
HCFA Rulings

Department of Health
and Human Services

Health Care Financing
Administration

Ruling No. 86-2

Date: July, 1986

HCFA Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, and related matters.

HCFA Rulings are binding on all HCFA components, the Provider Reimbursement Review Board and Administrative Law Judges who hear Medicare appeals. These decisions promote consistency in interpretation of policy and adjudication of disputes.

HCFAR 86-2-1

MEDICARE PROGRAM

Hospital Insurance Benefits (Part A)

Provider Reimbursement Review Board Jurisdiction Over Challenges to the Application or the Validity of the Medicare Regulation Governing Apportionment of Malpractice Insurance Costs (42 CFR 405.45)

HCFAR 86-2

Purpose: This Ruling states HCFA policy that the Provider Reimbursement Review Board lacks jurisdiction to hear a provider's challenge to the application or validity of 42 CFR 405.457 until the provider receives a Notice of Program Reimbursement (NPR) or revised NPR reflecting the fiscal intermediary's application of §405.457 to the provider's cost report, the amount in controversy (as calculated by reference to such NPR or revised NPR) is \$10,000 or more (\$50,000 in the case of a group appeal), and the provider timely requests a hearing on the NPR or revised NPR.

Citations: Section 1878 of the Social Security Act (42 U.S.C. 1395oo); 42 CFR Part 405, Subpart R

Pertinent History: On its 1983 cost report, the provider claimed reimbursement for malpractice insurance costs in excess of the amount allowable using the apportionment method mandated under 42 CFR 405.452(b)(1)(ii)(1980), recodified as 42 CFR 405.452(a)(1)(ii) ("1979 malpractice rule"). The provider received a Notice of Program Reimbursement reflecting an adjustment resulting from the intermediary's application of the 1979 malpractice rule, and timely filed a

HCFAR 86-2-2

request for a hearing with the Provider Reimbursement Review Board (the Board), together with a request for an expedited administrative review determination, pursuant to 42 CFR 405.1842, which would enable the provider to challenge the validity of §405.452(a)(1)(ii) in court without first obtaining a Board hearing. While the provider's request was pending before the Board, the Secretary removed the 1979 malpractice rule from the Medicare regulations and promulgated a superseding regulation, 42 CFR 405.457, governing apportionment of malpractice insurance costs for cost reporting periods beginning on or after July 1, 1979. 51 FR 11142, 11195-11196 (April 1, 1986). The preamble to the new regulation makes clear that the provisions of the new rule will be applied by the intermediaries to all open cost reports, including those for which the provider has timely appealed its reimbursement for malpractice insurance costs to the Board and the appeal is still pending. 51 FR 11149. The provider questions whether it may simply substitute in its pending appeal a challenge to the validity of the newly promulgated §405.457 and obtain an expedited administrative review determination from the Board without waiting for the intermediary to issue a revised NPR reflecting application of the new regulation. The provider proposes to estimate the amount of reimbursement it expects to receive under the new regulation for purposes of asserting the statutory minimum amount in controversy.

The Medicare statute, 42 U.S.C. §1395oo(a), provides that a Medicare provider may obtain a hearing "with respect to a [timely filed] cost report by a Provider Reimbursement Review Board" if (1) the provider "is dissatisfied with a final determination of ... its fiscal intermediary ... as to the amount of total program reimbursement due the provider ... for the period covered by such

HCFAR 86-2-3

report," (2) the amount in controversy is at least \$10,000, and (3) the provider files a request for a hearing within 180 days after "notice of the intermediary's determination" Medicare regulations at 42 CFR 405.1835 reiterate that a provider may obtain a hearing before the Board only if an "intermediary determination has been made with respect to the provider," the provider's hearing request is timely, and the amount in controversy is \$10,000 or more. See also 42 U.S.C. §1395oo(b); 42 CFR 405.1837 (group appeal jurisdictional prerequisites).

For cost reporting periods prior to the onset of the Prospective Payment System (PPS) and for non-PPS providers, "intermediary determination" is defined in the regulations as "a determination of the amount of total reimbursement due the provider, pursuant to §405.1803 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." 42 CFR 405.1801(a)(1). "Amount in controversy" for purposes of appealing pre-PPS reimbursement determinations is computed under the regulations "by deducting the adjusted total reimbursable program costs due the provider on a reasonable cost basis from the total reimbursable costs claimed by the provider." 42 CFR 405.1839(a)(2). See also 42 CFR 405.1839(b)(2) (group

appeals). Section 405.1807 of the regulations provides that an intermediary determination shall be final and binding on the parties to the determination unless it is revised in accordance with §405.1885, or a Board hearing is requested and a hearing decision rendered. Section 405.1885 provides that an intermediary decision shall be reopened and revised by the intermediary upon notification by the Health Care Financing Administration (HCFA) that the

HCFAR 86-2-4

decision is inconsistent with applicable law, regulations or general HCFA instructions. That section also permits reopening and revision of matters at issue on the cost report on motion of the intermediary or the provider, so long as the request to reopen is made within 3 years of the intermediary determination or Board hearing decision. Pursuant to this provision, an intermediary may in its discretion grant a provider's motion to reopen its determination with respect to certain matters at issue on the cost report while declining to permit reopening with respect to other matters affecting the NPR. Section 405.1889 of the regulations provides that "[w]here a revision is made in a determination or decision on the amount of program reimbursement," the revision "shall be considered a separate and distinct determination of decision to which the provisions of [§405.1835 and other sections relating to administrative and judicial review] are applicable."

