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INTRODUCTION

The Medicare health insurance program for the elderly and disabled was created in 1965. The Secretary of the Department of Health and Human Services (the “Secretary”) now administers the program, in large part under the auspices of the Health Care Financing Administration (“HCFA”). Medicare covers both medical facility expenses, commonly known as “Part A” costs, and charges for professional services, commonly known as “Part B” costs. Medical institutions, such as hospitals and skilled-nursing-facilities, participate in the Medicare program pursuant to provider contracts with the Secretary. Such providers usually interact with the program through a “fiscal intermediary,” a private insurance company also under contract with the Secretary.

Once the Medicare program began operations, payment disputes arose out of the determinations made by the intermediaries. Initially, a provider dissatisfied with its Medicare payment could bring an action in Claims Court, asserting breach of the provider

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2. See 42 U.S.C. § 1395cc (1994). Part A Medicare providers include: hospitals, skilled-nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies and hospices. See 42 U.S.C. § 1395x(u) (1994). In this article, the term “providers” is a shorthand reference for these types of institutions.

agreement. In 1973, the Provider Reimbursement Review Board ("the Board" or "PRRB") was created to provide for administrative review of such disputes. Pursuant to this process, providers dissatisfied with the amount of Part A program reimbursement determined by the fiscal intermediary must exhaust the administrative remedies before the Board as a jurisdictional prerequisite to judicial review. Thus, the provisions of 42 U.S.C § 1395oo governing PRRB jurisdiction and scope of review are critical to a provider's ability to obtain judicial review of Part A reimbursement disputes.

Historically, the Secretary and providers have clashed over whether the Board conducts de novo review of the provider's right to Part A payment or purely appellate review of the fiscal intermediary's reimbursement determination. Providers contend that 42 U.S.C. § 1395oo empowers the Board to decide all reimbursement matters for the cost reporting period at issue, while the Secretary contends that the statute contains an implicit exhaustion requirement limiting Board review to claims expressly presented to and decided by the fiscal intermediary.

This article details the history of that dispute from the Secretary's original narrow reading of the statute to the Supreme Court's rejection of that view. Also explained are the Secretary's attempt to breathe new life into the restrictions previously imposed on PRRB hearings and the peculiar judicial response to the Secretary's current position — courts of appeals that originally agreed with the Secretary now adopt the providers' view and vice-versa. Finally, a unified reading of 42 U.S.C. § 1395oo is proposed.

I. THE STATUTORY LANGUAGE GOVERNING PRRB JURISDICTION AND SCOPE OF REVIEW

A. The Statutory Prerequisites for PRRB Jurisdiction over a Part A Payment Dispute

Medicare providers report their costs on an annual basis by filing a Medicare cost report. The fiscal intermediary audits and "settles" the cost report by making audit adjustments thereto; thereafter the

intermediary issues the Notice of Program Reimbursement ("NPR"), the determination of total Part A reimbursement due the provider for the cost-reporting period in question. In most cases, the NPR triggers the administrative review process before the PRRB.

As amended, 42 U.S.C. § 1395oo(a) delineates the process through which a provider obtains a PRRB hearing as follows:

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 cost report by a Provider Reimbursement Review Board (hereinafter referred to as the "Board") which shall be established by the Secretary in accordance with subsection (h) and (except as provided in subsection (g)(2)) any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1886 [42 U.S.C. § 1395ww(b) or (d)] and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may obtain a hearing with respect to such payment by the Board, if —

(1) such provider —

(A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to [42 U.S.C. § 1395h] 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 title [42 U.S.C. § 1395 et seq.] for the period covered by such report, or

(ii) is dissatisfied with a final determination of the Secretary as to the amount of payment under subsection (b) or (d) of section 1886 [42 U.S.C. § 1395ww(b) or (d)],

(B) has not received such final determination from such intermediary on a timely basis after filing such report, where such report complied with the rules and regulations of the Secretary relating to such report, or

(C) has not received such final determination on a timely basis after filing a supplementary cost report, where such cost report did not so comply and such supplementary cost report did so comply,

(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), or, with respect to appeals under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.

Thus, the statute imposes three prerequisites for PRRB jurisdiction: (1) provider dissatisfaction with the determination of reimbursement or payment due (or the absence of such determination); (2) an amount in controversy in excess of $10,000; and (3) a hearing request filed within 180 days of the date the provider received (or should have received) the disputed determination.

B. 42 U.S.C. § 1395oo(d): The PRRB's Scope of Review Once It Obtains Jurisdiction

Congress also expressly defined the Board's scope of review once it obtains jurisdiction over a Part A reimbursement dispute. 42 U.S.C. § 1395oo(d) provides in pertinent part:

[T]he Board shall have the power to affirm, modify, or reverse a final determination 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 tension between the provider dissatisfaction required as a jurisdictional prerequisite by subsection (a) and the broad scope of Board review provided for in subsection (d) generated the "self-disallowance" controversy between the Secretary and providers.

II. SELF-DISALLOWANCE: THE SECRETARY READS THE STATUTE TO REQUIRE THAT PROVIDERS RAISE ALL ISSUES WITH THE FISCAL INTERMEDIARIES AS A PRECURSOR TO PRRB REVIEW

A. The Agency View: A Fiscal Intermediary Ruling is a Prerequisite to PRRB Review

As practice began before the PRRB, the Secretary advanced the self-disallowance theory to limit the scope of a Board hearing to
review of issues that were first presented to and decided by the fiscal intermediary. The statutory jumping-off point for this theory is the dissatisfaction requirement set forth in 42 U.S.C. § 1395oo(a)(1)(A)(i), (ii). The HCFA and the fiscal intermediaries read this requirement as a mandate for issue-specific Board jurisdiction and review. According to this view, the Board can only review issues arising out of a provider's explicit claim for reimbursement of specific costs, followed by an intermediary's audit adjustment that adversely affected (disallowed) those costs. This view is supported by the *PRRB Hearing Manual* that discusses the elements of a Board hearing request and requires that the provider identify the "specific intermediary adjustment items" in dispute. Thus, claims that the provider failed to raise with the intermediary are deemed to be "self-disallowed" and not subject to PRRB review.

The initial Board decisions regarding self-disallowance were inconsistent. In some instances, the Board reviewed reimbursement claims that had not been initially raised with the fiscal intermediary. However, the Board eventually adopted the self-disallowance theory and supplied a detailed description of the statutory construction that formed the basis of that view in *Mt. Zion Hospital Hill-Burton Group Appeal v. Blue Cross & Blue Shield Ass'n*. In applying the self-disallowance theory to refuse jurisdiction over an issue raised for the first time before the PRRB, the Board stated:

The statutory phrases "... dissatisfied with a final determination of its intermediary ... amount in controversy ..." and "... covered by such cost report ..." certainly

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9. *PRRB Hearing Manual* § 1100.131, as reprinted in [1988-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 7514. The *Hearing Manual* has since been superseded by Chapter 29 of the *Provider Reimbursement Manual* (HIM 15-I). However, the agency still requires the provider to identify the fiscal intermediary's audit adjustment that is in dispute as part of a request for Board review. *See Provider Reimbursement Manual* § 2921, as reprinted in 2 Medicare & Medicaid Guide (CCH) ¶ 7701.


indicate that a provider must have made an overt disclosure-notice of its posture on a particular issue which ordinarily would be evidenced by claiming reimbursement for a particular item on the cost report. The regulations clearly require that as a condition precedent the provider must have claimed the cost in its filed cost report to give rise to any controversy. Without any notice of a claimed cost on a cost report, the intermediary is precluded from considering the matter and making any final determination for that particular item which especially applies to self-disallowed costs. The intermediary's final determination is a statutory prerequisite for Board (or judicial) jurisdiction. Thus, the Board's jurisdiction flows from the intermediary's NPR with respect to the filed cost report, and disputes arising from costs claimed in the cost report.

The provider's entitlement to a hearing is conditioned upon the three subsections immediately following the word "If" on [sic] the basic section – see 42 USC 1395oo(a) cited above. Accordingly, the statutory language does require dissatisfaction with the Intermediary's final determination and for a controversy to exist. As stated above, the provider must disclose its position on an issue so the Intermediary can consider and make a final determination which was not done in this case. This is essential to Board jurisdiction.12

The HCFA's views on self-disallowance were buttressed by the rule of judicial deference to an agency's interpretation of a statute committed to the agency's care.13 Thereafter, the PRRB and the HCFA consistently applied the theory to deny Board jurisdiction over issues that had not been expressly claimed in a provider's cost report and reviewed by the fiscal intermediary.14

B. The Provider's View: The PRRB Possesses Broad Power to Revise the Cost Report

Providers challenged self-disallowance, often focusing on 42 U.S.C. § 1395oo(d) which defines the Board's scope of review to include matters not raised with the intermediary.15 Providers read

12. Id. at 9,841.
14. See, e.g., Part III(C) infra and cases cited therein.
15. See, e.g., Ravenswood, [1982 Transfer Binder] ¶ 31,945 at 9,608 (discussing
subsection (d) as providing for review of issues whether or not reimbursement had been claimed before the intermediary. Further support for the providers' view is found in the opening paragraph of the statute. While subsections (a)(1)(A)(i) and (ii) require dissatisfaction with the reimbursement determination as a prerequisite to PRRB review, the opening paragraph of 42 U.S.C. § 1395oo(a) provides that a Board hearing should review a cost report, not the intermediary's reimbursement determination respecting that cost report.

Even though subsection (a) specifies the cost report as the subject of a Board hearing and subsection (d) provides for a broad scope of review during such a hearing, the HCFA Administrator continued to apply the self-disallowance theory, holding that the Board lacked jurisdiction even if the provider reported the costs but did not expressly seek reimbursement for those costs. Thus, the stage was set for judicial review of self-disallowance.

C. The Pre-1988 Split in the Circuits Regarding Self-Disallowance

Not surprisingly, given the large amount of money that is usually at stake in Part A disputes, providers often sought judicial review of the administrative decisions denying Board jurisdiction over self-disallowed claims. At the court of appeals level, resolution of these cases fell into three different categories: (1) acceptance of self-disallowance theory in all instances; (2) rejection of self-disallowance in favor of broad PRRB review (on a mandatory or discretionary basis); and (3) rejection of self-disallowance only in those instances where the intermediary was without authority to provide the reimbursement or payment relief at issue.

