



UNITED STATES
CIVILIAN BOARD OF CONTRACT APPEALS

APPELLANT'S MOTION FOR SUMMARY RELIEF IN CBCA 2775
GRANTED IN PART; RESPONDENT'S MOTION FOR SUMMARY RELIEF
IN CBCA 2775 DENIED; CBCA 2774 DISMISSED FOR LACK OF JURISDICTION:
October 2, 2014

CBCA 2774, 2775

McALLEN HOSPITALS LP, dba
SOUTH TEXAS HEALTH SYSTEM,

Appellant,

v.

DEPARTMENT OF VETERANS AFFAIRS,

Respondent.

Jeffery Weinstein of The Weinstein Law Group, PLLC, Washington, DC, counsel for Appellant.

Mary A. Mitchell and Bart Evans, Office of Regional Counsel, Department of Veterans Affairs, Houston, TX, counsel for Respondent.

Before Board Judges **STEEL, DRUMMOND, and LESTER**.

LESTER, Board Judge.

McAllen Hospitals LP, dba South Texas Health System (appellant or STHS), filed appeals from two separate contracting officer's final decisions, claiming that the Department of Veterans Affairs (respondent or VA) did not pay appellant the correct contractual amount for services rendered.

Appellant argues: (1) it is entitled under its medical and hospital services contract to be paid at a Case-Mix Group (CMG) rate (a rate of reimbursement that it contends is higher than the Diagnostic-Related Group (DRG) rate) for inpatient rehabilitation services because it is a Medicare-certified Inpatient Rehabilitation Facility (IRF); and (2) the VA's Fees Basis Claims System (FBCS) variously augmented and reduced reimbursement amounts so that respondent underpaid and overpaid appellant for services throughout the life of the contract. Having returned the overpayments, appellant seeks reimbursement to remedy the underpayments.

Appellant filed a motion for summary relief, asking the Board to grant the appeals in the aggregate amount of \$1,054,473.90 – \$976,603.66 in CBCA 2774 and \$77,870.24 in CBCA 2775. Respondent filed a motion for summary relief seeking denial of appellant's appeals.

Background

On October 20, 2008, the VA issued a solicitation seeking proposals for a one-year indefinite-quantity contract, with four one-year option periods, through which the awardee would provide general medical and hospital services for veterans in the Lower Rio Grande Valley region in south Texas. The solicitation indicated that the VA would be the primary payor of services for eligible/enrolled individuals, with payment to be made in accordance with the contract's Schedule of Supplies/Services:

VA shall be the primary payor for an eligible/enrolled individual (defined in section B.4.6) whether or not the individual has a service-connected injury or illness. Payment shall be made in accordance with this Schedule of Supplies/Service.

Appeal File, Exhibit 11, Clause B.2.1 (Bates 001025).¹ Clause B.2.2 of the solicitation provided that “[p]ricing for this contract [would be] based on actual services provided in accordance with contract percentage of current Medicare rates” and that “[a]djustments in pricing during the term of the contract [would] be limited to published changes in Medicare rates.” *Id.*, Clause B.2.2 (Bates 001025).

The types of services that the awardee was to provide were identified under various Contract Line Item Numbers (CLINs). In CLIN 0001 of the solicitation, the VA identified

¹ All exhibits referenced in this decision are found in the appeal file, unless otherwise noted.

a broad category of inpatient hospital services covered by the contract that the VA was to pay using DRG codes, DRG being a specific reimbursement methodology identified in Medicare regulations. Exhibit 11, Clause B.3.1 (Bates 001027); *see* 42 CFR 412.60 (2013) (discussing DRGs). Other CLINs identified other particular services, including specialty professional services (covered by the Current Procedure Terminology (CPT) reimbursement methodology) (CLIN 0002), as well as lab pathology, anesthesia, physical medicine and rehab, pulmonary rehab, and radiology support services (CLIN 0003). Exhibit 11 (Bates 001027-29). Despite these listings, the VA made clear in the solicitation that it could not and did not intend to identify every type of service that it expected to acquire under the contemplated contract and that, after award, it might add services not listed:

While the quantities are based on historical data, they do not represent the entire volume or breadth of services [Veterans Health Administration (VHA)] intends to acquire under this contract. VA intends to purchase all services related to the Contract Line Item Number (CLIN) listed in Section B. After award VA may have need to add services not listed. If such needs arise, VA will ask the contractor if such services can be provided and, if so, VA may negotiate a modification to add those services.

Exhibit 11, Clause E.5.4 (Bates 001101) (emphasis added); *see* Exhibit 11 (Bates 001171) (“If additional services are required in the future that the VA did not foresee at the time of award, the VA can negotiate and modify the contract to add the required services.”).

Clause B.2.5 of the solicitation indicated that, for purposes of “determining the total estimated dollar amount” of the anticipated contract during the award evaluation process, the VA would use a list of DRG and CPT codes that the VA had included in the solicitation, along with the identified estimated quantities:

For determining the total estimated dollar amount of award, the VA will use the list of DRG and CPT codes in Attachment D.1. Pricing Schedule, and the estimated quantities shown there. All DRG and CPT codes are not listed in the Pricing Schedule, but the Contractor will be required to provide inpatient care services for any Medicare DRG and CPT code when authorized by the VA.

