PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2016-D22

PROVIDER – Select Specialty Medicare Dual Eligible Bad Debts CIRP Groups

Provider Nos.: Various
(See Appendix I)

vs.

MEDICARE CONTRACTOR –
Novitas Soultions, Inc.

DATE OF HEARING -
December 18, 2013

Cost Reporting Periods Ended –
December 31, 2006; December 31, 2007; December 31, 2008; December 31, 2009; December 31, 2010

CASE NOs: 08-0252GC; 08-1945GC; 09-1473GC; 10-1130GC and 11-0590GC

INDEX

ISSUE STATEMENT:

Whether the Centers for Medicare & Medicaid Services ("CMS") must-bill policy applies to the Providers' dual eligible bad debts when the Providers did not participate in the Medicaid Program.[1]

DECISION

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Provider Reimbursement Review Board ("Board") has determined that the long term care hospitals ("LTCHs") in this consolidated group appeal:

(1) Were unable to participate in the state Medicaid program because the state Medicaid program did not and would not enroll that *type* of provider; or

(2) Could have enrolled and participated in the state Medicaid program but the provider made a business decision not to do so.

The Board affirms the Medicare Contractors' dual eligible bad debt adjustments for those providers that chose not to enroll in the state Medicaid program. The Board reverses the Medicare Contractors' dual eligible bad debt adjustments for those providers in states where the Medicaid program would not enroll LTCHs and remands those providers back to the Medicare Contractors to determine the appropriate amount of bad debt reimbursement.

INTRODUCTION

Select Medical Corporation ("Select") owns and operates the Medicare-certified LTCHs in these five group appeals (the "Select LTCHs").[2] The Select LTACHs are located in various states. *None* of the Select LTCHs were enrolled as Medicaid providers in the state of their location. Three Medicare contractors,[3] including Wisconsin Physicians Service Insurance Corporation ("WPS"), Mutual of Omaha, and Novitas, (collectively, the Medicare Contractors") denied the Select LTCHs' bad debt claims because the Select LTCHs failed to obtain remittance advices ("RAs") from their state's Medicaid programs to document their bad debt claims. The total amount in controversy is estimated at over $19 million.[4]

The Select LTCHs timely appealed their bad debt reimbursement to the Board and met the jurisdictional requirements for a hearing. The Select LTCHs were represented at the hearing by Jason M. Healy, Esq. of The Law Offices of Jason M. Healy PLLC. The Medicare Contractors were represented by Arthur Peabody, Jr., Esq. of the Blue Cross and Blue Shield Association.

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[1] Stipulations at ¶1 (Dec. 18, 2013) ("Stipulations").
[2] *See* Appendix 1 (list of the LTCHs participating in this consolidated appeal by CIRP group and fiscal year).
[3] Fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs") will be referred to as Medicare contractors.
[4] Stipulations at ¶ 9.

STATEMENT OF THE FACTS

For the cost reports in this appeal, the Medicare Contractors denied Medicare bad debt reimbursement for unpaid co-insurance and deductibles, for Medicare beneficiaries who were also eligible for Medicaid benefits under the applicable state's Medicaid program (these beneficiaries are commonly referred to as "dual eligible beneficiaries"). In addition, there are certain "qualified Medicare beneficiaries or "QMBs" who are either a dual eligible or are entitled to Medicare Part A, whose family incomes do not exceed 100 percent of the federal poverty line ("FPL"), and whose resources do not exceed certain resource-eligibility standards.[5] Based on the testimony at the hearing, it is the Board's understanding that the bad debts at issue involves both dual eligibles and QMBs.[6] The Medicare Contractors denied the bad debt reimbursement because the Select LTCHs did not comply with Medicare's "must bill" policy.

The Board has considered CMS's "must bill" policy as it relates to "duel eligible beneficiaries" and QMBs on numerous occasions. This policy requires that, prior to claiming a bad debt, a provider must: (1) bill the state Medicaid program for unpaid deductible and copayment amounts; and (2) obtain a statement (*i.e.*, a remittance advice or RA) from the state Medicaid agency identifying the amount of payment or the reason for non-payment.

