PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2015-D29

PROVIDERS –
HealthSouth 2006 SSI Percentage Group
HealthSouth 2007 SSI Percentage CIRP Group

Provider Nos.: Various

vs.

MEDICARE CONTRACTOR –
Cahaba Government Benefits Administrators, LLC

DATE OF HEARING -
August 12, 2015

Cost Reporting Periods Ended -
September 28, 2006; September 30, 2006;
December 31, 2006; May 31, 2007;
June 30, 2007; December 31, 2007

CASE NOs.: 09-0861GC and 09-1942GC

INDEX

ISSUE STATEMENT:

Does the Provider Reimbursement Review Board ("Board") have jurisdiction to review the Medicare Contractor's determination of low-income patient ("LIP") adjustments for the 2006 and 2007 HealthSouth SSI Percentage CIRP Groups ("HealthSouth")?

DECISION:

After considering the Medicare law and program instructions, the evidence presented, and the parties' contentions, the Board concludes that it does have jurisdiction to review the Medicare Contractors' determination of the Low Income Patient ("LIP") adjustments for HealthSouth, including the understatement of the 2006 and 2007 LIP SSI ratios. The Board remands this matter to the Medicare Contractors to recalculate HealthSouth's LIP adjustment using the most recently updated Supplemental Security Income ("SSI") ratios published by the Centers for Medicare and Medicaid Services ("CMS") for 2006 and 2007.

INTRODUCTION:

This consolidated group appeal involves sixty-five rehabilitation hospitals which are part of HealthSouth Corporation (collectively referred to as "HealthSouth").[1] The Medicare contractor[2] currently assigned to HealthSouth is Cahaba Government Benefits Administrator ("Medicare Contractor"). The Medicare Contractor issued LIP adjustment payments to HealthSouth for 2006 and 2007. HealthSouth appealed these LIP adjustment payments claiming that they did not reflect the proper SSI ratio.

STATEMENT OF FACTS

HealthSouth appealed Notices of Program Reimbursement ("NPRs") for FYs 2006 and 2007 cost reports. As part of these NPRs, the Medicare Contractor calculated HealthSouth's LIP adjustment payment using the latest available SSI ratio published by CMS. HealthSouth timely appealed the Medicare Contractor's calculation of the LIP adjustment payment for each cost report, on the basis that the SSI ratios issued by CMS and utilized by the Medicare Contractor on the final settled cost reports were understated and, as such, improperly reduced payments to HealthSouth. HealthSouth maintains that it should be paid an additional $79,591 in Medicare reimbursement.[3] The Medicare Contractor challenged the Board jurisdiction on the basis that the

[1] Appendix A includes a listing of the 65 providers by case number and fiscal year that remain in this consolidated group appeal. Originally, there were 26 providers in Case No. 09-1942 but 2 providers were remanded pursuant to CMS Ruling 1498-R ("1498-R"). Specifically, the Board remanded the SSI ratio issue for the 26 providers in Case No. 09-1942GC and the 41 providers in Case No. 09-0861GC pursuant to 1498-R on December 10, 2012, and February 19, 2013. The Board then vacated the 1498-R remands of the SSI ratio issue in these cases on July 11, 2014 because the Board found that the majority of the participants in Case Nos. 09-1942GC and 09-0861GC were rehabilitation hospitals receiving a LIP adjustment and 1498-R applies only to DSH adjustments. On August 12, 2015, the Board remanded the SSI ratio issue for 2 of the 26 Providers in for Case No. 09-1942GC (Providers 2 and 16) because these hospitals were not rehabilitation hospitals and did not receive a LIP adjustment but rather received a DSH adjustment.

[2] Fiscal intermediaries ("FIs") and Medicare Administrative Contractors ("MACs") will be referred to as "Medicare Contractors".

