,[28] the PRRB's preliminary procedures are narrowly prescribed by the amended rule. First, the PRRB must give the parties an opportunity to submit factual evidence and legal arguments, on which the PRRB must issue findings of fact and law based on the provisions of Section 413.24(j)(3);[29] i.e., the PRRB's focus is restricted to the provider's cost report. Second, the PRRB's "specific findings of fact and conclusions of law . . . must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction over a specific item or take any other of the actions specified in paragraph (c) of this section."[30]

***The Four Types of PRRB Decisions***

"Upon giving the parties to the appeal the Board's written specific factual findings and legal conclusions (pursuant to paragraph (b)(1) of this section) on the question of whether the provider's cost report included an appropriate cost report claim for the specific item under appeal, the Board must proceed to issue one of . . . four types of overall decisions."[31] The four types of decisions are: a hearing decision, an expedited judicial review (EJR) decision granting EJR,[32] a jurisdictional dismissal decision, and a decision deny denying EJR.[33] Here the rule becomes somewhat complex, as follows, in further prescribing the PRRB's actions regarding each of these four types of decisions:

*A PRRB Hearing Decision*[34]

The PRRB's factual findings and legal conclusions regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal must be contained in a PRRB hearing decision. The regulation is further prescriptive, providing that if the PRRB finds that the provider's cost report contained an appropriate claim, the "decision must also address whether the other substantive reimbursement requirements for the specific item are also satisfied . . . ."[35] If, however, the PRRB finds that the provider's cost report did not contain an appropriate claim, "the Board has discretion whether or not to address in the Board's hearing decision whether the other substantive reimbursement requirements for the specific item are also satisfied."[36]

The PRRB may permit reimbursement under this type of decision, "but only if the Board further determines in such final hearing decision that all the other substantive reimbursement requirements for the specific item are also satisfied."[37] Otherwise, it "is not reimbursable, regardless of whether the Board further determines in such final hearing decision that the other substantive reimbursement requirements for the specific item are or are not satisfied."[38]

*A PRRB EJR Decision Granting EJR*[39]

The PRRB's factual findings and legal conclusions regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal must be contained in a PRRB decision granting EJR.

If the PRRB finds that the cost report included an appropriate claim for the specific item under appeal, "the specific item is reimbursable in accordance with Medicare policy, but only to the extent permitted by the final decision of a Federal court pursuant to the EJR provisions of . . . the [Medicare] Act . . . ."[40] Otherwise, the item is not reimbursable unless the PRRB's findings "are reversed or modified by the final decision of a Federal court . . ." and "[o]nly to the extent otherwise permitted by the final decision of a Federal court pursuant to the EJR provisions of [the Medicare Act]."[41]

*A PRRB Jurisdictional Dismissal Decision*[42]

The PRRB's factual findings and legal conclusions regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal must not be contained in a PRRB juris-

dictional dismissal decision. The PRRB may not permit reimbursement under this type of decision.

*A PRRB EJR Decision Denying EJR*[43]
The PRRB's factual findings and legal conclusions regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal must not be contained in a PRRB decision denying EJR. If the PRRB conducts further proceedings, the PRRB's factual findings and legal conclusions regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal must be included if EJR is granted and must not be included if there is a jurisdictional dismissal decision or a decision denying EJR.

The rule also prohibits the PRRB from issuing specific types of decisions, orders, and other actions. Thus, if the PRRB finds that the cost report did not include an appropriate claim for the specific item under appeal, the PRRB may not, based on that finding, deny jurisdiction over the item, decline to exercise jurisdiction over that item, or impose sanctions (including the sanctions specified in 42 C.F.R. § 405.1868(b), (c), or (d)) except as provided in 42 C.F.R. § 405.1873(f).[44] Further, without regard to the PRRB's findings whether the cost report included an appropriate claim for the specific item under appeal, the PRRB may not:

> (I) Deny jurisdiction over the specific item under appeal, based on (in whole or in part) the absence, in the final contractor determination or Secretary determination under appeal, of an adjustment, revision, correction, or other change to the specific item under appeal, or the lack of a particular determination by the contractor or the Secretary regarding the specific item. Exception: If the provider's appeal of the specific item is based on a reopening of such item (pursuant to § 405.1885) where the specific item is not revised, adjusted, corrected, or otherwise changed in a revised final contractor or Secretary determination, the Board must deny jurisdiction over the specific item under appeal (as prescribed in §§ 405.1887(d) and 405.1889(b));
>
> (II) Decline to exercise jurisdiction over the specific item under appeal, based on (in whole or in part) the absence, in the final contractor determination or Secretary determination under appeal, of an adjustment, revision, correction, or other change to the specific item under appeal, or the lack of a particular determination by the contractor or the Secretary regarding the specific item; or
>
> (III) Take any of the actions set forth in § 405.1868(b), (c), or (d), impose any sanction, or take any other action against the interests of any party to the appeal, except as provided in paragraph (f) of this section, based on (in whole or in part) the absence, in the final contractor determination or Secretary determination under appeal, of an adjustment, revision, correction, or other change to the specific item under appeal, or the lack of a particular determination by the contractor or the Secretary regarding the specific item.[45]

***CMS Administrator Review***
The final decision of the PRRB is subject to review by the CMS Administrator.[46] The applicable rule, 42 C.F.R. § 405.1875(a)(2)(v), was amended to provide that the decision of the Administrator "will address, the Board's specific findings of fact and conclusions of law in such hearing decision or EJR decision . . . on the question of whether the provider's cost report included an appropriate claim for the specific item under appeal (as prescribed in § 413.24(j) of this chapter)." Thus, this review is focused on the cost report.

## Comments
In furtherance of the professed interest of eliminating jurisdictional disputes regarding the Presentment Requirement, CMS has linked the cost reporting and the appeal rules. As noted in this article, a dramatic shift has taken place during the past quarter century from the broad appeal rights the Supreme Court recognized in *Bethesda* to what, in a very practical sense, has become a game of "gotcha" in which one misstep can result in forfeiture of appeal rights and Medicare payment. The procedural requirements for asserting and pursuing an appeal are reminiscent of the long-abandoned Common Law Forms of Action, in which the "form" of the action outweighed the substance of the cause of action.[47] Cost report filing requirements essentially have become conditions of payment, and thus CMS may deny payment to a provider who fails to satisfy such procedural requirements even if substantive requirements have been satisfied. This amendment reflects a major paradigm shift, effectively devoting the resources of PRRB more greatly to resolving the question of "what did the provider claim, and when did the provider claim it?"

Further, the amended rules ignore the provider's right under 42 U.S.C.§ 1395oo(a) to appeal *the final determination of payment*, which typically occurs upon issuance of an NPR several years after the cost report is filed. In effect, to use a baseball analogy, the batter is being required to swing before the pitcher throws the ball. Indeed, in order for a provider to appeal unlawful CMS action, the amended rules require a provider to be aware of the action. Frequently, however, providers do not possess this knowledge. One example is the litigation successfully challenging the Rural Floor Budget Neutrality Adjustment, in which greater than 2,200 hospitals nationwide filed appeals culminating in *Cape Code Hospital v Sebelius*.[48] A second wave of hospitals filed appeals after CMS settled the litigation.[49] A precious few hospitals would have recovered the payment to which they were entitled had they been required to include this item in their cost reports, since most hospitals did not and could not be aware of this issue when they filed their cost reports.

Historically, a provider would seek assistance from its legal counsel or consultant upon receipt of the final determination, typically the NPR. Under the new Section 413.24(j) rule, however, the scope of the appeals process, in large part, will

begin with, and will be determined by, the cost report filing. To ensure effective appeals, assistance from legal counsel may be required at the earlier cost report filing stage rather than the later NPR date. Like the new rules or not, the fact is that they apply to the provider's fiscal year beginning January 1, 2016. Providers, along with their legal and consulting representatives, are well advised to comply with the new cost reporting requirements to assure that payment is made for all items desired and that appeals are preserved for items that the provider is prohibited from claiming.

## About the Author

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**This article is not intended to furnish legal advice. Readers wishing to discuss this article may contact Mr. Marcus at kmarcus@honigman.com or 313-465-7470.*