Exhibit 11, Clause B.2.5 (Bates 001026). In Attachment D.1 to the solicitation, the VA represented that the purpose of using the identified DRG and CPT codes was to provide the VA with a basis for uniformly comparing competing offers during the contract award decision-making process and not to limit the VA’s ability during contract performance to purchase necessary medical services:

Representative DRG or CPT codes have been supplied in this Price Schedule to provide a uniform methodology to evaluate proposed offers. These codes and sample quantities (volumes), while based on historical data, are for illustrative purposes only and do not represent the entire volume or breadth of services VHA intends to acquire under this contract. VA intends to purchase all services related to the Contract Line Item Number (CLIN) Service Area listed in Contract B.3. Schedule of Services.

Exhibit 17, at 1.² The VA further made clear in the solicitation that, despite the method of price evaluation, “[t]hroughout the life of the contract VA will pay current Medicare rates in effect at the time of performance.” Exhibit 11, Clause E.5.4 (Bates 001102).

On or about November 28, 2008, STHS submitted an offer in response to the solicitation, proposing to provide both inpatient hospital services and medical services. STHS asserts that it is a designated Inpatient Rehabilitation Facility (IRF) under Medicare rules, *see* 42 CFR 412.600 to .632 (discussing IRFs), although IRF status was not a requirement of, and was not mentioned in, the solicitation.

On April 9, 2009, the VA awarded the contract to STHS. The contract required STHS to invoice the VA according to the various CLINs listed in the solicitation using the negotiated rate of reimbursement for each CLIN. The contract also stated the expected minimum and maximum expenditures per CLIN. The negotiated rate of reimbursement was 103% or 106% of current Medicare rates, depending on the service provided and the corresponding CLIN. *See* Exhibit 9, Clause B.3.1 (Bates 000608). The Attachment D-1 pricing schedule further specified the type of services, corresponding CLINs and Medicare codes, and the proposed price for each service, *see* Exhibit 17, but, as previously discussed, not all possible services were set out in the pricing schedule. Inpatient rehabilitation services were not specifically set out in the pricing schedule.

To receive reimbursements, the contract required appellant to submit “medical claims,” which it defined as “invoices prepared and submitted by the contractor that consist of the charges of the provider(s) for the health care services rendered to veterans as authorized by the VA.” Exhibit 9, Clause B.4.6 (Bates 000623). Pursuant to the contract, appellant was to submit its “medical claims” to the VA through the VA’s claims processing

² Similarly, in PowerPoint slides from a pre-solicitation conference, held July 22, 2008, the VA indicated on a page titled “Pricing” that the sample DRG/CPT codes were to provide “a uniform methodology to evaluate all proposed offers equally” and to allow “[f]lexibility to add additional services by negotiation.” Exhibit 12.

system – originally, the VistA Fee System and, later, the FBCS.³ According to STHS, some of these “medical claims” included payment requests for inpatient rehabilitation services provided by an IRF, for which STHS sought payment under the CMG reimbursement methodology rather than under the DRG reimbursement methodology.⁴ STHS alleges that, although DRG codes for inpatient rehabilitation services exist, IRFs generally receive a higher level of payment for inpatient rehabilitation under the CMG code than facilities providing inpatient rehabilitation without an IRF designation.

On April 4, 2011, appellant sent a formal claim to the contracting officer (CO) stating that respondent had not paid it according to current Medicare rates for hospital (institutional) claims and physician (professional) claims between April 6 and September 30, 2009. STHS asserted that it had been both overpaid and underpaid on numerous hospital claims, that it had reimbursed the VA for any identified overpayments, and that it was entitled to proper payment on the underpaid hospital claims:

As noted on the contract, page 7 of 68, Section B.2, Schedule of Items – Service, No. 2: “Pricing for this contract is based on actual services provided in accordance with contract percentage of current Medicare rates”.

³ The contract originally required respondent to process claims through the VistA Fee System, *see Exhibit 9, Clause B.4.6* (Bates 000624), but, through Modification No. 0002 dated October 1, 2010, this requirement was changed to require claims processing through the FBCS. *See Exhibit 7* (Bates 000596). It appears from the record that the processing system in place during the time periods at issue in the two CDA claims before the Board – April 2009 through September 2009, and October 2009 through September 2010 – would have been the VistA Fee System, not the FBCS. In fact, one of the Inspector General reports that appellant references indicates that the FBCS was intended to replace and improve upon the VistA Fee System, but was not fielded until at least December 2010 (if not later). *See Exhibit 24* (VA Office of Inspector General Report No. 09-03408-227, Veterans Health Audit of Non-VA Inpatient Fee Care Program, at 9 (Aug. 18, 2010)). Nevertheless, because appellant repeatedly references the FBCS in its complaint and in its briefing, and because it is clear that appellant is complaining about underpayments allegedly caused by the VA’s claims processing system, we will use the acronym “FBCS” to encompass both the FBCS and its predecessor system, the VistA Fee.

⁴ None of the medical claims are in the record in this case. Respondent did not include them in the appeal file, and appellant did not include them in its supplemental appeal file.

Since implementation of [the] contract, Hospital (institutional) claims have not been paid based on STHS current Medicare rates and Physician (professional) claims for all CPT's at the current Medicare rate. STHS has repeatedly requested the payment scheme followed by [VA Texas Valley Coastal Bend Health Care System (VATVCBHCS)] so that the accounts could be adjusted appropriately. To date, STHS has not received this information. STHS has been refunding overpayments as based on our payment methodology. We are requesting VATVCBHCS to reimburse on accounts identified as under paid.

Attached to this letter is supporting documentation including Excel spreadsheets of underpaid claims from the beginning of the Contract (April 6, 2009) to the end of VATVCBHCS fiscal year (September 30, 2009). Hospital claims' supporting documentation includes a UB 04, an Explanation of Benefits (EOB) and a screen print per account of the expected DRG reimbursement for inpatients as well as the Outpatient Fee schedule. Physician claims' supporting documentation includes the Excel spreadsheet and a copy of your EOB.