1. The D. C., Fourth and Sixth Circuits Endorsed Self-Disallowance

a. Athens II: The D. C. Circuit Endorses Self-Disallowance as the Proper Construction of 42 U.S.C. § 1395oo(a) & (d)

The D. C. Circuit accepted the self-disallowance theory as a valid reading of 42 U.S.C. § 1395oo in 1984. Its second opinion in Athens...
Community Hospital, Inc. v. Schweiker endorsed the Secretary's view, declaring 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."\(^{17}\)

The Athens II analysis of subsection (a) is multi-faceted. First, focusing on the dissatisfaction requirement, the court stated that it did "not think Congress intended to permit a provider to claim dissatisfaction based upon its own failure to request reimbursement of a cost item."\(^{18}\) Second, the court perceived the PRRB to exercise purely appellate powers, refusing to construe the statute to allow de novo Board review of claims newly raised by providers.\(^{19}\) The court also noted that broad PRRB review would interfere with the finality of reimbursement determinations contemplated by the regulations that provide for the discretionary reopening of NPRs. The D. C. Circuit perceived the statute to be ambiguous and deferred to the regulations promulgated by the agency charged with administering the Medicare program.\(^{20}\) Finally, Athens II noted that the PRRB itself had, by then, applied self-disallowance to refuse jurisdiction in at least four cases.\(^{21}\)

The D. C. Circuit adopted a narrow reading of the power delineated in 42 U.S.C. § 1395oo(d). According to this reading, the PRRB was not granted a broad mandate to examine all aspects of a cost report. Rather, that subsection only empowered the Board "to revise aspects of the reimbursement calculation not actually contested by the provider, and possibly not considered by the intermediary (because not claimed for reimbursement by the provider), when such revision is necessary to accommodate PRRB revisions of other matters that were claimed by the provider, decided adversely by the intermediary, and then contested by the provider to the PRRB."\(^{22}\)

\(^{17}\) 743 F.2d 1, 5-6 (D.C. Cir. 1984) ("Athens II").

\(^{18}\) Id. at 6.

\(^{19}\) Id. at 7, citing its own prior opinion, Athens Community Hosp., Inc. v. Schweiker, 686 F.2d 989, 997 (D. C. Cir. 1982), modified, 743 F.2d 1 (1984).

\(^{20}\) Athens II, 743 F.2d at 7-8.

\(^{21}\) Id. at 8 & n.12 (citing Mt. Zion, [1983-1 Transfer Binder] ¶ 32,370, the PRRB Letter in Case No. 82-109 and two other unreported PRRB jurisdictional decisions).

\(^{22}\) Id. at 9.
b. The Fourth and Sixth Circuits Follow the D.C. Circuit's Lead

The U.S. Court of Appeals for the Fourth Circuit followed the D.C. Circuit's lead in accepting the self-disallowance reading of 42 U.S.C. § 1395oo. The court, ascribing a purely appellate review role to the Board, held that "a provider must affirmatively place an issue in controversy at the time it files its cost report in order to preserve its ability to appeal the matter to the PRRB."24

The U.S. Court of Appeals for the Sixth Circuit not only endorsed self-disallowance, it extended the application of the implicit exhaustion requirement that is the foundation of the theory. Fiscal intermediaries must follow the Medicare regulations. Thus, it would be futile to challenge the validity of a regulation in a filing submitted to the intermediary. However, the Sixth Circuit applied self-disallowance to such claims, even though it recognized that the application of the theory in such circumstances did not serve the policies that generally underlie the exhaustion doctrine because the intermediary cannot offer any remedy regarding a challenge to the validity of a regulation.27

2. The First, Seventh and Ninth Circuits Reject Self-Disallowance

The Secretary's self-disallowance interpretation of 42 U.S.C. § 1395oo was not well received in other circuits. While analyzing the question differently, the Courts of Appeals for the First, Seventh and Ninth Circuits all rejected self-disallowance.

a. The First Circuit: The Board Has Discretionary Authority to Review Self-Disallowed Claims

The First Circuit's St. Luke's Hospital v. Secretary of Health and

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24. Id. at 1262-63 (footnote omitted).
Human Services decision rejected the self-disallowance theory of PRRB jurisdiction. Initially, the court recognized that the Board is not solely an appellate review entity. Specifically, the court noted that the Board's role is hybrid in nature — its initial fact-finding functions of receiving testimony, cross-examination and new evidence necessarily imply review of some claims raised for the first time at the Board level. St. Luke's also questioned the Secretary's apparent presumption that Congress intended only limited review of a private entity's decision as to the disbursement of public funds.

The First Circuit disagreed with the limited reading accorded 42 U.S.C. § 1395oo(d) by the D. C. Circuit in Athens II. The court held that the plain language of subsection (d), which expressly permits the Board to "consider matters not brought to the intermediary's attention," provides for broad PRRB review. St. Luke's, however, analogizing to the limited instances wherein appellate courts will review issues not raised before the trial court, held this power was discretionary and should be exercised sparingly by the Board, thus defusing concerns of adverse practical consequences. Proper exercise of the discretionary power specified in subsection (d) would prevent review, in hearings triggered by reopening decisions, of issues that were not reconsidered during the reopening.

The First Circuit also rejected the Secretary's plea for judicial deference to the agency's reading of 42 U.S.C. § 1395oo. First, the statutory language was unambiguous, precluding judicial deference to the agency's interpretation. Second, deference is proper only when the agency has consistently set forth its interpretation; given the Board's vacillating stance on self-disallowance, deference was not due in this instance. Further, 42 U.S.C. § 1395oo(e) grants the Board the power to make rules governing its procedure. Thus, the Board's ability to regulate the exercise of its broad scope of review

28. 810 F.2d 325, 332 (1st Cir. 1987).
29. Id. at 328-29.
30. Id. at 329.
31. Id.
32. Id.
33. Id. at 329-30. Indeed, the D.C. Circuit's worries regarding broad review of post-reopening revised NPRs is refuted by the pertinent regulation, which specifies that such revised NPRs are separate and distinct determinations. See 42 C.F.R. § 405.1889 (2000). As explained below, the case law now is clear that, on appeal from such revised NPRs, providers can only raise issues that were revised or reconsidered during the reopening. See discussion at Part V(C)(1), infra.
34. St. Luke's, 810 F.2d at 331 (citing Chevron, 467 U.S. at 842-45).
35. Id.
eliminated any need to read the statute as precluding review of newly raised issues. Finally, St. Luke's noted that deference cannot be employed to frustrate a congressional purpose and held that "[t]o interpret this statute as denying the Board the power to hear issues not raised below seems wrong, to the point where any additional 'weight' given to the administrator's interpretation simply cannot carry the day."37

b. The Seventh Circuit: 42 U.S.C. § 1395oo(d) Requires Rejection of Self-Disallowance

The Seventh Circuit rejected self-disallowance in St. Mary of Nazareth Hospital Center v. Department of Health and Human Services.38 Focusing almost exclusively on 42 U.S.C. § 1395oo(d), the court agreed with providers that the plain language of that provision "allows the Board to consider matters outside of the cost reports" as filed with the intermediaries.39

c. The Ninth Circuit: The Board Must Hear Self-Disallowed Claims

The U.S. Court of Appeals for the Ninth Circuit employed a different approach to reject self-disallowance in Adams House Health Care v. Heckler.40 First, the court held that the plain language of 42 U.S.C. § 1395oo(d) empowered the Board to review matters not presented to the fiscal intermediary.41 The Ninth Circuit also rejected the Secretary's inference that the dissatisfaction required by subsection (a)(1)(A) was an implicit mandate that providers first present every reimbursement claim to the intermediary: "Section (a) requires that a provider be dissatisfied with the total amount of reimbursement offered by an intermediary, not with the intermediary's reasoning with respect to any specific costs."42

The Ninth Circuit was not persuaded by the D. C. Circuit's concerns about potential adverse consequences of expansive Board

36. Id. at 331-32.
37. Id. at 332 (citing, inter alia, FEC v. Democratic Senatorial Campaign Comm., 454 U.S. 27, 32 (1981)).
39. St. Mary's, 698 F.2d at 1346.
40. 817 F.2d 587 (9th Cir. 1987), vacated and remanded, 485 U.S. 1018, (1988), and aff'd after remand, 862 F.2d 1371 (1988).
41. Adams House, 817 F.2d at 591.
42. Id. at 592.
review. Concerns as to frivolous provider claims were baseless because the Medicare Act contains antifraud provisions.43 Concerns that the Board would not have the benefit of the fiscal intermediary’s input were rectified by the Board’s hybrid function of initial fact-finding and review.44 Finally, broad PRRB jurisdiction would not vitiate the cost report filing deadline because the timely filing of an original or supplemental cost report is a prerequisite to a Board hearing.45 The Adams House panel also found that, as the Board was granted appellate and de novo fact-finding powers, there was no conflict between broad Board review and the reopening process.46

The Ninth Circuit also refused to defer to the agency’s interpretation. Adams House echoed St. Luke’s, which refused deference because of the Board’s inconsistency in applying self-disallowance, and further noted that the judiciary, not the agency, possesses the requisite expertise as to jurisdictional questions.47 Thus deference was not proper in this instance.

Finally, construing 42 U.S.C. §§ 1395oo(a) and (d) together, the Adams House court concluded that the Board must hear new issues raised by providers. The court noted that subsection (d) defines the Board’s powers once a hearing is properly requested.48 If a provider has met subsection (a)’s jurisdictional prerequisites, the Board has no power to refuse to hear issues that were not first presented to the intermediary.49 The Adams House decision presents the broadest view of jurisdiction and scope of review in PRRB cases.