[3] *See* Providers' Response to Medicare Contractor's Jurisdictional Challenge, at 3.

federal statute precludes administrative review of the LIP adjustment.[4]

As part of the Balanced Budget Act of 1997, Congress promulgated 42 U.S.C. § 1395ww(j) to create the inpatient rehabilitation facility prospective payment system ("IRF-PPS") for cost reporting periods beginning on or after October 1, 2002.[5] The statute required that the IRF-PPS rates be based on estimates of inpatient operating and capital costs of IRFs using the most recent cost report data available.[6]

The IRF-PPS rates are subject to certain adjustments.[7] This case focuses on one of these adjustments, LIP adjustment, specified at 42 C.F.R. § 412.624(e)(2). Congress did not specifically identify the LIP adjustment in the IRF-PPS statutory provisions. Rather, the Secretary created and implemented the LIP adjustment based on her discretionary authority established under § 1395ww(j)(3)(A)(v) to adjust the IRF-PPS payment rate "by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities."[8]

DISCUSSION, FINDINGS OF FACTS, AND CONCLUSIONS OF LAW:

JURISDICTION OVER THE LIP ADJUSTMENT

The Medicare Contractor contends the language of 42 U.S.C. § 1395ww(j)(8)(B)[9] unambiguously precludes administrative and judicial review of the IRF-PPS rates established under 42 U.S.C. § 1395ww(j)(3)(A). The Medicare Contractor maintains that, because the IRF-PPS rate is comprised of both the general federal rate based on historical costs and *all* adjustments to that federal rate (including, but not limited to, the LIP adjustment at issue), the statute prohibits administrative and judicial review of the LIP adjustment.[10] Accordingly, the Medicare Contractor argues that the Board is divested of jurisdiction to hear HealthSouth's appeal because it must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[11]

HealthSouth responds that Congress precluded judicial review of the Secretary's establishment of the base IRF-PPS rate and *certain* adjustments, but did not preclude review of whether the Medicare Contractor properly calculated the LIP adjustments pursuant to the Secretary's formula.[12]

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[4] *See* Medicare Contractor's Jurisdictional Challenge at 3, ¶10.
[5] Pub. L. No. 105-33, § 4421, 111 Stat. 251, 410 (1997).
[6] 42 U.S.C. § 1395ww(j)(3)(A).
[7] *See* 42 U.S.C. §§ 1395ww(j)(3)(A)(i) – (v) √ja ; 42 C.F.R. § 412.624(e).
[8] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[9] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 1886(j)(7) of the Act [42 U.S.C. § 1395ww(j)(7)] to section 1886(j)(8) [42 U.S.C. § 1395ww(j)(8)] and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs.
[10] Medicare Contractor's Jurisdictional Challenges at 2.
[11] 42 C.F.R. § 405.1867; Medicare Contractor's Jurisdictional Challenges at 2.
[12] Providers' Response to Medicare Contractor's Jurisdictional Challenge at 1.

HealthSouth disputes the number of Medicaid days used in the *calculation* of the SSI fraction supplied by CMS and used by the Medicare Contractor, not the *establishment* of the underlying IRF LIP formula used to calculate LIP adjustments in general. HealthSouth contends that § 1395ww(j)(8) does not prohibit its challenge as to whether CMS and its agents utilized the proper data elements in executing that formula.[13] HealthSouth maintains that, while § 1395ww(j)(8) prohibits administrative or judicial review for certain aspects of the establishment of the IRF payments, there is no specific language within § 1395ww(j)(8) prohibiting administrative or judicial review as it pertains to the calculation of LIP.[14] Even if the Board were to agree with the Medicare Contractor that § 1395ww(j)(8) limits review of the "rates" and the adjustment formula, Congress expressly referred only to "rates" in § 1395ww(j)(8) as not being subject to review, not the adjustments that are made to the rates as applicable.[15]

In addition, HealthSouth points to Congress's use of the term "paragraph (3)" within § 1395ww(j)(8)(B) and invokes the "common interpretative cannon of *expressio unius est exclusio alterius"*[16] by asserting that if the term "paragraph (3)" was intended to cover *all* adjustment formulas referenced in § 1395ww(j)(3)(A)(i) through (3)(A)(v), and to cover *all* adjustment calculations pursuant to such formulas, as the Medicare Contractor alleges, then there would have been no need to include additional limiting subparagraphs (A), (C) or (D) in § 1395ww(j)(8)[17] to specify that certain adjustments are non-reviewable.