Exhibit 1 (Bates 000018). Through this claim, appellant sought to recover a total of \$77,870.24 in underpayments and requested that the CO issue a final decision in accordance with the contract's Disputes clause.⁵

On June 1, 2011, appellant sent a second formal claim to the CO making the same arguments but claiming \$976,603.66⁶ of underpayments between October 1, 2009, and September 30, 2010.⁷ Exhibit 1 (Bates 000009). To supplement both claims of underpayments, appellant sent a total of 1434 "medical claims" (none of which are in the record here) to the CO. Although STHS indicated in its motion for summary relief that this

⁵ The April 4, 2011, claim letter itself did not expressly identify the \$77,870.24 figure, but both appellant and respondent agree that the figure was identifiable from the documentation that accompanied the claim.

⁶ As with the April 4, 2011, claim, the June 1, 2011, claim letter itself did not expressly identify the \$976,603.66 figure, but appellant and respondent agree that the amount was identifiable from the documentation that accompanied the claim.

⁷ Appellant also contends, and respondent does not dispute, that between 2009 and 2010, respondent overpaid on other claims by \$1.2 million and that STHS has voluntarily refunded this amount.

claim was “certified,” Appellant’s Motion for Summary Relief at 7, the record does not contain a copy of the certification required by the Contract Disputes Act (CDA), 41 U.S.C. § 7103(b) (2012).

In her final decisions on the two claims, the CO interpreted the April 4 and June 1, 2011, claims to complain about the VA’s application of DRG codes to pay for inpatient rehabilitation services and its failure to pay IRF claims under the CMG code. Exhibit 1 (Bates 000021). She determined that the contract at issue limited payments for authorized services to the DRG and CPT codes. She held that inpatient rehabilitation services were considered inpatient hospital services and were therefore paid at the DRG rate under CLIN 0001. Accordingly, the CO found that STHS, although a Medicare-certified IRF, was not entitled to the higher CMG rates for providing inpatient rehabilitation services.

On March 13, 2012, appellant timely appealed both of the contracting officer’s final decisions, and we consolidated the cases.

Cross-Motions for Summary Relief

Appellant filed a motion for summary relief, arguing that it is entitled to damages for underpayments because (1) respondent should reimburse it at the CMG rate for inpatient rehabilitation services, and (2) the FBCS altered reimbursement amounts so that appellant was variously underpaid and overpaid.

Respondent also filed a motion for summary relief, arguing that the plain meaning of the contract only allowed for DRG and CPT reimbursement rates. Respondent then argues that the Board does not have jurisdiction to hear the issue involving the FBCS because appellant did not present this issue to the CO, as required by the CDA.

Discussion

Jurisdictional Issues

I. Standard of Review

Subject matter jurisdiction is a threshold matter involving a tribunal’s “power to hear a case,” and a tribunal must dismiss a case over which it lacks jurisdiction. *Arbaugh v. Y&H Corp.*, 546 U.S. 500, 514 (2006); *see Steel Co. v. Citizens for a Better Environment*, 523 U.S. 83, 94-95 (1998) (tribunal must decide jurisdiction before proceeding to the merits). Jurisdiction “may be challenged at any time by the parties or by the [tribunal] *sua sponte*.” *Folden v. United States*, 379 F.3d 1344, 1354 (Fed. Cir. 2004). When considering a motion

to dismiss for lack of subject matter jurisdiction, a tribunal accepts as true the undisputed allegations in the complaint and draws all reasonable inferences in favor of the plaintiff. *Trusted Integration, Inc. v. United States*, 659 F.3d 1159, 1163 (Fed. Cir. 2011). Nevertheless, when a question of the tribunal’s jurisdiction is raised, “either by a party or by the [tribunal] on its own motion, the [tribunal] may inquire, by affidavits or otherwise, into the facts as they exist.” *Land v. Dollar*, 330 U.S. 731, 739 n.4 (1947). The party invoking the Board’s jurisdiction bears the burden of establishing it by a preponderance of the evidence. *McNutt v. General Motors Acceptance Corp.*, 298 U.S. 178, 189 (1936); *Reynolds v. Army & Air Force Exchange Service*, 846 F.2d 746, 748 (Fed. Cir. 1998); *Rocovich v. United States*, 933 F.2d 991, 993 (Fed. Cir. 1991).

II. Jurisdiction to Entertain CBCA 2774

While reviewing the parties’ briefing on summary relief, the Board identified a potential jurisdictional defect in one of STHS’s claims – the \$976,603.66 claim at issue in CBCA 2774 – that neither party raised. Because subject matter jurisdiction “can never be forfeited or waived,” *Arbaugh*, 546 U.S. at 514, tribunals “have an independent obligation to determine whether subject-matter jurisdiction exists, even in the absence of a challenge from any party.” *Id.* Accordingly, we consider this issue *sua sponte*.

The CDA requires that “[e]ach claim by a contractor against the Federal Government relating to a contract shall be in writing” and “shall be submitted to the contracting officer for a decision.” 41 U.S.C. § 7103(a)(1), (2). It also requires that, for any claim in excess of \$100,000, the contractor must certify the claim, as follows:

For claims more than \$100,000 made by a contractor, the contractor shall certify that –

- (A) the claim is made in good faith;
- (B) the supporting data are accurate and complete to the best of the contractor’s knowledge and belief;
- (C) the amount requested accurately reflects the contract adjustment for which the contractor believes the Federal Government is liable; and
- (D) the certifier is authorized to certify the claim on behalf of the contractor.