3. The Eleventh Circuit’s Bifurcated View of Self-Disallowance

The U.S. Court of Appeals for the Eleventh Circuit adopted a bifurcated analysis of the self-disallowance question. Initially, the Eleventh Circuit adopted the Athens II reading of 42 U.S.C. § 1395oo in North Broward Hospital District v. Bowen.50 The

43. Id. (citing 42 U.S.C. § 1395nn).
44. Id. at 592-93 (citing St. Luke’s, 810 F.2d at 328). Moreover, the fiscal intermediary is a party to all Board hearings. See 42 C.F.R. § 405.1843 (2000). Thus, the Board will hear the intermediary’s views regarding all reimbursement matters at issue in a PRRB hearing.
45. Adams House, 817 F.2d at 593.
46. Id.
47. Id. at 593-94.
48. Id. at 594.
49. Id.
50. 808 F.2d 1405 (11th Cir. 1987), vacated and remanded, 485 U.S. 1018 (1988), and
North Broward panel viewed the PRRB as exercising only appellate, not de novo review powers. "The reimbursement review procedure is modeled after the civil litigation procedure, and the PRRB's review of the fiscal intermediary's decision is limited in the same manner as an appellate court's review of a trial decision: The claim had to be brought at the initial hearing to be recognized on appeal."51

However, the Eleventh Circuit later carved out an exception in Tallahassee Memorial Regional Medical Center v. Bowen, focusing on the type of claim that had been self-disallowed.52 The Tallahassee Memorial panel held that, if the fiscal intermediary could award reimbursement of the costs at issue, North Broward controlled and the provider must present the claim to the intermediary in order to preserve it for Board review.53 However, the Eleventh Circuit recognized that certain reimbursement issues, such as challenges to the validity of a regulation, were beyond the intermediary's authority.54 The court examined the legislative history of 42 U.S.C. § 1395oo, noting that the 1980 amendments thereto added a provision whereby providers could avoid exhausting fruitless administrative remedies if the agency was without authority to rule in the provider's favor.55 The court found that the language of 42 U.S.C. § 1395oo(d) was irrelevant because the 1980 amendment only referred to 42 U.S.C. § 1395oo(a).56 Freed from stare decisis as to the North Broward decision, which focused on subsection (d), the Tallahassee Memorial panel held that the PRRB could hear self-disallowed challenges to the validity of Medicare regulations.57

51. North Broward, 808 F.2d at 1409 n.6.
53. Tallahassee Mem'l, 815 F.2d at 1457-58.
54. Id.
56. Tallahassee Mem'l, 815 F.2d at 1461.
57. Id. at 1463. While the distinction drawn in Tallahassee Memorial is valid, the analysis seems incomplete. Assuming that 42 U.S.C. § 1395oo(d) has no bearing on an issue subject to the expedited judicial review process created by the 1980 amendment to subsection (f)(1), the court acknowledged that the key to expedited review was satisfaction of the requirements of subsection (a). Id. And North Broward adopted the D. C. Circuit's view, announced in Athens II, that self-disallowance was the proper reading of subsection (a). Thus, Tallahassee Memorial arguably should have, but did not, analyze the "dissatisfaction" requirement.
III. Bethesda: The Supreme Court's Analysis of the Self-Disallowance Theory

The Supreme Court examined this split in the circuits in Bethesda Hospital Ass'n v. Bowen. The Court acknowledged that the self-disallowance theory is grounded in the view that the dissatisfaction mandated by 42 U.S.C. § 1395oo(a)(1)(A) is an implicit requirement that providers exhaust the administrative remedies available at the intermediary level prior to seeking PRRB review. Bethesda employs a tripartite analysis, examining the dissatisfaction requirement of subsection (a), the broad scope of review granted the Board by subsection (d) and the Board's role in expedited judicial review cases under subsection (f)(1). After analyzing the statute as a whole, the Court rejected self-disallowance as a "strained interpretation . . . inconsistent with the express language of the statute."  

A. The Dissatisfaction Required by 42 U.S.C. § 1395oo(a)

The type of reimbursement claim brought by the providers in the case sub judice, a challenge to the validity of a regulation, drove the Bethesda analysis of 42 U.S.C. § 1395oo(a). Although agreeing that "a provider's dissatisfaction with the amount of total reimbursement is a condition to the Board's jurisdiction" and acknowledging that a hypothetical provider's failure to initially request permissible payment might preclude such dissatisfaction, the Court recognized that this analysis did not apply if the provider challenged a regulation. As the intermediaries are without authority to "award reimbursement except as the regulations provide . . . any attempt to persuade the intermediary to do otherwise would be futile." The Court concluded that, given the intermediary's inability to provide relief in cases challenging the validity of a regulation, providers in such cases "could claim dissatisfaction, within the meaning of the statute, without incorporating their challenge in the cost reports filed with their fiscal intermediaries."  

60. Id.
61. Id. at 401-02.
62. Id. at 404-05.
63. Id. at 404.
64. Bethesda, 485 U.S. at 405.
B. The Proper Construction of 42 U.S.C. § 1395oo(d)

Although the analysis of subsection (a) revolved around the specific facts presented, the Court's interpretation of the scope of review mandated by subsection (d) is more broad-based:

While the express language of subsection (a) requires the result we reach in the present case, our conclusion is also supported by the language and design of the statute as a whole . . . . Section 1395oo(d), which sets forth the powers and duties of the Board once its jurisdiction has been invoked, explicitly provides that in making its decision whether to affirm, modify, or reverse the intermediary's decision, the Board can "make any other revisions on matters covered by such cost report . . . even though such matters were not considered by the intermediary in making such final determination." This language 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.65

C. The Roles of the Board and the Intermediary Under 42 U.S.C. § 1395oo(f)(1)

Finally, again turning to the specific claim at issue, a regulatory challenge subject to expedited judicial review under 42 U.S.C. § 1395oo(f)(1), the Court distinguished the roles of the Board and the fiscal intermediaries. The fiscal intermediary has no authority regarding claims subject to expedited judicial review and plays no part in shaping the controversy for judicial review.66 While the Board is also without authority to rule on a challenge to the validity of a regulation, its role is different: The Board must determine whether the issue is beyond its authority and, thus, proper for expedited judicial review.67 Given these different roles, the Court concluded that it was unnecessary to first present

65. Id. at 405-06 (internal citation omitted).
66. Id. at 406-07.
67. Id.
regulatory challenges to the intermediaries.68

IV. INTERPRETATIONS OF BETHESDA BY THE JUDICIARY AND THE SECRETARY

A. The Initial Interpretation of Bethesda by the Courts Of Appeals

In conjunction with its Bethesda decision, the Supreme Court granted certiorari in three other cases, vacated the decisions of the Courts of Appeals therein, and remanded the cases for further review in light of Bethesda.69 The post-remand decisions in those cases by the Courts of Appeals for the Ninth, Eleventh and Sixth Circuits represent the first application of Bethesda.

1. The Ninth Circuit’s Second Adams House Decision

Following the remand, the Ninth Circuit again considered PRRB jurisdiction in view of the facts at issue in Adams House.70 Rather than challenging a regulation, the provider therein challenged an interpretive guideline published by the HCFA in the Provider Reimbursement Manual.71 The Ninth Circuit held this difference to be inconsequential; by submitting its cost report in accordance with the Manual, the provider followed the Secretary’s instructions. As the Supreme Court noted in Bethesda, “the submission of a cost report in full compliance with the unambiguous dictates of the Secretary’s rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed . . . .”72

Having concluded that the dissatisfaction requirement of subsection (a) did not preclude PRRB jurisdiction, the Ninth Circuit followed the Supreme Court’s lead in analyzing the entire statute to determine the scope of PRRB review in the case.73 The court concluded that, under subsection (d), once the PRRB obtains jurisdiction, it has the power to review matters covered by the cost report regardless of whether the precise issues were first raised.

68. Id. at 407.
70. 862 F.2d 1371 (9th Cir. 1988).
71. Id. at 1374-75.
72. Id. at 1375 (quoting Bethesda, 485 U.S. at 404).
73. Id.
with the intermediary. The provider need only reflect the cost in the cost report to ensure PRRB review of the claim.

In addition, the Ninth Circuit relied on yet another provision of the statute to uphold PRRB review of claims not presented to the fiscal intermediary. While dissatisfaction with the intermediary's determination is a jurisdictional prerequisite, the PRRB does not review the determination. Rather, the opening paragraph of subsection (a) specifies that the provider obtains a hearing with respect to the cost report. Once the dissatisfaction requirement was satisfied, the PRRB could review all matters covered by the cost report, regardless of whether the precise nature of the claim was previously disclosed to the intermediary.

2. The Eleventh Circuit's Post-Remand Decision in North Broward

As the Eleventh Circuit's subsequent description in Tallahassee Memorial makes clear, North Broward involved a claim that, although subject to intermediary authority, the providers "inexplicably failed to raise with their intermediaries." Thus, rather than filing a cost report in accordance with rules precluding reimbursement then challenging the rules, the North Broward providers failed to claim costs that were reimbursable under the existing rules. However, in its post-remand North Broward decision, the court sub silentio disregarded this fact, finding that "it would have been useless for the provider to have made a claim before the fiscal intermediary . . . ." As this characterization was on all-fours with Bethesda, the Eleventh Circuit concluded that the claim was within the Board's jurisdiction and thus subject to judicial review.

3. The Sixth Circuit's Post-Remand Interpretation of Bethesda

The facts at issue in University of Cincinnati v. Bowen must be

74. Id.
75. Id. at 1375-76 (citing Bethesda, 485 U.S. at 405-06).
76. Id. at n.3.
77. In addition, the Ninth Circuit reaffirmed its prior Adams House ruling, finding that the Board must exercise its power to review claims as to costs completely omitted from the cost report. Id. at 1375-76.
78. 815 F.2d at 1457 (citing North Broward, 808 F.2d at 1405 n.2).
79. 850 F.2d 1548, 1549 (11th Cir. 1988).
80. Id.
derived from a review of a number of decisions. The case involved claims for medical education costs for three separate cost-reporting periods, arising out of the provider's "mistaken belief" as to whether the costs were reimbursable.\(^{81}\) This original description is ambiguous as to whether the provider claimed that a reimbursement rule or regulation was invalid or merely failed to claim payment for the costs.

However, a subsequent opinion addressing the same provider's claim for reimbursement of the identical costs for later years clearly defined the nature of the claim. Rather than a challenge to a regulation or rule that precluded reimbursement, the provider challenged the intermediary's interpretation and application of the regulation to disallow its claimed costs.\(^{82}\) Thus illuminated, the first University of Cincinnati decision addressed reimbursement claims apparently subject to the intermediary's authority.

Following Bethesda, the Sixth Circuit, in an unpublished and unreported memorandum opinion, vacated its original decision.\(^{83}\) Therefore, it appears that the Sixth Circuit followed the second prong of the Bethesda analysis and found the issue properly before the Board.