In reviewing this matter, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

> There shall be no administrative or judicial review . . . of the establishment of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),
>
> (C) outlier and special payments under paragraph (4), and
>
> (D) area wage adjustments under paragraph (6).

Consistent with its recent decision in *Mercy Hospital v. First Coast Service Options, Inc.* ("*Mercy*"),[18] the Board concludes § 1395ww(j)(8) prohibits administrative review of the establishment of both the IRF-PPS payment rates under 42 U.S.C. § 1395ww(j)(3) and *only*

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[13] *Id.* at 2-3.
[14] *Id.* at 3-4.
[15] *Id.* at 3.
[16] Providers' March 13, 2013 Response to Medicare Contractor's Jurisdictional Challenge at 5.
[17] *Id.* at 5- 6.
[18] PRRB Dec. No. 2015-D7 (Apr. 3, 2015).

certain enumerated adjustments to those rates as specified in 42 U.S.C. §§ 1395ww(j)(2), (4), and (6).

In reaching this legal conclusion, the Board recognizes that the both the Medicare Contractor in this appeal and the Administrator's decision to reverse the Board's decision in *Mercy*[19] read the statutory language much more broadly by maintaining that the phrase "the prospective payment rates under paragraph (3)" as used in §1395ww(j)(8)(B) encompasses both the general IRF-PPS rate (*i.e*., the unadjusted federal rate) and any and *all* adjustments to those rates, including the LIP adjustment. However, the Board disagrees with the Medicare Contractor and the Administrator's decision in *Mercy* for the following reasons:

1) As explained below, a thoughtful examination of the *entirety* of § 1395ww(j) confirms that the phrase "the prospective payment rates under paragraph (3)" as used in § 1395ww(j)(8) ("Paragraph 8") does *not* encompass *all* of § 1395ww(j)(3) ("Paragraph (3)"). Rather, the Paragraph 8 reference prohibiting review is *limited* to only prohibiting the review of the general federal "rates" *before* they are "adjusted" by the items enumerated in Clauses (i) to (v) of Paragraph (3)(A). The adjustments enumerated in Clauses (i) to (v) include the LIP adjustment that the Secretary established pursuant to her discretionary authority granted under Clause (v).

   To illustrate, one of the adjustments enumerated in Paragraph (3) is the area wage adjustment. Specifically, the area wage index is named as an adjustment in Paragraph (3)(A)(iii) and Paragraph (3)(A)(iii) then cross references Paragraph (6) where the wage index adjustment is defined. Significantly, Paragraph (8) specifically prohibits administrative review of the area wage adjustment under Paragraph (6). Logically, if the phrase "the prospective payment rates under paragraph (3)" in Paragraph (8)(B) were broadly interpreted to encompass *both* the general federal rate established in Paragraph (3) *and* any and *all* adjustments to the federal rate specified in Paragraph (3), as asserted by the Medicare Contractor and the Administrator, then the specific prohibition on administrative review of the area wage adjustment in Paragraph (8)(D) would be redundant and superfluous because a specific prohibition on the wage index adjustment to the federal rate would *already* be encompassed by the broadly interpreted reference to Paragraph (3) in Paragraph (8)(B). Similarly, the interpretation proposed by the Medicare Contractor and the Administrator would render other references in subsection (j), including outliers and special payments in Paragraph (8)(C), redundant and equally nonsensical.