The parties have stipulated the adjustments at issue in these group appeals were made to cost reports for fiscal years ("FYs") 2006 through 2010 and relate to bad debts for unpaid deductibles and copayments for dual eligible patients[7] as well as for QMBs as clarified post-hearing.[8] The parties have also stipulated that the state Medicaid programs have refused to process the claims and issue Medicaid RAs because the Select LTCHs were not enrolled as Medicaid providers.[9]

The regulations governing bad debts are located at 42 C.F.R. § 413.89 (2004).[10] Subsection (a) establishes the general rule that bad debts are deductions from revenue and are not to be included in allowable costs. However, in order to ensure that Medicare-covered costs are not shifted to individuals who are not covered by the Medicare program, subsection (d) specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs. Bad debts must meet the following criteria specified in subsection (e) to be considered allowable:

(1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
(2) The provider must be able to establish that reasonable collection efforts were made.
(3) The debt was actually uncollectible when claimed as worthless.

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[5] 42 U.S.C. § 1396d(p).
[6] *See* Provider Post-Hearing Brief at 4.
[7] Stipulations at ¶ 4. *See also id.* at ¶¶ 15-19.
[8] *See* Provider Post-Hearing Brief at 4.
[9] *Id.* at ¶ 7.
[10] Redesignated from 42 C.F.R. § 413.80 pursuant to 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

CMS has provided extensive guidance on its bad debt policy in the Provider Reimbursement, Manual, CMS Pub. No. 15-1 ("PRM 15-1"), §§ 308, 310, 312 and 322. PRM 15-1 § 308 requires that the provider make reasonable collection efforts and apply sound business judgment to determine that the debt was actually uncollectible. PRM 15-1 § 310 states that a "reasonable collection effort" involves the issuance of a bill on or shortly after discharge or death….[11] However, this section by its own terms, is inapplicable to indigent patients and specifically refers to § 312 which allows providers to "deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively."[12]

While this language absolves the providers from taking further steps to prove the dual eligible patient indigent, subsection C of § 312 requires providers to "determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian . . . ."[13]

Further, federal law[14] requires state Medicaid programs to pay the deductibles and coinsurance for dual eligible individuals and QMBs but the State may limit such payment to the state Medicaid program's "payment ceiling" which is generally the maximum amount that the state Medicaid program would pay for the service. As a state often limits its obligation to pay deductibles and coinsurance to this ceiling, and this ceiling is close to (just above or below) the Medicare payment, state Medicaid programs often pay little to no portion of the Medicare deductibles and coinsurance due for dual eligibles and QMBs. PRM 15-1 § 322 is entitled "Medicare Bad Debts Under State Welfare Programs" and, consistent with §§ 310 and 312, this section discusses bad debts involving dual eligibles and QMBs in terms of a State's "obligation" or responsibility to pay. These PRM provisions predate and, accordingly, comply with the Bad Debt Moratorium. The key sentences relevant to this appeal are:

> *Where the State is obligated* either by statute or *under the terms of its plan to pay* all, or *any part, of the Medicare deductible or coinsurance amounts*, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible and coinsurance amounts that the state is not obligated to pay can be included as a bad debt under Medicare, *provided that the requirements of § 312* or, if applicable, ***§ 310*** *are met.*[15]

First, this excerpt confirms that, if the Medicaid State plan provides for payment of Medicare

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[11] PRM 15-1 § 310 (copy included at Medicare Contractor Exhibit I-4).
[12] PRM 15-1 § 312.
[13] *Id.* at 3.
[14] *See* 42 U.S.C. §§ 1396a(a)(10)(E), 1396a(n)(2), 1396d(p).
[15] (Emphasis added.)

coinsurance and deductibles (in whole or in part), then the amount of the payment cannot be allowable as Medicare bad debt. Second, this excerpt cross-references the requirements of §§ 310 and 312 confirming that, *at a minimum*, the § 310 requirement to "bill . . . the party responsible" is applicable to claims involving dual eligibles and QMBs.[16] Finally, in order to be eligible for Medicaid payment (whether for a dual eligible or QMB), most state Medicaid programs require that a provider be enrolled or certified as a provider in the state Medicaid program.[17]

In §4008(c) of the Omnibus Budget Reconciliation Act of 1987,[18] Congress enacted a noncodified statutory provision that became known as the "Bad Debt Moratorium." In 1988, in §8402 of the Technical and Miscellaneous Revenue Act of 1988,[19] Congress retroactively amended the Bad Debt Moratorium. In 1989, in §6023 of the Omnibus Budget Reconciliation Act of 1989,[20] Congress again retroactively amended the Bad Debt Moratorium. As a result of these subsequent changes, the Bad Debt Moratorium essentially has two prongs: (1) the first prong prohibits CMS from changing its bad debt policy in effect on August 1, 1987; and (2) the second prong is a hold harmless provision that prohibits CMS from requiring a provider to change its bad debt collection policy when the Intermediary had accepted that policy prior to August 1, 1987.[21] The Select LTCHs have only made arguments relative to the first prong.[22]