B. The Secretary's Restrictive Reading of Bethesda

1. The HCFA's Attempts to Limit the Extent of Bethesda

From the moment the decision was handed down, the HCFA has attempted to limit Bethesda to instances where it would have been futile for the provider to first present the issue to the intermediary. As the HCFA Administrator stated in 1990, if there "was no regulation or other agency policy that directed the Provider not to claim these costs on its cost report," the Board lacked jurisdiction to review the provider's claim that the costs should be reimbursed.\(^{84}\) Thereafter, the HCFA consistently held that Bethesda is limited to cases where the intermediary is without authority to address the provider's claim.\(^{85}\) Initially, the HCFA Administrator did

\(^{81}\) Univ. of Cincinnati v. Bowen, 809 F.2d 307, 308 n.1 (6th Cir. 1987).
\(^{83}\) 1 Medicare & Medicaid Guide (CCH), Medicare Case Table, at 379 (June 25, 1998).
\(^{85}\) See, e.g., Bon Secours Heartlands Home Health Agency v. Blue Cross & Blue Shield Ass'n, [1993-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 41,690 (HCFA Adm'r,
not address the *Bethesda* discussion of subsection (d). Later decisions disparagingly characterize the provider's reliance on subsection (d) as an attempt to impermissibly bootstrap an untimely presented claim onto a properly presented appeal. Even when citing *Bethesda*, such later agency decisions do not address the Supreme Court's statement that "[t]he only limitation prescribed by Congress is that the matter must have been 'covered by the 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." This failure to fully address *Bethesda* undermines the HCFA's current analysis.

2. The PRRB's Inconsistent Readings of Bethesda

The PRRB's post-*Bethesda* decisions are in conflict. In some instances, the PRRB follows the HCFA's lead and holds that *Bethesda* only applies where it would have been futile to first raise the issue with the intermediary. In other instances, the PRRB holds that self-disallowed claims that could have been presented to and decided by the intermediary are within its jurisdiction and scope of review. As with the early HCFA decisions, any discussion of subsection (d) is noticeably absent from the Board decisions that limit *Bethesda* to instances where it would have been futile for the provider to raise the issue with the intermediary. When the Board hears a self-disallowed claim, it may cite the *Bethesda* discussion of subsection (d) as the source of its jurisdiction.

C. The Second Wave of Judicial Interpretation of Bethesda

As noted above, the initial judicial application of *Bethesda*...
occurred in cases remanded for reconsideration in 1988, all of which dealt with the intermediary's original determination of the amount of reimbursement due for the cost-reporting periods in question. The second wave of judicial opinions interpreting PRRB jurisdiction and scope of review under Bethesda is more expansive, generally addressing three separate fact patterns: Board hearings triggered by (1) revised NPRs; (2) original NPRs; and (3) intermediary refusals to reopen NPRs. In virtually every case, the decision turns upon whether the reimbursement determination that triggered the request for a Board hearing is a determination explicitly described in 42 U.S.C. § 1395oo(a).

1. Later Judicial Interpretations of the Impact of Bethesda in Revised NPR Cases

Revised NPRs are later determinations that change the reimbursement for a given cost-reporting period, made after the intermediary reopens the original NPR to reconsider an aspect, or aspects, thereof. Such revised NPRs are subject to PRRB review, in accordance with the regulations set forth in 42 C.F.R. Subpart R. In many PRRB cases arising out of revised NPRs, providers attempted to raise issues decided in the original NPR but not addressed in the revised NPR. Provider success in obtaining review of such issues is dependent in large part on the scope of the reopening.

Almost invariably, when a provider raises an issue that was not revisited during the reopening which led to the revised NPR, the courts hold that subsection (d) is inapplicable. The prevailing judicial analysis in this setting examines the interplay between the statutory framework of 42 U.S.C. § 1395oo, establishing the PRRB and setting forth its powers in regard to the intermediary's original reimbursement determination for a given cost-reporting period, and the regulatory scheme of 42 C.F.R. §§ 405.1885-89, providing for reopenings to reconsider that original determination and subsequent Board review of the revised NPRs. Subsection (a)(1)(A)(i) only describes original, not revised NPRs; accordingly, the analysis focuses on the regulations providing for review of

93. Id.
revised NPRs. As 42 C.F.R. § 405.1899 only provides for review of the revised NPR, the PRRB is without authority to review claims not implicated by the reopening that led to the revised NPR.

In addition to review of the statutory and regulatory text, judicial analysis in this setting often invokes a policy basis for denying review of issues that were settled in the original NPR and not considered during the reopening that generated the revised NPR. Permitting providers to raise any issue relating to the reopened cost-reporting period, regardless of whether that issue was reconsidered during the reopening, would thwart the policy of finality embodied in the appeal deadline specified by the statute.

The result is decidedly different when providers raise issues, reconsidered during the reopening, but for which no reimbursement change is made in the revised NPR. In this setting, the courts have held that the provider can obtain Board review of issues that were revisited as part of the process that results in the revised NPR. The analysis in cases where an issue was raised during the reopening, but not addressed in the revised NPR, is remarkably similar to the Bethesda analysis of subsection (d) scope of review in cases triggered by an original NPR. In both settings, once a provider timely requests a hearing regarding a reimbursement determination with which it is dissatisfied, the Board’s jurisdiction is properly invoked and its scope of review extends to all matters that were subject to the intermediary’s review, regardless of whether the intermediary made an explicit determination regarding the precise issue in question.

95. Albert Einstein, 830 F. Supp. at 851; HCA, 27 F.3d at 618-19; French Hospital, 89 F.3d at 1418-19.
96. Id.
97. Albert Einstein, 830 F. Supp. at 850; French Hospital, 89 F.3d at 1420.
98. Edgewater Hosp., Inc. v. Bowen, 857 F.2d 1123, 1134 (7th Cir. 1988), modified, 866 F.2d 228 (1989); French Hospital, 89 F.3d at 1420. See also Albert Einstein, 830 F. Supp. at 848 (provider may appeal items “examined or changed” during reopening); Del. County Mem’l Hosp. v. Sullivan, 836 F. Supp. 238, 245 (E.D. Pa. 1991) (provider may appeal items presented for review during the reopening). But see St. Mary of Nazareth Hosp. v. Schweiker, 741 F.2d 1447, 1449-50 (D.C. Cir. 1984) (a pre-Bethesda opinion holding that the PRRB cannot review claims presented during a reopening that do not result in revised reimbursement).
99. Compare Bethesda, 485 U.S. at 405, with Edgewater, 857 F.2d at 1134 and French Hospital, 89 F.3d at 1420. Indeed, such parallel analysis is supported by similarities in the text of the applicable statute and regulations. 42 C.F.R. § 405.1889 provides for PRRB review of revised NPRs pursuant to the regulations governing Board proceedings. 42 C.F.R. § 405.1869 (1978) empowers the Board to include issues not previously considered by the intermediary. Thus, consistent with the Bethesda analysis of 42 U.S.C. § 1395oo(d), that similarly worded regulation should be read to include Board review of matters presented to the intermediary during the reopening, regardless of whether the intermediary actually
2. Later Judicial Interpretations of the Impact of Bethesda on Appeals from Original NPRs

Three courts of appeals, the Seventh, D. C. and First Circuits, have again analyzed Board jurisdiction and scope of review under 42 U.S.C. § 1395oo regarding hearings arising out of original NPRs. Unfortunately, as with the prior split regarding self-disallowance, the circuits have again drawn three different conclusions as to the viability of the self-disallowance doctrine after Bethesda. Somewhat remarkably, the courts of appeals for the Seventh and D. C. Circuits now take views diametrically opposed to their prior positions.

a. The Seventh Circuit Adopts the Secretary’s Limited Reading of Bethesda

Both of the Seventh Circuit’s post-Bethesda decisions adopt the agency’s position, focusing on the Bethesda Court’s discussion of 42 U.S.C. § 1395oo(a). Little Company I interpreted the Supreme Court’s discussion of subsection (a) as suggesting “that a hospital that does not ask its intermediary to reimburse it for all of the costs for which it is entitled to be reimbursed cannot, on appeal to the Board, first ask for new costs.” Accordingly, absent a regulation or other rule precluding reimbursement, the PRRB, in a case arising out of an original NPR, cannot review issues that had not first been presented to the intermediary.

Noticeably absent from the Little Company I decision is any analysis, or even mention, of 42 U.S.C. § 1395oo(d). The reconsidered those issues and rendered a decision by revising the reimbursement related thereto.


101. Little Company I, 24 F.3d at 993; Little Company II, 165 F.3d at 1165.

102. Little Company I, 24 F.3d at 993.

103. The Seventh Circuit’s Little Company I decision also rests on a separate analysis. Id. at 998-90. The precise issue in that case was the proper assignment of DRGs under Medicare’s Prospective Payment System. Id. Pursuant to 42 C.F.R. § 412.60 (1985), a provider has a separate route to challenge such DRG assignments. Id. The Little Company I court qualified its holding regarding the scope of PRRB jurisdiction over original NPR appeals by noting that the provider had failed to exhaust this separate administrative remedy. Id. at 993.

104. The failure to discuss subsection (d) is all the more puzzling given that, prior to Bethesda, the Seventh Circuit relied on that subsection to reject the agency’s self-disallowance theory. See St. Mary, 688 F.2d at 1346.
underlying district court decision did, however, address that portion of the statute, finding that subsection (d) only permits the Board "to adjust the cost reports in certain circumstances to facilitate the remedy it imposes." The provider could not, according to the district court, employ subsection (d) to "bootstrap" issues, not contested with the intermediary, into a PRRB hearing triggered by the original NPR.

The *Little Company II* decision follows the same pattern. The Seventh Circuit's opinion again interprets the statutory language discussing dissatisfaction as a requirement that the intermediary be given the "first shot" at all issues, except those that are beyond the "intermediary's competence." This includes a requirement of "pleading in the alternative" whereby providers must inform the intermediaries of all possible alternative reimbursement theories. Again the court did not discuss 42 U.S.C. § 1395oo(d). However, the district court opinion below did address subsection (d), again holding that the section only applies to the scope of review once Board jurisdiction obtains and cannot be used to "bootstrap" new issues into a PRRB hearing.