Id. § 7103(b)(1). “[T]here is nothing in the CDA that excuses contractor compliance with the explicit CDA claim requirements.” *M. Maropakis Carpentry, Inc. v. United States*, 609 F.3d 1323, 1329 (Fed. Cir. 2010).

“Certification of a claim of more than \$100,000 is not only a statutory requirement, but also a jurisdictional prerequisite for review of a contracting officer’s decision before this Board.” *Red Gold, Inc. v. Department of Agriculture*, CBCA 2259, 12-1 BCA ¶ 34,921, at 171,121 (citing *Fidelity Construction Co. v. United States*, 700 F.2d 1379, 1384 (Fed. Cir. 1983)); see *W.M. Schlosser Co. v. United States*, 705 F.2d 1336, 1338-39 (Fed. Cir. 1983); *Essex Electro Engineers, Inc. v. United States*, 702 F.2d 998, 1004 (Fed. Cir. 1983). Although a contractor can correct a defective claim certification after an appeal is filed, see 48 CFR 33.207(f), it cannot remedy a complete failure to certify. *K Satellite v. Department of Agriculture*, CBCA 14, 07-1 BCA ¶ 33,547, at 166,154; see *B&M Cillessen Construction Co. v. Department of Health and Human Services*, CBCA 931, 08-1 BCA ¶ 33,753, at 167,084 (2007); *CDM International, Inc.*, ASBCA 52123, 99-2 BCA ¶ 30,467, at 150,514; see also 48 CFR 33.201 (“[f]ailure to certify shall not be deemed to be a defective certification”).

Here, although STHS has represented that the June 1, 2011, claim was “certified,” Complaint ¶ 35, we were unable to locate any evidence in the record to support that statement. In response to our inquiry about the missing certification, appellant’s counsel stated in a letter dated September 23, 2014, that STHS “is unable to locate the certification that it believes accompanied the claim,” but that STHS “believes that the certification may have been placed in one of the six boxes of claim material, referenced in the claim, that were provided to the VA contracting officer as supporting documentation.” Appellant’s counsel further asserted that, “[a]lthough STHS cannot locate the original certification, it believes that it was submitted, since the contracting officer in conjunction with counsel, prepared a final decision, which would not have been required absent a properly certified claim.”

As the appellant, STHS bears the burden of proving jurisdiction by a preponderance of the evidence. See *McNutt*, 298 U.S. at 189; *Reynolds*, 846 F.2d at 748. To satisfy this burden, STHS must establish that it is “more probable” than not that STHS submitted its certification with its June 1 claim. See *LaLonde v. Secretary of Health & Human Services*, 746 F.3d 1334, 1338 (Fed. Cir. 2014) (defining “preponderance” standard). STHS’s belief that it “may” have placed a certification in a box accompanying the June 1 claim is simply insufficient to meet that burden. Even had STHS affirmatively declared that it submitted the certification, counsel’s statement is devoid of any specific information tending to support that fact – he does not identify the purported certification’s signatory or the person who purportedly prepared it for signature, he does not identify specific persons who recall seeing the submitted CDA certification, and there is no indication that an unsigned copy (drafted

contemporaneously with the June 1 claim submission) was found on the drafter’s computer hard drive or in paper form. Further, STHS presents no affidavits or declarations from the fact witnesses who would have prepared and signed the certification, and “[a]llegations without support are not evidence.” *Castle*, AGBCA 97-128-1, 97-1 BCA ¶ 28,833, at 143,845. Counsel’s reference to a vague generalized recollection of an unsupported corporate belief is simply insufficient to establish certification by a preponderance of the evidence.

It is true, as STHS notes, that the CO actually issued a final decision on the June 1 claim. *See Exhibit 1* (Bates 000007). Issuance of a decision in response to an uncertified claim, however, does not cure or waive the jurisdictional defect. *Red Gold*, 12-1 BCA at 171,722; *Hemmer-IRS Limited Partnership v. General Services Administration*, GSBCA 16134, 04-1 BCA ¶ 32,509, at 160,814. Further, the CO’s action in issuing the decision does not necessarily indicate that, as respondent suggests, STHS must have certified the claim. In fact, a comparison of the final decisions issued in response to the April 4 claim and the June 1 claim strongly suggest that the June 1 claim was, in fact, not certified. In its April 4 claim, STHS sought an amount below the \$100,000 certification threshold, and the contracting officer issued a final decision denying that claim. The contracting officer’s final decision in response to the June 1 claim was virtually identical to the prior final decision, except for the addition of the following sentence to the conclusion: “In addition, claims submitted to the Agency in excess of \$100,000 must be certified in accordance with FAR 33.207(c).” Exhibit 1 (Bates 000007). Although the CO did not expressly state that STHS’s June 1 claim was uncertified, had the claim been accompanied by the required CDA certification, the addition of that sentence to the final decision would seemingly have no purpose, suggesting that it was not certified. In any event, STHS’s inability to produce a copy of its certification, coupled with its failure to identify the putative signatory to or preparer of such a certification and the absence of any affirmative definitive statement under oath and by declaration that the certification was definitely provided to the VA with the June 1 claim, preclude STHS from meeting its burden of establishing the necessary prerequisite to this Board’s jurisdiction to entertain CBCA 2774.