The Select LTCHs were not enrolled as Medicaid providers in the relevant state Medicaid programs during the time periods at issue.[23] In some states, the state Medicaid program did not permit LTCHs to enroll as Medicaid providers.[24] Other states allowed enrollment of LTCHs but the Select LTCHs chose not enroll.[25] In either case, the state Medicaid program refused to process claims submitted by the Select LTCHs and issue Medicaid RAs, because the Select LTCHs were not enrolled as Medicaid providers.[26]

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[16] The Board recognizes that CMS issued a transmittal in November 1995 revising cost reporting instruction on bad debt documentation to allow providers "in lieu of billing" to submit alternative documentation to establish that nonpayment would have occurred if the crossover claim had been billed. *See* PRM 15-2, Ch. 11, Transmittal No. 4 (Nov. 1995) (revising PRM 15-2 § 1102.3). However, the Board notes that this decision does *not* opine on whether this 1995 transmittal does or does not violate the Bad Debt Moratorium (*i.e.*, whether that portion of CMS' "must bill" policy that requires billing of crossover claims even when nonpayment would have occurred if the crossover claim had been billed violates the Bad Debt Moratorium) because neither this sub-issue nor this transmittal are relevant to deciding the issues in this case.

[17] 42 C.F.R. § 431.107 (2006). *See* Provider Exhibit P-42 at 3 (copy of the Michigan Dept. of Health, Medicaid Provider Manual § 2 (July 1, 2008)); Provider Exhibit P-41 (copy of the Bureau of TennCare Policy Manual, Policy No. PRO 07-001 ¶ 1)).

[18] Pub. L. No. 100-203, 101 Stat. 1330, 1330-55 (1987).

[19] Pub. L. No. 100-647, 102 Stat. 3342, 3798 (1988).

[20] Pub. L. No. 101-239, 103 Stat. 2106, 2167 (1989).

[21] Reprinted at 42 U.S.C. S 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."

[22] While the Select LTCHs have asserted that they relied on the Medicare Contractors' prior practice in granting its bad debts involving dual eligible and QMBs, the Select LTCHs have not alleged (nor presented any evidence) that this practice started prior to 1987. Accordingly, the second prong is not relevant.

[23] Stipulations at ¶ 5.

[24] *Id.* at ¶ 6.

[25] Transcript ("Tr.") at 64:14 - 68:7.

[26] Stipulations at ¶¶ 7, 8.

DISCUSSION, FINDINGS OF FACT, CONCLUSIONS OF LAW:

The Select LTCHs contend that, prior to 2007, the Medicare Contractors[27] did not require non-Medicaid-participating providers to bill the state for Medicare cost-sharing amounts and obtain an RA from the state in order to be reimbursed for bad debt.[28] The Medicare Contractors reversed this policy when settling the FY 2005 cost reports, [29] using the "must bill" policy to require that both participating and non-participating Medicaid providers bill the state Medicaid programs, and obtain a RA before claiming Medicare bad debt. Following a remand of the FY 2005 case in 2012, the Select LTCHs responded by billing 102 claims to 6 state Medicaid programs and reported that they received letters stating that the state Medicaid program was unable to process these claims and could not issue RAs.[30] Later, in 2013, the Select LTCHs filed 83 Medicaid claims to 23 different state Medicaid programs for the cost years at issue in this case and received similar letters from the state Medicaid programs.[31] Citing responses from the state Medicaid programs, the Select LTCHs maintain that they were unable to obtain Medicaid RAs with payment determinations for these claims and that the Medicare Contractors should reimburse them for the Medicare bad debts at issue.[32]

The Select LTCHs argue that applying CMS' "must bill" policy (*i.e*., the requirement to bill the state Medicaid program and obtain a RA in order to claim Medicare bad debt) to this case violates the Bad Debt Moratorium."[33] The Select LTCHs maintain that the Medicare Contractors' denial of the bad debt claims at issue is unsupported by statute or regulation and that the Medicare Contractors' application of the "must bill" policy is arbitrary and capricious.[34] The Select LTCHs assert that they relied on the longstanding agency practice that allowed non-Medicaid-participating providers to claim bad debts without obtaining Medicaid RAs.