Thus, in both *Little Company* decisions, the Seventh Circuit did not address 42 U.S.C. § 1395oo(d), and the district court opinions cite *Bethesda* as support for the Secretary's limited reading of that subsection. This, however, seems to be an overly restrictive view of *Bethesda*, which provides that subsection (d) empowers the Board "to review and revise a cost report with respect to matters not contested before the fiscal intermediary." The district court view in both cases conforms to the D. C. Circuit's prior interpretation of subsection (d). But the D.C. Circuit no longer reads the statute in so restrictive a manner.

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106. *Id.* This case is a likely genesis of the later HCFA decisions that employ the same "bootstrap" terminology. *See Conemaugh*, [1999-1 Transfer Binder] ¶ 80,126, at 200,483.


108. *Id.* at 1166.


112. *See Athens II*, 743 F.2d at 6.
b. The D. C. Circuit Ascribes a Broad Reading to Bethesda

In *HCA*, the D.C. Circuit acknowledged that *Bethesda* repudiated its prior restrictive reading of 42 U.S.C. § 1395oo(d) in cases arising out of original NPRs. *HCA* analyzes Board jurisdiction and the impact of subsection (d) in a case triggered by a revised NPR.\(^{113}\) Confronted with a claim that subsection (d) controlled regarding review in such cases, the D. C. Circuit acknowledged that, in cases where Board jurisdiction and scope of review is governed by the statute, a provider need not present a claim to the intermediary as a prerequisite of Board review. The *HCA* panel analyzed the statutory language, as construed in *Bethesda*, holding that “once Board jurisdiction pursuant to subsection (a) obtains, anything in the original cost report is fair game for a challenge by virtue of subsection (d).”\(^{114}\)

However, *HCA* also found that cases arising out of revised NPRs are controlled by the regulations, not by the statute; thus, the provider's reliance on subsection (d) was unavailing as authority for expansive Board jurisdiction and scope of review in a case triggered by a revised NPR. The court held that the Board could not hear issues decided in the original NPR that had not been reconsidered during the reopening.\(^{115}\)

c. The First Circuit Renews Its Discretionary Approach to Board Jurisdiction

The First Circuit recently confirmed that its prior views on PRRB jurisdiction and scope of review set forth in *St. Luke's* — that is, that the Board has discretion to review issues within the intermediary's authority that were not first raised with the intermediary — remain unchanged by *Bethesda*.\(^{116}\) The *Maine General* majority characterized *Bethesda* and the prior decisions by the various circuits, for example, *St. Luke's*, *Adams House* and *Athens II*, as cases dealing with Board jurisdiction under 42 U.S.C. § 1395oo as a whole, not just the dissatisfaction requirements of subsection 1395oo(a)(1)(A)(i).\(^{117}\) The majority held that the *Bethesda* passage addressing dissatisfaction “is explicitly dictum —

\(^{113}\) *HCA*, 27 F.3d at 617-18.
\(^{114}\) *Id.*
\(^{115}\) *Id.*
\(^{116}\) *Maine General*, 205 F.3d at 499-501.
\(^{117}\) *Id.* at 498-99.
'those circumstances are not present here.' "118 Moreover, the majority noted that "[t]he Secretary's position that 1395oo(a) incorporates an unwaivable and unyielding exhaustion requirement is essentially the same reading that the court rejected in Bethesda as a 'strained interpretation . . . inconsistent with the express language of the statute.' "119

Accordingly, the Maine General majority concluded that Bethesda did not undermine the St. Luke's analysis that a provider could be dissatisfied (within the meaning of subsection (a)) without first presenting a claim to the intermediary and that the Board could (but was not required to) review claims which were not first presented to the intermediary.120 In so holding, the Maine General majority found that the plain language of subsection (d) precluded any deference to the Secretary's views and was careful to again note the hybrid nature of the Board's role — "some features of initial factfinding (witnesses, cross-examination, new evidence) and some features of review."121

The Maine General dissenting opinion rejects all three rationales adopted by the majority. First, the dissent characterized St. Luke's as precedent that focused solely on 42 U.S.C. § 1395oo(d) and did not consider the dissatisfaction requirement of subsection (a).122 Further, the dissent found the Secretary's reading of the statutory term "dissatisfied" reasonable and thus entitled to Chevron deference.123 Finally, while the dissent agreed that the language in Bethesda discussing dissatisfaction was obiter dictum, the dissent viewed that passage as proof of the ambiguity in the statute that mandated deference to the Secretary's position.124

In its petition for rehearing, the agency argued that "[p]ermitting providers to entirely bypass the intermediary's expertise in favor of initial PRRB consideration of cost claims will have potentially disastrous consequences for Medicare's carefully-constructed system of review of such claims."125 The majority rejected this position, noting that the panel decision permitted the Board to

118. Id. at 499 (quoting Bethesda, 485 U.S. at 405).
119. Id. at 500 (quoting Bethesda, 485 U.S. at 404).
120. Id. at 499-501. Courts ordinarily defer to an agency interpretation of ambiguous statutory provisions that the agency is charged to implement. See Chevron, 467 U.S. at 842-43.
121. Maine Gen., 205 F.3d at 500 (citing and quoting St. Luke's, 810 F.2d at 328).
122. Id. at 503 (Cyr, J., dissenting).
123. Id. at 503-04 (Cyr, J., dissenting).
124. Id. at 504 (Cyr, J., dissenting).
adopt a blanket procedural rule refusing to exercise its power to hear such claims.126

3. The Impact of Bethesda on PRRB Jurisdiction to Review an Intermediary's Refusal to Reopen a Settled Cost Report

The courts have also interpreted Bethesda when examining whether PRRB jurisdiction extends to review of an intermediary's refusal to reopen a cost report.127 Initially, Bethesda was read to support Board jurisdiction over refusals to reopen because the Supreme Court had "rejected a restrictive reading of the Board's jurisdiction."128 Later opinions rejected this position, viewing Bethesda as an examination of the dissatisfaction necessary to support a provider's right to a PRRB hearing upon receipt of a reimbursement determination explicitly described by 42 U.S.C. § 1395oo(a).129 These courts found that analysis inapplicable to the question of whether a refusal to reopen was itself a final determination as to the amount of reimbursement due, a separate jurisdictional prerequisite under subsection (a)(1)(A).130 In addition, the analysis focused on the policy favoring finality when providers fail to request a Board hearing within the 180-day period specified by the statute.131

The Supreme Court has now resolved this dispute, finding that an intermediary's refusal to reopen a prior NPR is not subject to administrative or judicial review.132 Without any mention of Bethesda, the Visiting Nurse Court agreed with the Secretary that a refusal to reopen is not a final reimbursement determination described in and required by subsection (a)(1)(A).133 In so holding, the Court noted that the Medicare Act does not require any process for correction of reimbursement errors discovered after an original

126. Id. (citing Maine Gen., 205 F.3d at 501). Senior Judge Cyr again dissented and would have granted rehearing on the rationale that self-disallowance is a valid exercise of the agency's power to interpret 42 U.S.C. § 1395oo. Id.
128. Oregon, 854 F.2d at 349 n.5.
129. Good Samaritan, 894 F. Supp. at 690 n.8; Binghamton, 856 F. Supp. at 794 & n.5.
130. Id.
131. Mem'l Hospital, 779 F. Supp. at 1409; Binghamton, 856 F. Supp. at 796; Good Samaritan, 894 F. Supp. at 690.
132. Visiting Nurse, 525 U.S. at 455-56.
133. Id.
NPR becomes final. Finally, Visiting Nurse also invoked the "traditional rule of administrative law that an agency's refusal to reopen a closed case is generally 'committed to agency discretion by law' and therefore exempt from judicial review." The Court concluded that as the regulation that created the reopening process did not also provide for review of an intermediary's refusal to reopen an NPR, such a refusal was not subject to administrative or judicial review.

V. DELINEATING A UNIFIED THEORY OF BOARD JURISDICTION AND SCOPE OF REVIEW UNDER 42 U.S.C. § 1395oo

As demonstrated above, the viability of self-disallowance as an interpretation of 42 U.S.C. § 1395oo is driven, in large part, by the initial analytical focus. Thus, those who advocate for self-disallowance tend to focus on the dissatisfaction language in subsection (a)(1)(A)(i), concluding that this provision is an implicit exhaustion of administrative remedies requirement mandating presentation of all claims to the intermediary. On the other hand, those that advocate for de novo review by the PRRB tend to focus on subsection (d), finding therein the power for free ranging PRRB review of any issue covered by the cost report. Perhaps the most striking aspect of the history of this analytical dichotomy is the juxtaposed pre-and post-Bethesda positions of the various circuits;

134. *Id.* (citing Good Samaritan Hosp. v. Shalala, 508 U.S. 402 (1993)).
135. *Id.* (quoting ICC v. Locomotive Eng'rs, 482 U.S. 270, 282 (1987)).
136. Visiting Nurse appears to reinvigorate the "bitter with the sweet" due process analysis. See Arnett v. Kennedy, 416 U.S. 134, 153-54 (1974) (plurality opinion) (if a right is accompanied by procedural limitations on the exercise thereof, those invoking the right "must take the bitter with the sweet."). The concurring and dissenting Justices disagreed with this analysis. See *id.* at 167 (Powell and Blackmun, JJ., concurring) (once a right is created, due process attaches); *id.* at 188 (White, J., concurring and dissenting) (the state may define rights but "the Constitution defines due process"); *id.* at 211 (Marshall, Douglass and Brennan, JJ., dissenting) (bitter with the sweet approach renders due process "inapplicable to the deprivation of any statutory benefit--any 'privilege' extended by government--where a statute prescribed a termination procedure no matter how arbitrary or unfair.") The Supreme Court later rejected this analysis: "it is settled that the 'bitter with the sweet' approach misconceives the constitutional guarantee. While the legislature may elect not to confer a property interest . . . it may not constitutionally authorize the deprivation of such an interest, once conferred, without appropriate procedural safeguards." Cleveland Bd. of Educ. v. Loudermill, 470 U.S. 532, 541 (1985) (quoting *Arnett*, 416 U.S. at 167 (Powell, J, concurring in part)). But Visiting Nurse revives this analysis, holding that, where the regulation provides the right, the court should also look to the regulation for any review of the exercise thereof. Visiting Nurse, 525 U.S. at 454.
137. *See, e.g.*, Little Company II, 165 F.3d at 1165-66.
the Seventh Circuit, which originally rejected self-disallowance, now supports the theory and the D. C. Circuit, which originally accepted self-disallowance, now rejects that agency approach.\textsuperscript{139}

One guiding principle, made indisputably clear in \textit{Bethesda}, is that statutes must be construed as a whole.\textsuperscript{140} An examination of this statute as a whole, including provisions other than the dissatisfaction requirement and the language describing the scope of PRRB review, indicates that Congress intended that the Board enjoy both appellate and \textit{de novo} review powers. Moreover, the regulations defining the intermediary's role also support this construction of 42 U.S.C. § 1395oo.