   Further, the Board notes that the phrase "the prospective payment rates under paragraph (3)" as used in Paragraph (8)(B) is used again almost verbatim in Paragraph (6) concerning the area wage adjustment. Again, the area wage index is named as an adjustment *to* the prospective payment rates in Paragraph (3)(A)(iii) and Paragraph (3)(A)(iii) then cross references Paragraph (6) where the wage index adjustment is defined. Paragraph (6) states that the Secretary "shall adjust . . . *the prospective payment rates computed under paragraph (3)* for area differences in wage levels."[20] And, again,

[19] *Mercy*, Adm'r Dec. (June 1, 2015), *vacating and dismissing*, PRRB Dec. No. 2015-D7 (Apr. 3, 2015).
[20] (Emphasis added.)

under the Medicare Contractor's proposed interpretation, the term "the prospective rates under paragraph (3)" would include *both* the general federal rates and any and all associated adjustments named in Paragraph (3)(A), including but not limited to the area wage adjustment specified in Clause (iii) of Paragraph (3)(A). However, the Medicare Contractor's proposed interpretation would render the directive in Paragraph 6 (*i.e.*, "adjust . . . *the prospective payment rates computed under paragraph (3)* for area differences in wage levels") nonsensical because the proposed interpretation would necessarily mean that the Secretary was to adjust the "prospective payment rates under paragraph (3)" with the area wage adjustment notwithstanding that the term "prospective payment rates under paragraph (3)" would, per the Medicare Contractor's interpretation, already *include* the area wage adjustment. The Board's reading avoids this nonsensical circular outcome by finding that the adjustments *to* the "prospective payment rates computed under paragraph 3" are separate and external to the federal prospective payment rates which they modify.

Based on the above, the Board concludes that the statutory drafters clearly intended to limit review of *only certain* adjustments to the federal rate and, to this end, they specifically itemized those adjustments which are designated as non-reviewable in Paragraph (8). Accordingly, the Board is convinced that the statute must be read in this manner based on the Board's conclusion that the Medicare Contractor's proposed interpretation of the phrase "the prospective payment rates under paragraph (3)" in Paragraph (8)(B) cannot logically be reconciled with the entirety § 1395ww(j).[21]

2) The text of 1395ww(j)(8) prohibits administrative or judicial review of "the *establishment* of" the items listed in Subparagraphs (A) to (D). The Board finds that the use of the word "establishment" in the statute significant.[22] Similar to the provider in *Mercy*, HealthSouth is not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, as the appeal challenges no part of the August 2001 Final Rule in which the Secretary established the LIP adjustment itself (*i.e.*, the formula used to calculate the adjustment). Rather, HealthSouth is challenging whether the Medicare Contractor properly executed the LIP adjustments, specifically whether the Medicare Contractor's calculations of the LIP adjustments used the proper provider-specific data elements in the calculations.[23] The Board finds no prohibition in 1395ww(j)(8) to administrative or judicial review of *"the calculation of"* the LIP adjustment where the focus is on the accuracy of the provider-specific data elements being used in the LIP adjustment calculation. Significantly, the Administrator's decision in *Mercy* fails to address this distinction.

3) 42 U.S.C. § 1395ww(j)(3)(A)(v) specifically gives discretion to the Secretary to adjust the IRF-PPS rates by "other factors" which she determines to be necessary to properly reflect variation in the costs of treatment among IRFs.[24] The LIP adjustment is one of the "other factors" that the Secretary created. When Congress limited providers' appeal

[21] *Mercy* at 5-6.
[22] 42 U.S.C. § 1395ww(j)(8).
[23] Providers' March 22, 2013 Response to Medicare Contractor's Jurisdictional Challenge at 2 -3.
[24] 42 U.S.C. § 1395ww(j)(3)(A)(v).

rights, it specifically limited review over only certain factors.[25] The statute is silent on whether appeals are permitted for other adjustment factors, including transition period payments in Paragraph (1) or payment rate reductions for failure to report quality data in Paragraph (7).[26] Clearly, Congress could have precluded review of *all* of the adjustments to the IRF-PPS rates that are used to calculate the provider-specific payments rates for each IRF; however, it chose not to do so.