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[27] Significantly, the Select LTCHs do not assert that CMS (central or regional) gave them advice upon which they relied. In particular, Provider Exhibit P-9 at 4 is an email that refers to certain guidance being given by the Kansas City Regional Office. However, we do not have a copy of that guidance nor is the record clear when or to whom that guidance was issued. Further, the Select LTCHs have not claimed that they relied on that guidance. See Providers' Post-Hearing Brief at 34-35.

[28] Providers' Post Hearing Brief at 4-5; Provider Exhibit P-6 at 57-58, 63-64. In further support of their position that CMS did not require non-Medicaid-participating providers obtain an RA, the Select LTCHs cite to the 1995 instructions for completing CMS Form 339 (copy included at Provider Exhibit P-7). In particular, the 1995 instructions addressing bad debts required only that the provider furnish documentation of Medicaid eligibility and proof that non-payment would have resulted from the billing. *See* Providers' Post Hearing Brief at 5.

[29]Select Specialty FY 2005 cost year became a separate appeal which was decided by the Board on April 13, 2010. *See Select Specialty '05 Medicare Dual Eligible Bad Debts Grp. v. Wisconsin Physicians Serv.*, PRRB Dec. No. 2010-D25 (Apr. 13, 2010), *rev'd*, Adm'r Dec. (June 9, 2010). The Administrator's decision was appealed to the U.S. District Court for the District of Columbia ("Court") in *Cove Associates Joint Venture v. Sebelius*, 848 F. Supp. 2d 13 (D.D.C. 2012). The Court found in favor of the Secretary that the must bill policy was not new and did not require notice and comment rulemaking. The Court remanded the case to the Secretary on the limited issue of whether the Providers were justified in relying on the Secretary's prior failure to enforce the must bill policy. On remand, the Administrator issued a decision on March 15, 2016 and found that such "reliance was not reasonable."

[30] Providers' Post Hearing Brief at 14; Provider Exhibits P-17-22; Tr at 26, 76-79.

[31] Tr. at 25, 85-89.

[32] Providers' Post Hearing Brief at 16.

[33] *Id*. at 31-34.

[34] *Id*. at 35-36.

Accordingly, the Select LTCHs conclude that they should be allowed to claim the Medicare bad debts.[35]

The Select LTCHs also assert that CMS has recognized some exceptions to its "must bill" policy. Specifically, in briefs filed in connection with the *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142 (N.D. Cal. Oct. 11, 2001), the Secretary recognized the following "two unique instances where the Secretary permits providers to claim Medicare crossover bad debt without billing the State Medicaid agency" [36]:

1. Community mental health centers ("CMHCs").—CMHCs "are allowed to claim Medicare crossover bad debts without billing the State agency because CMHCs cannot bill the State agency given that they are not licensed by the State and, therefore, have no Medi-Cal provider numbers."[37]

2. Institutions for mental diseases ("IMDs").—IMDs "are permitted to claim Medicare crossover bad debts without billing the State agency where the services are provided to patients aged 22-64. This is because the Medicaid statute and regulations categorically preclude payment for services provided to patient aged 22-64 in IMDs, and the state accordingly has absolutely no responsibility for the coinsurance/deductibles associated with those particular services."[38]

The Select LTCHs argue that the rationale for CMHCs and IMDs is equally applicable in this case because, similar to CHMCs and IMDs, many state Medicaid programs do not recognize and certify LTCHs as providers and, therefore, will neither enroll them, process their Medicaid claims, nor issue RAs to them.[39]

Finally, the Select LTCHs contend that they satisfied the requirement of *submitting* claims for the fiscal years at issue and that they could not obtain RAs because the state Medicaid program simply refused to process the claims of a non-Medicaid participating provider. As a result, the Select LTCHs contend that they were forced to bear the costs of allowable Medicare bad debts, in violation of Medicare's statutory prohibition on cost shifting.[40] Further, they assert that, in connection with state Medicaid programs for which they did not enroll, the Medicare Contractors violated the Bad Debt Moratorium by requiring the Select LTCHs to obtain RAs from such state Medicaid programs prior to a claiming Medicare bad debt for a dual eligible or QMB.