Perhaps recognizing the problem created by the absent certification, STHS, in response to the Board’s inquiry regarding this issue, has provided the VA contracting officer with what it calls a “recertification,” containing the language required by the CDA and signed by STHS’s Chief Financial Officer. Unfortunately, that certification is dated September 22, 2014, long after this appeal was filed. Jurisdiction must be determined under the actual circumstances existing at the time the case is filed. *Sharman Co. v. United States*, 2 F.3d 1564, 1569 (Fed. Cir. 1993), *overruled in part on other grounds by Reflectone, Inc. v. Dalton*, 60 F.3d 1572 (Fed. Cir. 1995); *see Newman-Green, Inc. v. Alfonzo-Larrain*, 490 U.S. 826, 830 (1989) (jurisdiction “ordinarily depends on the facts as they exist” when the

case is filed). “[P]ost-filing events cannot create jurisdiction.” *Tyler House Apartments, Ltd. v. United States*, 38 Fed. Cl. 1, 17 (1997) (citing *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 571 n.4 (1992)). Accordingly, as this Board has repeatedly recognized, a certification issued during the pendency of a case has “no legal bearing on the Board’s jurisdiction over the subject appeal and [could not] serve to cure our lack of jurisdiction.” *B&M Cillessen Construction*, 08-1 BCA at 167,085 (citing *CDM International*, 99-2 BCA at 150,514).⁸

Because STHS’s June 1, 2011, claim exceeded \$100,000 and STHS has failed to establish that it was certified, we lack subject matter jurisdiction to entertain that claim. Accordingly, CBCA 2774, the case that is the subject of that claim, is dismissed for lack of jurisdiction.

III. Jurisdiction to Entertain CBCA 2775

The April 4, 2011, claim underlying CBCA 2775 seeks less than \$100,000 and, therefore, is not subject to the certification requirement discussed above. Nevertheless, respondent raises two jurisdictional arguments regarding the April 4 claim in its motion for summary relief, which we treat as a motion to dismiss.⁹

⁸ Further, at the moment, there is no valid final decision upon the newly certified claim that STHS could appeal. STHS will have no right of appeal until the CO issues a final decision on the newly certified claim or that claim is “deemed denied” by the passage of time. See *Ostaszewski v. Department of State*, GSBCA 16319-ST, 04-2 BCA ¶ 32,640, at 161,509 (“a contracting officer’s decision is ‘the very lynchpin and necessary prerequisite for the board’s jurisdiction’” (quoting *McDonnell Douglas Corp. v. United States*, 754 F.2d 365, 370 (Fed. Cir. 1985)).

⁹ In evaluating jurisdiction *sua sponte*, the Board also recognizes that, although appellant and respondent agree that the April 4, 2011, claim seeks a total of \$77,870.24, the claim letter itself does not expressly state that figure. A valid CDA claim seeking monetary relief must contain a demand for “the payment of money in a sum certain.” 48 CFR 2.201. Although no particular wording is necessary, the demand must contain “a clear and unequivocal statement that gives the contracting officer adequate notice of the . . . amount of the claim.” *Contract Cleaning Maintenance, Inc. v. United States*, 811 F.2d 586, 592 (Fed. Cir. 1987). Generally, then, “[t]o comply with the sum certain requirement for a valid claim, a fixed amount must be stated.” *ASP Denver, LLC v. General Services Administration*, CBCA 2618, 12-1 BCA ¶ 35,007, at 172,041. Nevertheless, the sum certain requirement is satisfied if a total “is readily calculable by simple arithmetic from the

(continued...)

First, respondent argues that, in STHS's claims to the CO, STHS requested relief based solely upon the VA's purported refusal to pay CMG rates for inpatient rehabilitation services. Respondent asserts that STHS's claims to the CO did not include any allegations relating to errors in payment arising out of problems with the FBCS. Accordingly, the VA asserts, the Board lacks jurisdiction over appellant's claim concerning the FBCS. In response, appellant argues that evidence concerning the integrity of the FBCS is highly relevant to its previous claims of underpayments and that these claims were presented to the CO.

Under the CDA, “[e]ach claim by a contractor against the Federal Government shall be submitted to the contracting officer for a decision.” 41 U.S.C. § 7103(a)(1). The Board has jurisdiction over appeals from a contracting officer’s final decision on claims that were either denied or deemed denied. *CB&I Federal Services LLC v. Department of Homeland Security*, CBCA 3112, et al., 14-1 BCA ¶ 35,550, at 174,210 (citing *Walsh/Davis Joint Venture v. General Services Administration*, CBCA 1460, 10-2 BCA ¶ 34,479). The purpose of this requirement is to allow the CO to pass judgment on the contractor’s entire claim. *Ketchikan Indian Community v. Department of Health and Human Services*, CBCA 1053-ISDA, et al., 13 BCA ¶ 35,436, at 173,808 (citing *Scott Timber Co. v. United States*, 333 F.3d 1358, 1366 (Fed. Cir. 2003)). Therefore, the Board does not have jurisdiction over new claims that were not presented to the contracting officer. *EHR Doctors, Inc. v. Social Security Administration*, CBCA 3522, 14-1 BCA ¶ 35,630, at 174,492 (citing *Santa Fe Engineers, Inc. v. United States*, 818 F.2d 856, 858 (Fed. Cir. 1987)). The Board does not require rigid adherence to the original claim, but “[r]ather, when a new claim is asserted that was not directly addressed in the appellant’s original claim submission, the tribunal must examine whether the newly posed claim derives from the same operative facts, seeks essentially the same relief, and, in essence, merely asserts a new legal theory for the recovery