4) The Secretary adopted a regulation limiting administrative and judicial review which mirrors the statutory limitations, specifically limiting review only to the "unadjusted" Federal payment rate. For the years in this appeal, 42 C.F.R. § 412.630 stated:

> Administrative or judicial review under 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factor, the *unadjusted* Federal per discharge payments rates, additional payments for outliers and special payments, and the area wage index.[27] *I*

Significantly, the term "the unadjusted Federal rate" is defined in 42 C.F.R. § 412.624(c) and it does not include any of the adjustments discussed in § 412.624(e), including the LIP adjustment. Further, the Secretary could have expanded the list of adjustments in § 412.630 to include the LIP adjustment but did not do so until the August 2013 Final Rule. During the period at issue, the Board finds that neither the statute nor the regulation precluded review of the LIP adjustment. In this regard, the Board concludes that the regulatory changes made in the August 2013 Final Rule are not applicable to this case because they were effective on October 1, 2013, and CMS did not specify any retroactive application of the changes to § 412.630.[28]

As noted above, the Administrator in *Mercy* reversed the Board's decision that it had jurisdiction over the LIP payment factors. The Administrator restated the Medicare Contractor's assertion that administrative and judicial review of the LIP adjustment is precluded because § 1395ww(j)(8) precludes review of the prospective payment rate under paragraph (3) as well as all adjustments articulated in subsequent paragraphs. The Board, however, remains unconvinced, and continues to disagree with the Administrator's overly broad interpretation.

Based on the above, the Board concludes that it has jurisdiction to hear LIP adjustment issues.

REMAND

The Board notes that CMS Ruling 1498-R requires recalculation of the Medicare

[25] 42 U.S.C. § 1395ww(j)(8).
[26] Reporting of quality data was required by § 3004 of the Affordable Care Act of 2010. CMS has adopted final rules to allow reconsideration and Board appeals for failure to provide documentation for the IRF Quality Reporting Initiative. *See* 78 Fed. Reg. 47860, 47919 (Aug. 6, 2013).
[27] (Emphasis added.)
[28] *See* 78 Fed. Reg. at 47860, 47901 (stating at 47901 that "the statute . . . is applicable to all pending cases regardless of whether it is reflected in regulations or not"). *See also Mercy* at 6-7.

disproportionate share hospital ("DSH") SSI fraction component of the DSH payment percentage and, consistent with that Ruling, CMS has issued revised SSI percentages for all hospitals for both DSH *and* LIP adjustment calculation purposes.[29] To this end, HealthSouth requested that the LIP SSI percentage issue be remanded to the Medicare Contractors so that the LIP adjustment could be recalculated using the revised SSI percentage.[30] Accordingly, as the Board has jurisdiction over LIP adjustments, the Board remands these HealthSouth cost reports back to the Medicare Contractors for recalculation of HealthSouth's LIP adjustment using the most recently updated SSI percentage published by CMS for 2006 and 2007.[31]

DECISION AND ORDER:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board concludes that it has jurisdiction to review the Medicare Contractors' determination of the LIP adjustments for HealthSouth, including the understatement of the LIP SSI ratios. The Board remands this matter to the Medicare Contractor to recalculate HealthSouth's LIP adjustments using the most recently updated SSI ratios published by CMS for 2006 and 2007.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte Benson, C.P.A.
Jack Ahern, M.B.A.

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 28, 2015

[29] *See* CMS MLN Matters No. SE1225 entitled "The Supplemental Security Income (SSI) Ratios for Fiscal Year (FY) 2006 through FY 2009 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)" (Released June 22, 2012) (stating that "[t]he SSI ratios are used for settlement purposes for IPPS and IRFs eligible for a Medicare DSH payment or *low income payment adjustment*, respectively" (emphasis added)).

[30] The Board notes that the Providers in Case Nos. 09-1942GC and 09-0861GC specifically requested this remand consistent with CMS Ruling 1498-R. *See* Providers' June 27, 2011 Request for Reinstatement at 1 (Case No. 09-1942GC); email dated Jan. 17, 2011 from the Providers' Representative to the Board (Case No. 09-0861GC).

[31] While 1498-R does not directly apply to LIP adjustment calculations, the Board's remand is consistent with 1498-R because the Medicare program defines and uses the SSI percentage in the same way for both the LIP and DSH adjustment calculations.