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[35] *Id.* at 38-39.
[36] Defendant's Memorandum in Reply to Plaintiffs' Opposition to Defendant's Motion for Summary Judgment at 9n.5, *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C–01–0142, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2001) (copy included at Provider Exhibit P-45).
[37] *Id.* (citations omitted).
[38] *Id.* (citations omitted).
[39] *Id.* at 75-78.
[40] *Id.* at 74; 42 U.S.C.§ 1395x(v)(1)(A)(i) (copy included at Provider Exhibit P-51).

For its part, the Medicare Contractors maintain that federal regulations require providers to "maintain sufficient financial records and statistical data for proper determination of costs payable under the program"[41] and that requiring a provider to obtain RAs from the state Medicaid program is the only way to meet this requirement. In addition, the Medicare Contractors state that one of the core justifications for the "must bill" policy is found in the statute at 42 U.S.C. § 1396d(p)(3) which imposes certain cost sharing on states for the Medicare coinsurance and deductibles of dual eligible Medicare patients. The Medicare Contractors assert that the need for CMS' must-bill policy as it relates to dual eligibles is plainly evident because a patient's Medicaid status may change over the course of a very short period and states are entitled to change, enhance, or modify provisions of their Medicaid state plans, including its cost sharing obligations under § 1396d(p). It is the state Medicaid program that maintains the most accurate and up-to-date patient information to make a determination of a patient's Medicaid eligibility status at the time of service and the state that must determine its cost sharing responsibility, if any, for any unpaid Medicare deductibles and coinsurance based upon the state plan in effect.[42]

Having considered the positions of the parties, the evidence presented and the statutory and regulatory authority, the Board finds that pre-1987 the bad debt policy in the PRM clearly established that providers have an obligation to bill "the responsible party." This decision differs from the Board's findings and conclusions in its 2010 decision involving Select's FY 2005. The Board now has the benefit of considering several federal court decisions on this matter as well as the Administrator's decision upon remand of Select's FY 2005 case.[43]

Three federal appeals courts have reviewed CMS' must bill policy. While none of the decisions applied the Bad Debt Moratorium, they are still instructive as to CMS' policy. The First Circuit concluded that "some version" of a "must bill" policy has generally been enforced and that a general requirement (as opposed to a *per se* requirement) to obtain a Medicaid remittance advice for crossover claims is entitled to deference where "the Secretary has made exceptions and accepted alternative documentation *from the State* where circumstances warranted the exception."[44] Similarly, the D.C. Circuit found that it is "sensible for the Secretary to require that the state determine in the first instance the Medicaid eligibility of the claims and the appropriate amount of state payment owed…"[45] Finally, the Ninth Circuit deferred to the Secretary's reasonable determination that "the must bill policy is a 'fundamental requirement to demonstrate'… that reasonable collection efforts [have been] made and that 'the debt was actually uncollectible when claimed [as worthless]."[46]

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[41] 42 C.F.R. § 413.20(a).
[42] Medicare Contractor Final Position Paper at 7-8.
[43] *Select Specialty '05 Medicare Dual Eligible Bad Debt Group v Blue Cross Blue Shield Association*, Decision of the Administrator, March 15, 2016, on remand from, *Cove Associates Joint Venture v Sebelius*, 848 F. Supp. 2d 13 (D.D.C. 2012)
[44] *Maine Med. Ctr. v. Burwell*, 775 F. 3d 470, 475, 480 (1st Cir. 2015) (emphasis in original).
[45] *Grossmont Hosp. Corp v. Burwell* 797 F. 3d 1079, 1085 (D.C. Cir. 2015), *reh'g en banc denied* (D.C. Cir. 2015).
[46] *Community Hosp. of Monterey Peninsula v. Thompson*, 323 F.3d 782, 792, 796 (9th Cir. 2003).

A. STATES IN WHICH THE SELECT LTCHS COULD BE CERTIFIED AS MEDICAID PROVIDERS BUT DID NOT ENROLL.

Our review of the record (including but not limited to Provider Exhibit P-100) shows that, for the state Medicaid programs in the following states, the Select LTCHs could have enrolled in those programs even though there are bad debts at issue involving those programs: Arkansas, Colorado, Florida, Georgia, Indiana, Iowa, Louisiana, Michigan, Missouri, Mississippi (except for Harrison County),[47] Nebraska, Oklahoma, Tennessee, Texas, West Virginia, and Wisconsin. Our review of the record also shows that, for the state Medicaid program in the following states, there is no evidence confirming whether LTCHs could or could not enroll in those programs even though there are bad debts at issue involving those programs: Missouri, Minnesota, Ohio, South Carolina, South Dakota, and Virginia. Without any evidence to the contrary, the Board must assume that the Select LTCHs could have enrolled in the state Medicaid programs for this second grouping. For purposes of this subsection, the Board will refer to the first and second group of state Medicaid programs collectively as "the States Allowing LTCH Enrollment."