⁹(...continued)

attachments” to the claim. *PHI Applied Physical Sciences, Inc.*, ASBCA 56581, et al., 13 BCA ¶ 35,308, at 173,337, *appeal dismissed*, No. 2013-1627 (Fed. Cir. Dec. 11, 2013); see *Metric Construction, Inc. v. United States*, 1 Cl. Ct. 383, 391 (1983) (sum certain requirement met with data “which allows for reasonable determination of the recovery available at the time the claim is presented and/or decided by the contracting officer”); *Madison Lawrence, Inc.*, ASBCA 56551, 09-2 BCA ¶ 34,235, at 169,207 (“when the amount can be calculated with reasonable effort, a contractor’s submission is sufficiently in a sum certain”). Here, the documents that accompanied the written claim are not in the record. Nevertheless, it is clear that both respondent and appellant were able to calculate the precise figure at issue from those documents. Accordingly, the sum certain requirement appears satisfied.

originally sought.” *Ketchikan Indian Community*, 13 BCA at 173,808-09 (citing *Scott Timber*, 333 F.3d at 1365).

In its April 4, 2011, claim, appellant alleged that, since the implementation of the contract, respondent has not reimbursed medical claims according to current Medicare rates. To support its argument, appellant sent 1434 “medical claims” as proof of underpayments. In her final decision, the CO acknowledged that the alleged underpayments may have various causes. In the complaint, appellant then asserts that underpayments were caused by the CMG/DRG rate dispute, as well as by faults within the FBCS.

We find that both the CMG/DRG rate dispute and the FBCS issue are encompassed within the April 4, 2011, claim. STHS alleged in its April 4 claim that “Hospital (institutional) claims have not been paid based on STHS current Medicare rates and Physician (professional) claims for all CPT’s at the current Medicare rates.” Exhibit 1 (Bates 000018). STHS also represented that it had “repeatedly requested” implementation of an appropriate payment scheme “so that the accounts could be adjusted appropriately.” *Id.* The claim does not limit itself to inpatient rehabilitation claims and, in fact, does not even use the words “inpatient rehabilitation” or “CMG.” It instead expansively encompasses underpayments, which would include both the CMG/DRG rate dispute and the FBCS payment issue. The allegations relating to the FBCS arise out of the same operative facts as those identified in the claim and request the same relief as that asserted in the claim. Appellant’s complaint merely asserts alternative theories for how the alleged underpayments occurred. The facts for both the claim and the complaint remain the same and require the CO and the Board to consider what services appellant rendered, how much the contract required respondent to pay for those services, and whether respondent paid the correct amount. The CO considered these factors in her final decisions, and the “new” assertion that the FBCS altered medical claim amounts is merely a theory about how the wrong amounts were paid and does not rise to the level of a separate claim. We have jurisdiction to entertain the claim underlying CBCA 2775.

Second, respondent argues that we lack jurisdiction to consider various documents that STHS references in its complaint or has included in a supplemental appeal file, including several VA Office of Inspector General (OIG) reports, Congressional Subcommittee hearing excerpts, and Medicare rules published in the Federal Register that “were never submitted to the Contracting Officer for a Final Decision.” Respondent’s Motion for Summary Judgment (Respondent’s Motion) at 13. The VA asserts that, “since it is patently clear that these submissions are irrelevant to the contract dispute before the Board, any discussion or review of these documents should be considered outside the jurisdiction of the Board.” *Id.* at 13-14.

Respondent has confused the issues of jurisdiction and relevance. Under the CDA, 41 U.S.C. §§ 7101-7109, the Board has jurisdiction to entertain appeals challenging a contracting officer’s final decision denying a contractor’s CDA claim. *Id.* §§ 7104(a), 7105(e)(1)(B). Here, as we have already found, we possess jurisdiction to entertain STHS’s appeal of the CO’s final decision underlying CBCA 2775. Whether the documents about which respondent complains actually support or relate to STHS’s factual and legal arguments goes to those documents’ relevance to this case. Under Rule 401 of the Federal Rules of Evidence, evidence is relevant if it “has any tendency to make a fact more or less probable than it would be without the evidence” and “the fact is of consequence in determining the action.” Fed. R. Evid. 401. Relevant evidence is admissible in a proceeding unless the United States Constitution, a Federal statute, the Federal Rules of Evidence, or other rules prescribed by the Supreme Court provide otherwise. Fed. R. Evid. 402. Although respondent could raise evidentiary objections to the relevance of the documents that STHS has cited, objections to particular pieces of evidence do not in any way affect the Board’s jurisdiction to entertain the underlying case. The Board’s jurisdiction arises from appellant’s timely appeal of the CO’s final decision at issue in CBCA 2775, not from the documents that appellant wants to use to support its arguments. Respondent’s attempt to turn evidentiary objections into an issue of subject-matter jurisdiction is wholly unfounded.¹⁰

Motions for Summary Relief

I. Standard of Review

Summary relief is this Board’s analogous procedure to summary judgment. *GE Capital Information Technology Solutions-Federal Systems v. General Services Administration*, GSBCA 15467, 01-2 BCA ¶ 31,445, at 155,306. “Summary relief is only

¹⁰ Respondent also asserts that, because the challenged documents were “never submitted to the Contracting Officer” as part of the claim, the Board cannot review them here. *See* Respondent’s Motion at 13. Respondent is wrong. This Board’s review of a challenge to a CO’s final decision is *de novo*, *Bay Shipbuilding Co. v. Department of Homeland Security*, CBCA 54, et al., 07-2 BCA ¶ 33,678, at 166,743 (citing *Wilner v. United States*, 24 F.3d 1397, 1401-02 (Fed. Cir. 1994) (*en banc*)), not a review limited to an administrative record developed before the CO. Although there may be evidentiary reasons that particular documents will not be admissible in a case, appellants in CDA cases are not barred from submitting documentary evidence to the Board in support of their appeals simply because they did not originally present that evidence to the CO. *See generally H.L. Smith, Inc. v. Dalton*, 49 F.3d 1563, 1566 (Fed. Cir. 1995) (supporting documentation need not accompany CDA claim for jurisdiction to attach on appeal).