APPENDIX A

Appendix A

Model Form G: Schedule of Providers in Group

Group Name: HealthSouth 2007 SSI Percentage Group

Representative: Rob Wisner

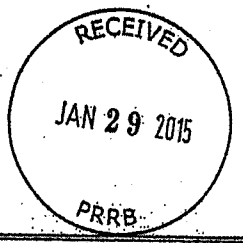
Case No.: 09-1942GC

Date Prepared: 10/4/2012

#	Provider Number	Provider Name/Location (city, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date of Add/ Transfer
1	39-3045	Sewickly, PA	06/30/07	Cahaba	02/14/08	07/31/08	168			08-2482	06/25/09
~~2~~ remanded	~~45-0758~~	~~Dallas Med Ctr, TX~~	~~05/31/07~~	~~Cahaba~~	~~05/12/08~~	~~08/20/08~~	~~100~~			~~08-2722~~	~~06/25/09~~
3	01-3029	N. Alabama, AL	05/31/07	Cahaba	04/15/08	08/20/08	127			08-2713	06/25/09
4	03-3032	Valley of the Sun, AZ	05/31/07	Cahaba	04/09/08	08/20/08	133			08-2712	06/25/09
5	45-3041	Forth Worth, TX	05/31/07	Cahaba	10/20/08	12/16/08	57			09-0494GC	06/25/09
6	44-3027	Kingsport, TN	05/31/07	Cahaba	10/16/08	12/16/08	61			09-0494GC	06/25/09
7	44-3028	Vanderbilt, TN	05/31/07	Cahaba	10/21/08	12/16/08	56			09-0494GC	06/25/09
8	39-3031	Mech Rehab, PA	06/30/07	Cahaba	11/20/08	12/16/08	26			09-0494GC	06/25/09
9	45-3044	Austin, TX	05/31/07	Cahaba	11/14/08	12/16/08	32			09-0494GC	06/25/09
10	04-3028	Fort Smith, AR	05/31/07	Cahaba	11/06/08	12/16/08	40			09-0494GC	06/25/09
11	39-3039	Nittany Valley, PA	06/30/07	Cahaba	10/21/08	12/16/08	56			09-0494GC	06/25/09
12	39-3037	York, PA	06/30/07	Cahaba	11/05/08	12/16/08	41			09-0494GC	06/25/09
13	39-3040	Altoona, PA	06/30/07	Cahaba	11/17/08	12/16/08	29			09-0494GC	06/25/09
14	45-3031	San Antonio, TX	05/31/07	Cahaba	10/16/08	12/16/08	61			09-0494GC	06/25/09
15	42-3028	Rock Hill, SC	05/31/07	Cahaba	10/21/08	12/16/08	56			09-0494GC	06/25/09
~~16~~ remanded	~~44-0162~~	~~Chattanooga, TN~~	~~05/31/07~~	~~Cahaba~~	~~10/21/08~~	~~12/16/08~~	~~56~~			~~09-0494GC~~	~~06/25/09~~
17	44-3030	Cane Creek, TN	05/31/07	Cahaba	11/04/08	12/16/08	42			09-0494GC	06/25/09
18	39-3027	Harmarville, PA	06/30/07	Cahaba	10/21/08	12/16/08	56			09-0494GC	06/25/09
19	01-3033	Phenix City, AL	05/31/07	Cahaba	11/03/08	12/16/08	43			09-0494GC	06/25/09
20	45-3090	Odessa, TX	05/31/07	Cahaba	11/04/08	12/16/08	42			09-0494GC	06/25/09
21	39-3026	Reading, PA	06/30/07	Cahaba	11/21/08	01/12/09	52			09-0494GC	06/25/09
22	39-3047	Geisinger, PA	06/30/07	Cahaba	11/20/08	01/12/09	53			09-0494GC	06/25/09
23	49-3031	Petersburg, VA	05/31/07	Cahaba	11/18/08	01/12/09	55			09-0494GC	06/25/09
24	19-3031	Alexandria, LA	12/31/07	TriSpan	01/13/09	02/12/09	30		79,591	09-0494GC	06/25/09
25	39-3046	Lake Erie, PA	06/30/07	Cahaba	11/10/08	02/12/09	94			09-0494GC	06/25/09
26	26-3028	St, Louis, MO	05/31/07	Cahaba	03/05/09	07/27/09	144			09-1942GC	07/27/09