For the States Allowing LTCH Enrollment, the Select LTCHs had no bar to enrolling as a Medicaid provider and obtaining a Medicaid billing number. The witness for the Select LTCHs testified that, for these states, the decision *not* to enroll in a particular state Medicaid program was a "business decision" considering the rate of reimbursement by that program.[48] Specifically, the witness explained that, in some cases, the Select LTCHs chose not to enroll as a Medicaid provider because many of the States Allowing LTCH Enrollment paid an LTCH a DRG amount based on a "short term acute care hospital" and the resulting reimbursement was "very poor."[49]

Notwithstanding their decision to not enroll in the States Allowing LTCH Enrollment, the witness explained that, as a result of the earlier court case, the Select LTCHs did submit during 2013 roughly 85-100 claims for the fiscal years at issue and some of these claims involved these states. However, none of these claims were paid, and the Select LTCHs received little communication back from the state Medicaid programs except to deny the claims because the Select LTCHs were not enrolled as Medicaid providers.[50] The Board's review of these documents shows that many of these claims were denied because of one of the following reasons: (1) the Select LTCHs *were not* enrolled as Medicaid providers and, therefore, the provider number was missing on the claim;[51] or (2) the claim was untimely.[52] None of the claims were denied because LTCHs *could not* enroll or that the claim was not payable.[53]

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[47] The record shows that, if an LTCH was located outside of Harrison County, Mississippi, it could enroll in Mississippi's state Medicaid program. In particular, the LTCH in Jackson was able to enroll backdated to 9/1/2008 when they applied. *See* Provider Exhibit P-100 at 102.
[48] Tr. at 68:6-7.
[49] Tr. at 64:20-66:13.
[50] Tr. at 86-87; Provider Exhibit P-98.
[51] Provider Exhibit P-15 at 1, 4, 10, 17, 23, 59.
[52] Provider Exhibit P-17 at 11; Provider Exhibit P-83 at 201; Provider Exhibit P-84 at 209; Provider Exhibit P-85 at 226; *Tr.* at 91:15-20.
[53] Provider Exhibit P-16 at 1; Provider Exhibit P-25 at 2.

As previously discussed, PRM 15-1 § 322 confirms that, if the Medicaid State plan provides for payment of Medicare coinsurance and deductibles (in whole or in part), then the amount of the payment cannot be allowable as Medicare bad debt. Significantly, this is a blanket requirement that it not predicated on whether the provider does or does not participates in the relevant Medicaid program.[54] Second, this excerpt cross-references the requirements of § 310 confirming that, *at a minimum*, the § 310 requirement to "bill . . . the party responsible" is applicable to crossover claims.[55]

Notwithstanding the § 322 need to determine whether the relevant state Medicaid program was "responsible," the Select LTCHs made business decisions not to enroll in the States Allowing LTCH Enrollment and have not submitted any documentation (whether in the form of RAs or other evidence[56]) that confirms the state Medicaid program is not responsible for Medicare coinsurance and deductibles of either dual eligibles or QMBs. Further, as previously noted, PRM § 322 pre-dates and complies with the Bad Debt Moratorium.[57]

Further, the Board notes that the record indicates that, in October 2004, the Medicare Contractors

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[54] *See also Cove Assocs. Jt. Venture v. Sebelius*, 848 F. Supp. 2.d 13, 25 (D.D.C. 2012).

[55] The Board recognizes that CMS issued a transmittal in November 1995 revising cost reporting instruction on bad debt documentation to allow providers "in lieu of billing" to submit alternative documentation to establish that nonpayment would have occurred if the crossover claim had been billed. *See* PRM 15-2, Ch. 11, Transmittal No. 4 (Nov. 1995) (revising PRM 15-2 § 1102.3). However, the Board notes that this decision does *not* opine on whether this 1995 transmittal does or does not violate the Bad Debt Moratorium (*i.e*., whether that portion of CMS' "must bill" policy that requires billing of crossover claims even when nonpayment would have occurred if the crossover claim had been billed violates the Bad Debt Moratorium) because neither this sub-issue nor this transmittal are relevant to deciding the issues in this case.