\textbf{A. Deriving a Unified Theory of PRRB Review}

\textit{1. The Statute Specifies the Cost Report, Not the NPR, as the Subject of the PRRB Hearing}

The validity of self-disallowance rests on the proposition that, under subsection (a)(1)(A)(i), a provider can only be dissatisfied with an intermediary's affirmative act to deny a provider's claim for reimbursement.\textsuperscript{141} Thus, self-disallowance supporters conclude that providers who cannot demonstrate this type of dissatisfaction can never invoke the Board's jurisdiction and, therefore, can never reach the broad scope of review specified in subsection (d).

This analysis, however, ignores other aspects of the statute. If dissatisfaction with an intermediary's affirmative act is the \textit{sine qua non} of Board review, then, logically, the subject of a Board hearing would be the intermediary's determination, the NPR and the underlying audit adjustments made to derive that NPR from the cost report submitted by the provider. But the statute expressly specifies a broader subject matter for PRRB hearings. As stated in the introductory paragraph of 42 U.S.C. § 1395oo, a provider that timely files its cost report "may obtain a hearing with respect to such cost report by" the PRRB. Restricting a Board hearing to review of the NPR is a limitation that is inconsistent with this statutory language.

\begin{itemize}
\item \textsuperscript{139} Compare \textit{St. Mary}, 698 F.2d at 1346-47, with \textit{Little Company II}, 165 F.3d at 1164-65. \textit{Compare Athens II}, 743 F.2d at 7-10, with \textit{HCA}, 27 F.3d at 617.
\item \textsuperscript{140} \textit{Bethesda}, 485 U.S. at 405 (citing Offshore Logistics, Inc. v. Tallentire, 477 U.S. 207, 220-21 (1986)).
\item \textsuperscript{141} See, e.g., \textit{Little Company II}, 165 F.3d at 1165-66.
\end{itemize}
2. Intermediary Inaction, as Well as the Issuance of the NPR, Can Give Rise to Board Review

Dissatisfaction with the NPR issued by the intermediary is not the only route to a PRRB hearing. Other subsections of the statute permit providers to invoke the Board's jurisdiction if the intermediary fails to timely render the NPR, whether based on the original cost report or a properly filed supplemental cost report. While 42 U.S.C. §§ 1395oo(a)(1)(B) and (C) require that the cost report be filed in accordance with the applicable Medicare rules and regulations, these subsections do not require dissatisfaction as a jurisdictional prerequisite. Indeed, because no NPR has been issued in these cases, the NPR cannot be the subject of the PRRB hearing and Board jurisdiction cannot be limited to review of the fiscal intermediary's reimbursement determination.

It seems anomalous to infer, when construing the statute as a whole, that Congress intended to restrict PRRB review to the NPR in cases where the provider awaits the intermediary's action, while at the same time intending that the Board review be unfettered regarding the cost reports of providers who seek review prior to the issuance of an NPR. As dissatisfaction is not the only route to the proper invocation of PRRB jurisdiction, dissatisfaction should not be read as an expansive (albeit implicit) exhaustion of remedies requirement that limits the Board's jurisdiction and scope of review.

3. A Provider Can Be Dissatisfied with Its Total Amount of Reimbursement Even If the Intermediary Makes No Audit Adjustments to the As-Filed Cost Report

42 U.S.C. § 1395oo(a)(1)(A)(i) does not require dissatisfaction with an intermediary's decision to disallow a specific claim for payment; it only requires that the provider be "dissatisfied with a final determination of ... its fiscal intermediary ... as to the amount of total program reimbursement due the provider ... ."

The Bethesda Court, in obiter dicta, observed that a provider who failed to request all available reimbursement in its cost report might not be able to claim dissatisfaction if the intermediary simply


143. The legislative history of these alternative routes to a PRRB hearing indicates that the only dissatisfaction required, if any, is dissatisfaction with an intermediary's failure to act. See S. CONF. REP. NO. 92-1605 (1972), reprinted in 1972 U.S.C.C.A.N. 5370, 5387-88 (discussing Senate Amendments to House Bill).
awarded reimbursement as claimed. In addition, the Court also characterized the Secretary's claim that the dissatisfaction provision was an implicit exhaustion requirement as a "strained interpretation . . . inconsistent with the express language of the statute." Thus, Bethesda cannot be fairly characterized as explicitly resolving the meaning of the dissatisfaction requirement; however, the Court's later analysis of the broad scope of PRRB review is only consistent with a broad reading of dissatisfaction.

At first blush, it may appear that the Secretary's contrary, more restrictive interpretation of the dissatisfaction requirement is entitled to deference. But deference is not appropriate when, as here, the statute addresses jurisdiction, a subject familiar to the judiciary, rather than a technical Medicare reimbursement issue requiring administrative expertise. More importantly, the Secretary is now not merely interpreting the statute; rather the Secretary now offers her interpretation of the Bethesda decision. Courts, rather than agencies, are the experts in interpreting judicial precedent and, thus, no deference is due the Secretary's post-Bethesda interpretation of the statute.

Moreover, the broader view of the dissatisfaction requirement finds support in the regulations defining the intermediary's role in the Medicare reimbursement process. Fiscal intermediaries "must audit the records of providers of services as necessary to assure proper payments." Payments are only proper if adjustments have been made to correct for claims that will result in underpayments as well as claims that will result in overpayments. Obviously, a provider can be just as dissatisfied with an intermediary's failure to make an adjustment to correct an understated claim as it can be with an intermediary's adjustment that improperly reduces a correctly stated claim. Indeed, at least prior to the

144. Bethesda, 485 U.S. at 405.
145. Id. at 404.
146. Id. at 405-06 (internal citation omitted).
147. See Chevron, 467 U.S. at 842-43 (courts defer to agency interpretations of ambiguous statutes); Maine Gen., 205 F.3d at 593-04 (Judge Cyr, dissenting, asserting that the Secretary's interpretation of the dissatisfaction provision is entitled to judicial deference).
148. See Wash. Hosp. Ctr. v. Bowen, 795 F.2d 139, 147 n.10 (D.C. Cir. 1986) (discussing PRRB jurisdiction). But see French Hosp., 89 F.3d at 1416 n.6 (expressly disavowing prior statements (Adams House, 817 F.2d at 592) that no deference is due an agency's interpretation of jurisdictional provision in a statute).
149. 42 C.F.R. § 421.100(c) (1982). An agency is bound by the plain language of its regulations. See, e.g., United States ex rel. Farese v. Luther, 953 F.2d 49, 52 (3d Cir. 1992).
150. In at least one PRRB case, an intermediary employee testified that the intermediaries are obligated to make adjustments that result in proper payment regardless of
commencement of a PRRB hearing, the intermediary acts as the provider’s advisor, not an adversary. Thus, even if a provider mistakenly fails to articulate a claim for proper payment, the regulations require that the fiscal intermediary correct that mistake to assure proper payment.

4. The PRRB’s Fact-Finding Powers Support De Novo Board Review

42 U.S.C. §§ 1395oo(c) and (d) lend further support to the de novo review theory. As noted above, subsection (d) empowers the Board to revise “matters covered by the cost report . . . even though such matters were not considered by the intermediary” when rendering the NPR. Subsection (d) also provides that the record before the PRRB “shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board.” Similarly, subsection (c) guarantees providers the right “to introduce evidence and to examine and cross-examine witnesses.” Such initial fact-finding powers are more consistent with de novo review than with a purely appellate function.

5. The PRRB Cannot Refuse to Hear Self-Disallowed Issues

In addition, the PRRB cannot adopt a blanket rule refusing to exercise its power over self-disallowed issues once a provider properly invokes Board jurisdiction. As the Ninth Circuit has twice noted, the opening paragraph of 42 U.S.C. § 1395oo entitles a provider to a PRRB hearing. Indeed, under the First Circuit’s view that it is permissible for the Board to adopt rules limiting the issues it will hear, the Board could, in theory, adopt a rule refusing to hear any claim, whether self-disallowed or first presented to the

whether the adjustment favors the Medicare program or favors the provider: “Q. My question is, is it your position that if the Provider makes a mistake that hurts the Provider, the Provider is bound by what it submitted? A. No. I think it works both ways.” Transcript Excerpt, PRRB Case No. 91-2673M, 6/12/96 Hearing at 1834 (on file with the author).


152. Allowing PRRB review of issues arising out of an intermediary’s failure to fulfill its obligation to discover and correct reporting errors that result in underpayment is consistent with a statutory scheme that permits a PRRB hearing based on other intermediary failures, such as the failure to timely issue an NPR. See 42 U.S.C. § 1395oo(a)(1)(B), (C).


154. Adams House, 817 F.2d at 594; Adams House II, 862 F.2d at 1375-76.
intermediary. The result is inconsistent with the Supreme Court’s statement that, once the Board’s jurisdiction is properly invoked, the only limitation on issues which the provider may present for review is that the “matter must have been ‘covered by the 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.”

6. Construing the Statute as a Whole as a Case Moves Through the PRRB Process

Construing the statute as a whole, the various provisions of 42 U.S.C. § 1395oo must be examined in the context of a PRRB case as it proceeds from the initial stages of jurisdictional review through the hearing process. Conemaugh provides a striking example of the contrast in the competing statutory interpretations as applied in this setting.