Appendix A

Model Form G: Schedule of Providers in Group



Group Name: HealthSouth 2006 SSI Percentage Group

Representative: Rob Wisner

Date Prepared: 1/29/2013

Case No.: 09-0861GC

#		Provider Number	Provider Name/Location (city, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date of Add/ Transfer
1	N6	32-3027	Albuquerque, NM	12/31/06	Cahaba	03/24/08	08/07/08	136	15	(12,248)	08-2549	09/11/08
2	N6	42-3025	Columbia, SC	12/31/06	Cahaba	03/14/08	08/15/08	154	8	(4,049)	08-2649	09/11/08
3	N6	10-3037	Largo, FL	12/31/06	Cahaba	12/18/07	06/04/08	169	9	(8,080)	08-2091	09/11/08
4	N6	42-3027	Charleston, SC	12/31/06	Cahaba	02/05/08	07/18/08	164	6	(571)	08-2288	09/11/08
5	N6	44-3029	Memphis, TN	12/31/06	Cahaba	01/07/08	07/03/08	178	6	(13,978)	08-2197	09/11/08
6	N2 N4	10-3028	Sunrise, FL	12/31/06	Cahaba	04/08/08	08/18/08	132	8	18,799	08-2956GC	09/30/08
7	N6	31-3029	Garden State, NJ	12/31/06	Cahaba	01/25/08	07/11/08	168	9	(1,686)	08-2351	09/11/08
8	N6	45-3053	Texarkana, TX	12/31/06	Cahaba	03/19/08	08/07/08	141	9	(1,237)	08-2545	09/11/08
9	N6	10-3033	Capital, FL	12/31/06	Cahaba	03/11/08	08/15/08	157	8	14,878	08-2650	09/11/08
10	N6	10-3032	Treasure Coast, FL	12/31/06	Cahaba	03/24/08	08/07/08	136	9	9,925	08-2542	09/11/08
11	N6	10-3031	Sarasota, FL	12/31/06	Cahaba	03/07/08	08/07/08	153	8	(891)	08-2543	09/11/08
12	N6	11-3027	Central, GA	09/28/06	Cahaba	01/29/08	07/11/08	164	8	4,286	08-2354	09/11/08
13	N2 N4	18-3027	Northern KY	12/31/06	Cahaba	04/08/08	08/18/08	132	6	(462)	08-2956GC	09/30/08
14	N2 N4	51-3028	Huntington, WV	12/31/06	Cahaba	04/15/08	08/18/08	125	8	5,228	08-2956GC	09/30/08
15	N6	51-3030	Mountain View, WV	12/31/06	Cahaba	11/28/07	04/23/08	147	11	(2,115)	08-2010	09/11/08
16	N6	05-3031	Bakersfield, CA	12/31/06	Cahaba	03/19/08	08/07/08	141	6	18,666	08-2547	09/11/08
17	N6	45-3040	No. Texas, TX	12/31/06	Cahaba	11/01/07	04/23/08	174	10	(5,161)	08-1827	09/11/08
18	N6	49-3028	Virginia, VA	12/31/06	Cahaba	01/31/08	07/11/08	162	10	7,370	08-2350	09/11/08
19	N6	03-3028	Tucson, AZ	12/31/06	Cahaba	03/19/08	08/07/08	141	8	1,973	08-2548	09/11/08
20	N6	51-3027	Western Hills, WV	12/31/06	Cahaba	11/28/07	05/23/08	177	9	6,859	08-2009	09/11/08
21	N6	20-3025	Portland, ME	12/31/06	Cahaba	03/19/08	08/07/08	141	8	(3,185)	08-2541	09/11/08
22	N2 N5	22-3026	Woburn, MA (terminating)	09/30/06	Cahaba	11/03/08	11/19/08	16	8	14,208	08-2956GC	11/20/08
23	N6	26-3027	Rusk, MO	12/31/06	Cahaba	03/17/08	08/15/08	151	10	12,683	08-2663	09/11/08
24	N6	10-3040	Panama City, FL	12/31/06	Cahaba	03/07/08	08/15/08	161	8	10,711	08-2660	09/11/08
25	N4	04-3031	Sherwood (Cen), AR	12/31/06	Novitas	05/22/08	08/18/08	88	15	5,673	08-2956GC	09/30/08
26	N4	04-3032	Fayetteville (NW), AR	12/31/06	Novitas	05/14/08	08/18/08	96	10	(512)	08-2956GC	09/30/08