appropriate where there is no genuine issue as to any material fact and the moving party is entitled to relief as a matter of law.” *Butte Timberlands, LLC v. Department of Agriculture*, CBCA 3232, 13 BCA ¶ 35,383, at 173,627 (quoting *Greene v. Department of Homeland Security*, CBCA 49, 07-2 BCA ¶ 33,668, at 166,700). A material fact is one that will affect the outcome of a case. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247 (1986). “Any doubt on whether summary relief is appropriate is to be resolved against the moving party. *Butte Timberlands*, 13 BCA at 173,627 (quoting *Greene*, 07-2 BCA at 166,700).

In these consolidated cases, both parties moved for summary relief, addressing two distinct issues: (1) whether appellant is entitled to payment at the CMG rate for providing inpatient rehabilitation services as a Medicare-certified IRF, and (2) whether respondent’s FBCS altered Medicare reimbursement amounts for services rendered. It is unclear from the record which of the 1434 patient claims are alleged underpayments because of the CMG rate issue and which can be attributed to the alleged alteration by the FBCS.

II. Claims for Underpayments Based on Appellant’s Status as an IRF

For inpatient rehabilitation services, appellant claims it is entitled to be reimbursed at the higher CMG rate (rather than at the DRG rate that respondent insists the contract requires) because it is a Medicare-certified provider of such rehabilitation services. The contract language determines whether STHS is limited to payment at DRG rates. Contract interpretation begins with the contract language’s plain meaning. *ACM Construction & Marine Group, Inc. v. Department of Transportation*, CBCA 2245, et al., 14-1 BCA ¶ 35,537, at 174,151 (citing *LAI Services, Inc. v. Gates*, 573 F.3d 1306, 1314 (Fed. Cir. 2009)). The contract is read as a whole to give reasonable meaning to all parts. *Gould, Inc. v. United States*, 935 F.2d 1271, 1274 (Fed. Cir. 1991). The inquiry ends if the plain language is unambiguous. *ACM Construction*, 14-1 BCA at 174,151 (citing *Hunt Construction Group, Inc. v. United States*, 281 F.3d 1369, 1373 (Fed. Cir. 2002)).

The contract language here is clear and unambiguous: it does not limit the contractor to DRG and CPT pricing for every service that the contractor might provide. Although the solicitation indicated that, in “determining the total estimated dollar amount” of the anticipated contract award, the VA would evaluate offers using “the list of DRG and CPT codes in Attachment D.1” to the solicitation “and the estimated quantities shown there,” see Exhibit 11, Clause B.2.5 (Bates 001026), that language clearly was intended to provide the VA with a basis for uniformly comparing competing offers during the contract award decision-making process and not to limit the VA’s ability to purchase necessary medical services, as the VA plainly stated in Attachment D.1 itself: “Representative DRG or CPT codes have been supplied in this Price Schedule to provide a uniform methodology to evaluate proposed offers.” Exhibit 17 at 1.

Even though the VA argues that the contract limits appellant to DRG and CPT pricing, it has identified nothing in Clause B.2.5 or in any other contract clause that expressly imposes such limits upon any and all services that appellant might perform. Although Clause B.2.5 of the contract states that, during contract performance, “the contractor will be required to provide inpatient care services for any Medicare DRG and CPT code when authorized by the VA,” Exhibit 9, Clause B.2.5 (Bates 000607), the clause does not preclude the VA from obtaining services that are not covered by a DRG or CPT code, and it does not expressly limit payment for such services to DRG and CPT codes.

In fact, in the solicitation, respondent expressly recognized the possibility that it would order services not expressly identified in the contract and that the VA would have to pay for those services: “After award VA may have need to add services not listed. If such needs arise, VA will ask the contractor if such services can be provided and, if so, VA may negotiate a modification to add those services.” Exhibit 11, Clause E.5.4 (Bates 001101). Clause B.2.2 states that “[p]ricing for this contract is based on actual services provided in accordance with contract percentage of current Medicare rates,” with adjustments in pricing during the term of the contract limited to “published changes in Medicare rates.” Exhibit 9, Clause B.2.2 (Bates 000606); *see Appeal File, Exhibit 11 (Bates 001102)* (“[t]hroughout the life of the contract, VA will pay current Medicare rates in effect at the time of performance”). Here, the “contract percentage” was 103% or 106% of Medicare rates, depending on the corresponding CLIN. *See Exhibit 9, Clause B.3.1 (Bates 000608).* Accordingly, to the extent that the VA obtained services, it had to pay for them at that percentage of the applicable Medicare rate, whether the proper code was a DRG, a CPT, or a CMG.

Under Medicare regulations, Medicare-certified IRFs are generally reimbursed at a CMG rate. *See 42 CFR 412.624* (discussing methodology for calculating payments to IRFs within CMGs); *see also CMS Manual System, Pub. 100-04 Medical Claims Processing, Transmittal 1104, at 71, available at* <http://www.cms.gov/Medicare/cms-forms/cms-forms/cms-forms-items/cms1196256.html>*(Medicare billing form showing that IRFs are billed at CMG rates).* The contract did not specifically address, or limit, the price to be paid for inpatient rehabilitation services by an IRF provider. Under the terms of this contract, STHS is entitled to price its reasonable and necessary IRF-provided inpatient rehabilitation services “in accordance with [the] contract percentage” – that is, 103% and 106% – “of current Medicare rates.” Exhibit 9, Clause B.2.2 (Bates 000606).