As described by the PRRB, the Conemaugh provider initially invoked PRRB jurisdiction by challenging three separate audit adjustments made by the intermediary, the negative reimbursement effects of which were reflected in the original NPR. Prior to the hearing, the provider raised two additional issues, one of which had not been presented to the intermediary in the cost report as originally filed. The PRRB’s decision tracked the statute — the provider timely and properly requested a hearing “and therefore the Board ha[d] jurisdiction over the Provider’s . . . cost report.” As the later-raised issue was covered by the cost report, that issue was “subject to Board review by virtue of 42 U.S.C. § 1395oo(d).” This analysis tracks Bethesda; the statutory structure:

[A]llows 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

155. Maine Gen., 205 F.3d at 501.
156. Bethesda, 485 U.S. at 406 (quoting 42 U.S.C. § 1395oo(d)).
158. Id. See also Stipulation and Request to Proceed on the Record, PRRB Case No. 95-0100, 7/28/98 (on file with the author). 42 C.F.R. § 405.1841(a)(1) (1988) permits providers to raise new issues at any time prior to the commencement of the Board hearing. The HCFA itself previously admitted that, pursuant to this regulation governing the form of PRRB hearings, once the Board assumes jurisdiction, “it is the cost year that is open and not the individual issue.” French Hosp., 89 F.3d at 1421 (quoting St. Mary’s Hosp. v. Blue Cross & Blue Shield Ass’n (HCFA Adm’n, May 5, 1983)).
160. Id.
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.\textsuperscript{161}

Now contrast the HCFA Administrator's \textit{Conemaugh} decision vacating for lack of jurisdiction. The intermediary claimed that the "Board only has jurisdiction over final determinations of the Intermediary."\textsuperscript{162} The Administrator agreed, stating that subsection (a) entitles a provider to a Board hearing "with respect to its fiscal intermediary's determination of its cost report."\textsuperscript{163} Once the subject of the PRRB hearing is limited to the intermediary's determination, it is logical to conclude, as did the Administrator, that any attempt to use the scope of review provisions set forth at subsection (d) to include issues that were not first presented to the intermediary is impermissible bootstrapping.\textsuperscript{164} This limited view of the meaning of subsection (d) can only be squared with the broad reading accorded that provision in \textit{Bethesda} by further limiting that case to the facts presented therein.\textsuperscript{165} But this reading is premised on limiting the subject matter of the PRRB hearing to the NPR, a limitation that is inconsistent with the opening paragraph of the statute that specifies the cost report, not the intermediary's determination thereof, as the subject matter of the hearing.\textsuperscript{166}

\section*{7. A Unified Theory of PRRB Jurisdiction and Scope of Review}

Construing the statute as a whole, self-disallowance must fail. The PRRB can obtain jurisdiction over the cost report under any subsection of 1395oo(a)(1). Dissatisfaction with an intermediary's determination is simply not a prerequisite to PRRB review under subsection (a)(1)(B) or (a)(1)(C).

In addition, the rationales offered to support self-disallowance when analyzing 42 U.S.C. § 1395oo(a)(1)(A) in isolation simply do not bear scrutiny. The original rationale, a purported inability to

\textsuperscript{161} \textit{Bethesda}, 485 U.S. at 405. Indeed, in accordance with 42 U.S.C. § 1395oo(a), this passage refers to the subject of the Board hearing as the cost report, not the NPR or the intermediary's audit adjustments.

\textsuperscript{162} \textit{Conemaugh}, [1999-1 Transfer Binder] ¶ 80,126, at 200,482.

\textsuperscript{163} \textit{Id}.

\textsuperscript{164} \textit{Id} at 200,483. \textit{See also Little Company II}, 165 F.3d at 1165.

\textsuperscript{165} \textit{Conemaugh}, [1999-1 Transfer Binder] ¶ 80,126, at 200,482.

\textsuperscript{166} 42 U.S.C. § 1395oo(a).
claim dissatisfaction, is refuted by the intermediary's regulatory obligation to ensure proper payment. The Secretary recently advanced two new rationales: The need for intermediary expertise regarding self-disallowed claims and the purported unmanageability of the system if self-disallowance is not upheld. However, the PRRB will obtain the benefit of the intermediary's expertise by the intermediary's participation as a party to the Board hearing. And, if anything is unmanageable, it is the alternative cost report model specified in *Little Company II*. The cost report is an extraordinarily complex document; changes in one area often produce ripple reimbursement and statistical effects that flow throughout the filing. Given the agency's claims regarding administrative burdens, it seems highly unlikely that intermediaries are equipped and prepared to review the multitude of cost report permutations that would occur if a provider is forced to protect its right to proper payment by specifying every alternative theory of reimbursement in the initial filing.

Finally, assuming that a challenge to an intermediary's affirmative act of disallowing a claim is a jurisdictional prerequisite, then all a provider must do is timely challenge an NPR that results from one or more audit adjustments, made by the intermediary, with a negative reimbursement impact of $10,000 or more. In the author's experience, a provider has little or no difficulty finding an audit adjustment or some other intermediary action with which it is "dissatisfied" to invoke PRRB jurisdiction. The Board hearing, however, is then held with respect to the cost report, not the NPR or any specific audit adjustment. Once the cost report has been brought before the PRRB for review, the scope of the Board's review is governed solely by subsection (d). Pursuant thereto, the only limitation on the scope of review is that issues arise from "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." Given this framework, a unified theory of PRRB review can be stated as follows: The PRRB has jurisdiction over all claims covered by the cost report, or the reopened portion(s) thereof, that

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167. *See 42 C.F.R. § 421.100(c) (1991).*
170. 165 F.3d at 1166.
171. *Id.*
172. *Bethesda, 485 U.S. at 405.*
were before the fiscal intermediary when the NPR (original or revised) was issued. This theory could be analyzed in the following sequence:

(1) A provider must timely file its cost report summarizing its costs and claims for the cost reporting period at issue (42 U.S.C. § 1395oo(a)), or the provider must timely file a supplemental cost report (42 U.S.C. § 1395oo(a)(1)(C)).

(2) The provider can then obtain a PRRB hearing if:
   * The intermediary delays the issuance of the NPR (42 U.S.C. § 1395oo(a)(1)(B)-(C)); or
   * The provider is dissatisfied with the reimbursement specified in the NPR (42 U.S.C. § 1395oo(a)(1)(A)(i)).
     A provider can be dissatisfied with:
     * The intermediary's affirmative act of disallowing a claim; or
     * The intermediary's failure, during the audit, to ensure proper payment by detecting and correcting a provider error (42 C.F.R. § 421.100(c)).

(3) As long as the provider timely requests a hearing and the amount in controversy is more than $10,000, the Board assumes jurisdiction over the cost report (42 U.S.C. § 1395oo(a)), or the reopened portion(s) thereof (Edgewater, 857 F.2d at 1134; French Hospital, 89 F.3d at 1420).

(4) The Board's scope of review in cases triggered by original NPRs extends to any reimbursement claim arising out of or related to the cost-reporting period (42 U.S.C. § 1395oo(d)). The scope of review in cases triggered by revised NPRs extends to any reimbursement claim reconsidered during the reopening (42 C.F.R. § 405.1869; see also Edgewater, 857 F.2d at 1134; French Hospital, 89 F.3d at 1420).173

173. The PRRB also hears disputes arising out of decisions that conclude separate requests for administrative relief that can be initiated once the NPR has been issued. See, e.g., 42 C.F.R. § 413.40(e), (g) (1998) (providers can obtain PRRB hearings regarding decisions on requests, filed within 180 days of the NPR, for cost-ceiling adjustments in PPS-exempt units). Applying the theory in such cases, the scope of Board review and available relief would be controlled by the range of the reimbursement matters open before the intermediary during the process that led to the NPR that triggered the subsequent request for administrative relief.
(5) To effectuate the finality concerns arising from the limitation on time to request a hearing (42 U.S.C. § 1395oo(a)(3)), Board hearings are limited to reimbursement claims covered by the cost report, or in revised NPR cases, the reopened portion(s) of the cost report. Thus, a provider cannot use a request for a Board hearing regarding later years to resurrect reimbursement claims pertaining to prior cost-reporting periods. Nor can a provider use a Board hearing regarding a revised NPR to resurrect reimbursement claims from that specific cost-reporting period which were not within the scope of the reopening that led to the revised NPR. The Board may hear only those reimbursement claims that were open before the intermediary and could have been considered during the process that generated the NPR, original or revised.

(6) Once before the PRRB, the provider may introduce new evidence regarding the costs incurred during the period covered by the cost report (42 U.S.C. § 1395oo(c) & (d)) or the reopened portion(s) thereof (42 C.F.R. § 405.1869). The intermediary also presents the PRRB with the benefit of its expertise regarding the issues addressed in the Board hearing (42 C.F.R. § 405.1843).

B. Application of the Unified Theory to Various NPR Scenarios

Deriving a uniform reading of the statute is only the first step. That reading must then be applied to the various reimbursement determinations that trigger a request for a PRRB hearing. As set forth above, this article examines the Board’s powers in three such settings: (1) a hearing requested following receipt of the original NPR setting forth the total Part A reimbursement due for a given cost-reporting period; (2) a hearing requested following receipt of a revised NPR, after a cost reporting period has been reopened and the amount of the reimbursement paid for that period has been altered; and (3) a hearing requested following an intermediary’s refusal to reopen a cost-reporting period.

1. The Scope of Board Review in Original NPR Cases

When a provider timely seeks a Board hearing after receipt of the original NPR for a cost-reporting period, the Board’s scope of
review is almost unlimited.\textsuperscript{174} As shown above, the jurisdictional requirement is met by dissatisfaction with the total amount of reimbursement awarded, whether the result of an intermediary's improperly disallowed claim or of a flawed intermediary audit that failed to detect and correct a provider reporting error. In addition, cases triggered by original NPRs do not implicate the preference for finality because, as a hearing was requested within 180 days of the original NPR, the reimbursement determination process has not, in any way, become final.\textsuperscript{175} Thus, the entire cost report is made subject to Board review and, as stated in Bethesda, PRRB review extends to all costs or expenses "incurred within the period for which the cost report was filed, even if such cost or expense was not expressly claimed."\textsuperscript{176} Moreover, as the provider is statutorily entitled to a PRRB hearing, the Board must hear issues raised by the provider, including self-disallowed claims.\textsuperscript{177}

2. The Scope of Board Review in Revised NPR Cases

The Board's powers are more limited in hearings requested following a revised NPR. In such cases, the preference for finality is somewhat implicated because the provider could have, but did not request a Board hearing after receipt of the original NPR. Thus, absent a reopening, the statutory appeal period would act as a bar to any review of reimbursement claims for that cost-reporting period.\textsuperscript{178} However, the preference for finality is not an absolute and should not outweigh other considerations once a cost report

\textsuperscript{174} The statute itself specifies two issues that are beyond PRRB review: A finding that expenses relate to items of services for which reimbursement is statutorily excluded and certain DRG classification methodologies. See 42 U.S.C. § 1395oo(g).