27	N6	17-3025	Topeka, KS	12/31/06	WPS	12/21/07	06/04/08	166	10	(1,138)	08-2088	09/11/08
28	N6	17-3026	Mid America, KS	12/31/06	WPS	11/30/07	05/27/08	179	1	(3,516)	08-2018	09/11/08
29	N2 N4	18-3028	Lakeview, KY	12/31/06	CGS	05/22/08	08/18/08	88	10	(5,289)	08-2956GC	09/30/08
30	N4	19-3028	Baton Rouge, LA	12/31/06	Novitas	05/14/08	08/18/08	96	2	7,466	08-2956GC	09/30/08
31	N6	22-3027	Braintree, MA	09/30/06	NHIC	03/20/08	08/15/08	148	N3	23,828	08-2641	09/11/08
32	N6	45-3042	Fort Worth So, TX	12/31/06	Novitas	01/02/08	07/03/08	183	13	(5,770)	08-2198	09/11/08
33	N2 N4	45-3047	Plano, TX	12/31/06	Novitas	06/03/08	08/18/08	76	13	19,238	08-2956GC	09/30/08
34	N6	45-3048	Beaumont, TX	12/31/06	Novitas	01/17/08	07/11/08	176	10	3,794	08-2355	09/11/08
35	N6	45-3056	Tyler, TX	12/31/06	Novitas	01/18/08	07/11/08	175	10	(6,480)	08-2343	09/11/08
36	N6	14-3028	Rockford, IL	12/31/06	Cahaba	01/31/08	07/11/08	162	9	(1,561)	08-2347	09/11/08
37	N6	29-3032	Las Vegas- Henderson, NV	12/31/06	Palmetto GBA	03/20/08	08/07/08	146	23	(7,402)	08-2550	09/11/08
38	N6	44-3031	North Memphis, TN	12/31/06	Cahaba	01/31/08	07/11/08	162	6	(2,949)	08-2349	09/11/08
39	N6	03-3034	Yuma, AZ	12/31/06	Cahaba	11/28/07	05/23/08	177	6	(540)	08-2008	09/11/08
40	N6	42-3029	Anderson, SC	12/31/06	Cahaba	03/03/08	07/30/08	149	13	(1,652)	08-2497	09/11/08
41	N6	10-3042	Springhill, FL	12/31/06	Cahaba	01/09/08	07/11/08	184	5	(970)	08-2196	09/11/08
										94,146		

Model Form G: Schedule of Providers in Group

Group Name: HealthSouth 2006 SSI Percentage Group

Representative: Rob Wisner **Date Prepared:** 1/29/2013

Case No.: 09-0861GC

NOTES:

N1 The Model Form G only includes providers where there is an amount in controversy. The providers that have been resolved through a revised NPR or no change to the original SSI will be withdr

N2 The provider has received a notice of reopening.

N3 Refer to email documentation in absence of audit adjustment.

N4 Providers were initally filed as individual appeals. Rather than establishing individual appeals, the Board created a mandatory group for the Low Income Patient/SSI issue(s)(08-2956GC) using these requests because the providers were commonly owned and were pursuing the same issue(s). This group was later restructured by the Board into 2 groups on February 18, 2009 – the LIP issue remained in case number 08-2956GC and the SSI percentage issue was separated out into this case number 09-0861GC.

N5 Provider filed directly into group 08-2956GC which was later restructured as noted in note N4

N6 Date of Add/ Transfer is the date of the letter in which HealthSouth advised that the previously filed individual appeals should be pursued as two separate mandatory groups.