Respondent argues that requiring it to pay Medicare rates is inappropriate because the VA “is not governed by Medicare or” the Department of Health and Human Services. Respondent’s Motion at 10. To the extent that the VA is arguing that it never needs to pay Medicare rates, the VA’s position appears in conflict with its own published regulations, through which it has voluntarily obligated itself to pay Medicare rates for inpatient hospital

services in at least certain situations. *See* 38 CFR 17.55, .56. It is unnecessary to evaluate the scope and meaning of those regulations, however, because, in the contract at issue here, the VA contractually bound itself to pay such rates. It plainly stated that it would pay the “contract percentage” of applicable Medicare rates. To the extent that the VA obtained reasonable and necessary IRF inpatient rehabilitation services, the contract does not permit respondent to limit its liability to DRG and CPT rates.

That being said, we hold here only that the contract does not limit potential recovery to DRG and CPT rates. We express no opinion at this time, and cannot on the basis of the current record, about the appropriateness of any individual IRF medical claim for which appellant might be seeking payment. Although appellant has argued that it is entitled to recovery at CMG rates for its IRF inpatient rehabilitation services, the medical claims for which it is seeking recovery are not a part of the record. Accordingly, the record does not indicate the means by which inpatient rehabilitation services through an IRF (rather than a non-IRF facility) were ordered or whether the use of an IRF was “reasonable and necessary” under Medicare rules. *See* 42 U.S.C. § 1395y(a)(1)(A) (limiting Medicare payments to “reasonable and necessary” services). To the extent that appellant identifies specific individual “medical claims” that it believes were not properly paid, which it will have to do to quantify its alleged underpayments, the VA may still raise challenges to the appropriateness of the use of an IRF in particular instances. *See United Medical Healthcare, Inc. v. Department of Health and Human Services*, 889 F. Supp. 2d 832, 841 (E.D. La. 2012) (discussing payment challenges to medical services that may not have been “reasonable and necessary” pursuant to Medicare rules). On the record here, we have no basis for addressing such issues. We hold here only that the VA cannot defend against “medical claims” seeking payment using a CMG code by asserting that STHS’s contract limits payments to DRG and CPT rates.

III. Claims for FBCS underpayments

The second issue is whether respondent’s FBCS¹¹ altered reimbursement amounts so that appellant was not paid according to current Medicare rates. The contract requires that respondent reimburse appellant in accordance with current Medicare rates plus a certain percentage. Whether or not the FBCS modified reimbursement amounts, the issue here is whether respondent paid appellant the proper amount for services rendered. If appellant can

¹¹ As previously discussed, it appears from the record that the VistA Fee System, not the FBCS, was the claims processing system in place during the time period at issue in CBCA 2775. We will assume for purposes of the pending motions that appellant’s discussion of the FBCS also encompasses the VistA Fee System.

prove that respondent paid less than the contractual amount, it will be entitled to the difference between “contract percentage” of the Medicare rate and the amount that respondent paid, regardless of the reason for the underpayment.

Unfortunately, the record here provides us with no basis for determining whether appellant received any underpayments through the FBCS. To support its argument, appellant has provided us with several OIG reports and other materials criticizing and identifying problems with the VistA Fee System and/or the FBCS, but not with any audit reports or accounting records establishing particular underpayments. None of the cited reports establish that, with regard to any particular payment that the VA owed appellant, appellant was underpaid. Appellant cannot recover based upon mere speculation that, because there were problems with the FBCS, it must have been underpaid. Instead, it has an affirmative burden to show that it suffered actual damage from the Government acts of which it complains. *See, e.g., Puritan Associates, Inc. v. United States*, 215 Ct. Cl. 976, 978 (1977) (appellant “must show it was damaged . . . by defendant’s derelictions”); *Willems Industries, Inc. v. United States*, 295 F.2d 822, 831 (Ct. Cl. 1961) (claimant must “prov[e] the fact of loss with certainty, as well as . . . the amount of loss with sufficient certainty so that the [eventual] determination of the amount of damages will be more than mere speculation”); *Winn-Senter Construction Co. v. United States*, 75 F. Supp. 255, 259 (Ct. Cl. 1948) (“[t]hese being suits for breach of contract, the plaintiffs had the burden not only of proving that there were breaches, but that they were harmed by the breaches, and the extent of the harm, within measurable limits”). Although criticisms of the FBCS may assist appellant in proving that it was underpaid, only a thorough analysis of STHS’s payment requests and receipts – either through fact accounting witnesses or an expert that appellant hires to assist in such an analysis – will provide the evidence that appellant will need to prove that it was underpaid in specific amounts.

Because neither appellant nor respondent was able to establish the existence, or absence, of underpayments in their respective motions for summary relief, we deny both parties’ motions to the extent that they address amounts to be recovered.

Decision

For the reasons stated above, CBCA 2774 is **DISMISSED**, in its entirety, **FOR LACK OF SUBJECT-MATTER JURISDICTION**. Appellant’s motion for summary relief in CBCA 2775 is **GRANTED IN PART**, and respondent’s motion is **DENIED**.

Because the record in CBCA 2775 is not sufficiently developed, we cannot currently rule on quantum. The Board will schedule a telephonic conference to discuss further proceedings.

HAROLD D. LESTER, JR.
Board Judge

We concur:

JEROME M. DRUMMOND
Board Judge

CANDIDA S. STEEL
Board Judge