\textsuperscript{175} Once the Board assumes jurisdiction, "it is the cost year that is open and not the individual issue . . . ." French Hosp., 89 F.3d at 1421 (quoting St. Mary's Hosp. v. Blue Cross & Blue Shield Ass'n (HCFA Adm'r, May 5, 1983)). See also Provider Reimbursement Manual § 2930.1.A ("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 the mailing of the notice, unless before that time the provider (entity) requests a hearing, or a late-filed request is accepted for good cause.").

\textsuperscript{176} Bethesda, 485 U.S. at 405.

\textsuperscript{177} See, e.g., Adams House II, 862 F.2d at 1374-75. The Board is, however, empowered to create rules that govern its proceedings. In this respect, concerns regarding administrative efficiency might be better served by reconsideration of the point in the proceedings by which the provider must raise all issues presented for review. 42 C.F.R. § 405.1841(a)(1) now permits the provider to raise issues at any time prior to the commencement of the hearing. Considerations of equity and efficiency might be better served if the provider had to raise all issues at least six months in advance of the hearing date, thus allowing the PRRB staff and counsel for the intermediary to more fully address all the issues presented for adjudication.

\textsuperscript{178} 42 U.S.C. § 1395oo(a)(3).
has been reopened.

In this revised NPR setting, even the Secretary agrees that Board review extends to those issues for which reimbursement is actually revised. However, the Board's authority should not be limited to the items for which reimbursement was revised. Rather, sound policy reasons establish that the Board's authority extends to all reimbursement claims arising out of the portions of the cost report that were reopened, regardless of whether the amount of reimbursement was actually revised.

First, when an agency reopens a proceeding and then issues a new and final order regarding the matter, that order is generally reviewable on the merits "even if it merely reaffirms the rights and obligations set forth in the original order." Thus, once a portion of a cost report has been reopened, review is governed by the scope of the reopening, regardless of whether the reopening results in revised reimbursement.

Second, permitting Board review of matters reopened, but not revised, in such hearings does not run afoul of the Supreme Court's admonition, in *Visiting Nurse*, that as the reopening process is created by regulation, review of reopening decisions must also be grounded in the regulations. 42 C.F.R. § 405.1889 specifies the revised NPR as a separate determination that triggers a right to Board review. But the broad scope of review specified in 42 U.S.C. § 1395oo(d) is repeated in the regulations governing Board proceedings, which describe the Board's review as extending to reimbursement matters that "were not considered in the intermediary's determination." Indeed, it seems indisputable that

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180. ICC v. Bd. of Locomotive Eng'rs, 482 U.S. 270, 278 (1987). See also *Visiting Nurse*, 525 U.S. at 455 (citing *Locomotive Eng'rs* as stating the general rule of review for administrative decisions).
181. Intermediaries ordinarily provide notice of which portions of a cost report are being reopened, the reasons for the reopening and permit the provider to submit evidence regarding the reopening. 42 C.F.R. § 405.1887 (1996). See also *Provider Reimbursement Manual* § 2932.A.
182. *Visiting Nurse*, 525 U.S. at 454. See also HCA, 27 F.3d at 619 (in cases triggered by revised NPRs, PRRB jurisdiction and scope of review is governed by the regulations, not the enabling statute).
183. Even if these regulations did not track the statute, serious questions would exist as to the agency's ability to provide for a Board hearing then restrict Board review. An agency cannot confer jurisdiction in excess of the authority specified in the statute creating a tribunal. See, e.g., St. Joseph's Hosp. of Kansas City v. Heckler, 786 F.2d 848, 853 (8th Cir. 1986); Ozark Mountain Reg'l Rehabilitation Ctr. v. Dep't of Health and Human Serv., 798 F. Supp. 16, 19-20 (D.D.C. 1992). Thus, PRRB hearings triggered by revised NPRs that result from reopenings can only be valid if such hearings are within the framework established by
a provider can be dissatisfied, within the meaning of the regulations governing Board hearings, with an intermediary's failure to revise reimbursement regarding a portion of the cost report that has been reopened to consider reimbursement revisions.  

Finally, as the Seventh Circuit noted in Edgewater, providers often seek reopenings to obtain reimbursement revisions. In this setting, it is illogical to afford Board review of those matters in which the provider has prevailed and obtained a reimbursement revision, yet deny review of those items which the intermediary has reopened, reconsidered, yet refused to revise. Simply put, in cases triggered by revised NPRs, Board review is limited to the scope of the matters reopened, not the claims for which reimbursement was actually revised.

3. Board Review of an Intermediary's Refusal to Reopen a NPR

The balance shifts once a provider fails to timely request a Board hearing regarding an original NPR and the intermediary refuses to reopen reimbursement for that cost-reporting period. In this setting, the Supreme Court has determined that, unlike review of matters where a reopening has occurred, where the intermediary refuses to reopen the NPR, the interest in finality outweighs the provider's right to proper reimbursement and the decision is not subject to administrative or judicial review. While proper reimbursement is thus dependent on the proper exercise of the intermediary's discretion, it is the provider's failure to timely seek a Board hearing

42 U.S.C. § 1395oo. Once the statute applies, it does so in its entirety, including the broad scope of review specified by subsection (d). However, as 42 C.F.R. § 405.1889 reiterates the broad powers conferred by the statute, the regulations can be easily construed as in accord with, not in contravention of, the statute they implement.

184. 42 C.F.R. § 405.1889 specifies 42 C.F.R. § 405.1835 as the regulation governing hearings regarding revised NPRs. In turn, 42 C.F.R. § 405.1835(a)(2) specifies 42 C.F.R. § 405.1841(a)(1) as the provision governing a request for a Board hearing. That regulation, in turn, specifies dissatisfaction with some aspect of the intermediary's determination as an element of a request for a hearing. 42 C.F.R. § 405.1841(a)(1) (1988). In this regard, dissatisfaction with an intermediary's failure to revise reimbursement as requested regarding a reopened issue parallels the dissatisfaction that arises when an intermediary fails to detect and correct a provider reporting error, thereby failing to assure proper payment as required by 42 C.F.R. § 421.100(c).

185. Edgewater, 857 F.2d at 1136-37.

186. Id. See also French Hosp., 89 F.3d at 1420.

187. Visiting Nurse, 525 U.S. at 455. See also Locomotive Eng'rs, 482 U.S. at 270 (generally discussing refusals to reopen administrative proceedings).
regarding the original NPR that generates this result.\(^{188}\)

**CONCLUSION**

Read as a whole, 42 U.S.C. § 1395oo clearly provides that the PRRB is more than just an appellate body that reviews the audit adjustments made by the fiscal intermediary in rendering an NPR. The Board's fact-finding powers, expressly conferred by statute, are inconsistent with a purely appellate function. Moreover, the alternative routes to a PRRB hearing specified in the statute do not require dissatisfaction with an intermediary's determination as a jurisdictional prerequisite. Finally, the statutorily specified scope of review clearly empowers the Board to hear issues that were not first presented to the fiscal intermediary, and the regulations expressly provide that the intermediary's views on all issues will be aired during the PRRB hearing.

The *Bethesda* Court found the Secretary's original

188. Although the interest in finality is significant, denying review of refusals to reopen will, in the author's opinion, increase the PRRB's caseload. *Visiting Nurse* depicts few intermediaries hard-pressed to identify overpayments, while each of the almost innumerable providers can "easily identify underpayments within 180 days of the NPR." 525 U.S. at 456. The Court also saw no defect in a reopening process that only corrected overpayments while underpayments went unredressed, and accepted the claim, apparently unsupported by the record, that intermediaries grant 30% to 40% of reopening requests. *Id.* But even if providers are better situated to identify errors, reimbursement claims often arise from precedent decided after the 180-day period expires. See, e.g., *Little Company II*, 165 F.3d at 1165 (claim based on recent Supreme Court authority). Moreover, when acquiescing in such decisions, the HCFA does not always reopen prior NPRs to make proper payment. See HCFA Ruling No. 97-2, February 2, 1997, reprinted in [1997-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 45,105 (ordering settlement of cases challenging disproportionate share hospital rule declared invalid by the courts but prohibiting the reopening of other settled cost reports to correct underpayments). After *Visiting Nurse*, no prudent provider will rely on the reopening process. Rather, well-advised providers will request a PRRB hearing as to every original NPR, then add issues under 42 C.F.R. § 405.1841(a)(1) as they are identified, ultimately resulting in additional hearing requests that further clog the PRRB's already crowded docket.

This result could have been avoided by acknowledging that a reopening request, which can be filed up to three years after the NPR was issued, is analogous to a Fed. R. Civ. P. 60(b) motion for relief from judgment, which can be filed up to one year after judgment was entered. Indeed, many of the Rule 60(b) grounds for relief (e.g., mistake, new evidence and fraud) are specified in *Provider Reimbursement Manual* § 2932.1 as grounds for reopening. A Rule 60(b) motion does not replace a timely appeal (Ackerman v. United States, 340 U.S. 193, 197 (1950)), but Rule 60(b) rulings are reviewed for abuse of discretion. *Bowder v. Dep't of Corrections*, 434 U.S. 257, 263 n.7 (1978). As the NPR is the initial Medicare reimbursement determination, the operation of Rule 60(b) appears to be the appropriate analogy for review of a refusal to reopen an NPR. But rather than Rule 60(b) motions, that are reviewable on appeal, the Supreme Court equated requests for administrative reopening to petitions for reconsideration by an appellate court, that are not subject to further review. *Locomotive Eng'rs*, 482 U.S. at 278 (cited in *Visiting Nurse*, 525 U.S. at 455).
self-disallowance theory a strained interpretation that was inconsistent with the statutory scheme when construed as a whole. Similarly, the Secretary's attempts to limit *Bethesda* to those instances when the intermediary is without authority to rule on the issue presented is a strained interpretation that is inconsistent with that decision when read as a whole. If, as the regulations provide, the Secretary intends to ensure proper payment to providers for services rendered to Medicare beneficiaries, the unnecessary procedural barrier raised by the self-disallowance theory should be discarded.