On April 1, 1986, the Secretary published an interim final regulation governing the apportionment for Medicare reimbursement purposes of malpractice insurance costs incurred by Medicare providers in cost reporting periods beginning on or after July 1, 1979. 51 FR 11142. Promulgation of this new regulation, 42 CFR 405.457, effective May 1, 1986, rendered a nullity the 1979 malpractice rule which had previously governed the apportionment of malpractice insurance costs for cost reporting periods beginning on or after July 1, 1979, and the superseded regulation was removed. 51 FR 11195. As the preamble to §405.457 explains, intermediary determinations based upon the superseded regulation will be revised to apply the provisions of §405.457, subject to the rules of administrative finality and reopening. See 51 FR 11149, 11187- 11188. Specifically, the preamble states in part:

HCFAR 86-2-5

The intermediary will automatically calculate reimbursement amounts for all open cost reports, including the cost reports for which the provider has timely appealed its reimbursement for malpractice insurance costs to the intermediary or the Provider Reimbursement Review Board (PRRB) in accordance with 42 CFR Part 405, Subpart R, of the Medicare regulations and that appeal is still pending. Within the reopening period specified in the regulations (that is, three years from the date of the NPR or last review decision), a provider may also request that a cost report determination be reopened for recalculation under this final rule.

51 FR 11149. Accordingly, if the intermediary has not yet issued a Notice of Program Reimbursement (NPR) with respect to a cost report, the intermediary will apply the provisions of 42 CFR 405.457 to the costs claimed for malpractice

insurance. (To avoid disadvantaging any provider for periods beginning prior to May 1, 1986, however, adjustments will not be made to the extent that they would result in less reimbursement than would have been due under the superseded regulation. See 51 FR 11149.) If the intermediary has already issued an NPR for a cost reporting period using the now-defunct apportionment method contained in 42 CFR 405.452(a)(1)(ii) and the provider has requested a Board hearing on the issue of reimbursement for malpractice costs, and if such appeal is still pending before the Board, the intermediary will issue a revised NPR reflecting its application of §405.457. Similarly, if the Board has issued a decision following a hearing, or certified a challenge to the validity of the superseded regulation for expedited administrative review pursuant to 42 CFR 405.1842, and the provider has timely filed a complaint which is still pending in federal court challenging the application or the validity of 42 CFR 405.452 (a)(1)(ii), the intermediary will issue a revised NPR reflecting application of §405.457. Finally, if the intermediary issued an NPR for a cost reporting

HCFAR 86-2-6

period reflecting adjustments resulting from application of the now-superseded §405.452(a)(1)(ii) and the provider did not timely request a Board hearing, the provider may within 3 years of the date of the NPR request reopening and a revised NPR to reflect application of §405.457; the intermediary's NPR for the affected cost reporting period will be reopened for the sole purpose of applying §405.457, unless the intermediary in its discretion agrees to reopen other matters at issue on the cost report, pursuant to 42 CFR 405.1885.

Under the Medicare statute and regulations, the intermediary's NPR provides the basis for Board review, as well as being the determinative factor in calculation of both the amount in controversy and the time limitation for filing a request for a hearing. Unless an NPR, reflecting an adjustment with which the provider disagrees, has been issued, the Board therefore lacks jurisdiction to hear a provider's appeal.

Ruling: Accordingly, it is held that the Board has no jurisdiction to grant a hearing to a provider that wishes to challenge the application or the validity of 42 CFR 405.457 with respect to a cost reporting period until such time as the intermediary issues to the provider an NPR or revised NPR reflecting application of that regulation (including in the case of those pre-May 1, 1986 cost reporting periods in which no adjustments are made due to the intermediary's determination that the superseded regulation yielded greater reimbursement, an NPR or revised NPR reflecting this determination under the new regulation). Similarly, the Board has no jurisdiction to entertain a provider's request for expedited administrative review to challenge the validity of §405.457 until such an NPR or revised NPR is issued. The Board may not entertain such a request

HCFAR 86-2-7

based on a provider's pending challenge to the application or validity of 42 CFR 405.452(a)(1)(ii), which no longer has effect; nor may the amount in controversy

for purposes of determining Board jurisdiction be calculated by reference to the provider's estimates rather than by reference to the intermediary's final determination.

This result will not unduly delay the administrative and judicial review of provider claims for malpractice insurance costs, since intermediaries have already begun to issue tentative settlements under 42 CFR 405.457 in pending cases, and in many of these cases, revised NPRs will be issued within the next several weeks.

Moreover, for most cost reports to which the 1979 malpractice rule was originally applied and with respect to which the providers have submitted sufficient information to the intermediaries to facilitate the application of §405.457, HCFA anticipates that revised NPRs will be issued by fall 1986.

DATED: July 2, 1986

/s/ Glenn M. Hackbarth for
William L. Roper, M.D.
Administrator,
Health Care Financing
Administration

Effective Date: July 2, 1986

U.S. Government Printing Office 1986 - 91-264 42197