## Endnotes

1 *See, e.g.*, King & Spalding Health Headlines, Nov. 2, 2015, *available at* http://www.kslaw.com/News-and-Insights/PublicationDetail?us_nsc_id=9224.
2 Display copy published October 30, 2015; Official rule published in 80 Fed. Reg. 70298, 70551-70580 (commentary), 70597-70602 (appeals rules), 70603-70604 (cost reporting rule) (Nov. 13, 2015).
3 A provider is a hospital, hospice program, critical access hospital, comprehensive outpatient rehabilitation facility, renal dialysis facility, federally qualified health center, home health agency, rural health clinic, skilled nursing facility, and any other entity designated a provider under the Medicare Act. 42 C.F.R. § 405.1801(b)(1).
4 42 U.S.C. § 1395oo.
5 *Id.* § 1395oo(h).
6 *Id.* § 1395oo(a). The appeals statute was amended with the advent of the Prospective Payment System with the addition of Paragraph (a)(1)(A)(ii): "is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title . . . ."
7 80 Fed. Reg. 70564.
8 PRRB Dec. No. 79-D22 (Apr. 13, 1979) (Medicare and Medicaid Guide (CCH) ¶ 29,913).
9 485 U.S. 399 (1988).
10 *See* 42 C.F.R. § 1835(a)(1)(ii); PRRB Rules, Section 7.2C.
11 The Presentment Requirement was successfully challenged for an appeal from a "delayed NPR" (an appeal filed within 180 days of the first anniversary of a properly filed cost report) under 42 U.S.C.§ 1395oo(a)(1)(B) and (a)(3), resulting in an injunction issued by the court in *Charleston Area Med. Ctr. v Sebelius,* No. 13-766 (D.D.C. Aug. 6, 2014). The court in that case enjoined CMS, the PRRB, and the MACs from invoking 42 C.F.R. § 405.1835(a)(1)(ii) where a provider appeals from a delayed NPR.
12 80 Fed. Reg. 70564.
13 *Id.* at 70565.
14 *Id.* at 70569.
15 42 C.F.R. § 413.24(j)(1).
16 *Id.* § 413.24(j)(2)
17 *Id.* § 413.24(j)(3). CMS has stated that the decision whether to accept an amended cost report is solely within the discretion of the MAC. In practice, the PRRB will not assert jurisdiction over the MAC's refusal to accept an amended cost report. One exception is that solely for additional disproportionate share hospital Medicaid eligible days the provider has one year to file an amended cost report. 80 Fed. Reg. 70553.
18 42 C.F.R. § 413.24(j)(4).
19 *Id.* § 413.24(j)(5).
20 42 C.F.R §§ 405.1803-1834.
21 80 Fed. Reg. 70565.
22 42 C.F.R. § 405.1835(b)(2)(iii).
23 80 Fed. Reg. 70298, 70551-70580. The preamble discussion and the regulatory text are *available at* https://www.gpo.gov/fdsys/pkg/FR-2015-11-13/pdf/2015-27943.pdf.
24 42 C.F.R. § 405.1873(a).
25 *Id.*
26 *Id.* § 405.1873(b).
27 *Id.*
28 42 U.S.C. § 1395oo(d) and (e).
29 42 C.F.R. § 405.1873(b)(1).
30 *Id.* § 405.1873(b)(2).
31 *Id.*
32 The PRRB is bound by the Medicare Act, regulations, and CMS rulings. If an appeal over which the PRRB possesses procedural jurisdiction challenges any of these legal authorities, the PRRB is required to grant EJR, which enables the provider to file a complaint in federal district court. 42 U.S.C. § 1395oo(f)(1).
33 42 C.F.R. § 405.1873(d) and (e).
34 *Id.* § 405.1873(d)(1).
35 *Id.* § 405.1873(d)(1)(i).
36 *Id.* § 405.1873(d)(1)(ii).
37 *Id.* § 405.1873(f)(1)(i).
38 *Id.* § 405.1873(f)(1)(ii).
39 *Id.* § 405.1873(d)(2).
40 *Id.* § 405.1873(f)(2)(i).
41 *Id.* § 405.1873(f)(2)(ii).
42 *Id.* § 405.1873(e)(1).
43 *Id.* § 405.1873(e)(2).
44 *Id.* § 405.1873(c)(1).
45 *Id.* § 405.1873(c)(2).
46 42 C.F.R. § 405.1875.
47 For an historical discussion of the Common Law Forms Of Action, *see* Medieval Sourcebook: F.W. Maitland: The Forms of Action At Common Law, 1909 *available at* http://legacy.fordham.edu/halsall/basis/maitland-formsofaction.asp.
48 677 F.Supp. 2d 18 (D.D.C. 2009); vacated, 630 F.3d 2013 (D.D.C. 2011).
49 *See CMS May Owe $3 Billion,* Modern Healthcare, Apr. 14, 2012, *available at* http://www.modernhealthcare.com/article/20120414/MAGAZINE/304149931.

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