[56] The Select LTCHs point to the 1995 bad debt instructions for the CMS Form 339 to support their position that an RA is not required yet they did not comply with those instructions. These instructions specify that, "to establish that Medicaid is not responsible for payment," the provide may, in lieu of billing, furnish documentation of Medicaid eligibility and proof that "non-payment would have occurred if the . . . claim had been filed with Medicaid." However, the Select LTCHs have not furnished any evidence that the States Allowing LTCH Enrollment are not responsible for payment under the state Medicaid plan had a claim been filed. As the Select LTCHs have not submitted evidence outside of RAs to demonstrate that the States Allowing LTCH Enrollment had no responsibility for coinsurance and deductibles, the Board need not address: (1) whether this other documentation would be acceptable; or (2) whether the CMS' position that the "must bill" policy necessarily includes obtaining an RA from a state even when that state has no responsibility violates the Bad Debt Moratorium.

[57] In support of its position, the Board notes the following examples of pre-1987 agency statements and Board cases applying CMS' bad debt policy: HCFA Action No. HCFA-AT-77-73 (MMB) (July 5, 1977) (responding to questions about a change in federal law in January, 1968 which made payment of Medicare deductible and copayments by the state Medicaid program optional) (copy included as Board Exhibit B-1); *Geriatric and Med'l Ctrs., Inc. v. Blue Cross Ass'n,* PRRB Dec. No. 82-D62 (Mar. 3, 1982) (finding that "the cost of these services were not included in payments for services covered by the State of Pennsylvania"), *decl'd* review, HCFA Adm'r (Apr. 23, 1982); *Concourse Nursing Home Grp. Appeal v. Travelers Ins. Co.*, PRRB Dec. No. 1983-D152 (Sept. 27, 1983) (finding that "the Provider has furnished no documentation which would support its contentions that it had established collection policies and procedures or that actual collection efforts were made to obtain payments from the patients or the Medicaid authorities before an account balance was considered . . . bad debt"), *decl'd review*, HCFA Adm'r (Nov. 4, 1983); *St. Joseph Hospital v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 84-D109 (Apr. 16, 1984) (finding that "the Provider did not attempt to bill the State of Georgia for its Medicaid patients"), *decl'd review*, HCFA Adm'r (May 14, 1984).

advised the Select LTCHs that they would be required to bill the state Medicaid program for dual eligible and QMBs.[58] Through July 2007, however, some of the Medicare Contractors continued to reimburse some of the Select LTCHs for bad debts without requiring them to bill Medicaid and obtain RAs.[59] Documentation in the record indicates that these Select LTCHs did not apply to be Medicaid providers until mid-to-late 2007.[60] As a result, the Select LTCHs cannot demonstrate their compliance with the requirement to determine that "no other source other than the patient would be legally responsible for the patient's medical bill…" as is required by Medicare bad debt policy.[61] The fact that the Select LTCHs were informed of the Medicare Contractors' directive in 2004 but did nothing to become a Medicaid provider until after the end of the cost report years at issue, indicates that the Select LTCHs continued to make a business decisions not to apply, until it became obvious that they had no other recourse but to become a Medicaid provider.[62] The Board concludes that the Medicare Contractor's disallowance of the Select LTCHs' bad debt was proper as it relates to the States Allowing LTCH Enrollment.

B. STATES IN WHICH THE SELECT LTCHS COULD NOT BE CERTIFIED AS MEDICAID PROVIDERS.

During the testimony at the hearing Select indicated that, in some instances, they were unable to submit claims to the state Medicaid program because the state Medicaid program would not enroll or certify LTCHs as Medicaid providers.[63] The Board members requested that Select identify which state Medicaid programs would not enroll LTCHs but Select did not respond to this request post-hearing.

As a result of the Select LTCH's lack of response to the Board's request, the Board reviewed the documentation submitted by the parties and determined that, in several states for various periods of time, it does appear LTCHs were unable to enroll as a Medicaid provider and, therefore, were unable to bill the relevant state Medicaid programs. Based on its review, the Board determined that, in following 6 states during the specified fiscal years, providers were unable to enroll in the relevant state Medicaid program and obtain a Medicaid provider number as a LTCH:

1. Alabama: FYs 2006, 2007, 2008, 2009, 2010.[64]
2. Delaware: FYs 2006, 2007, 2008.[65]
3. Mississippi for Harrison County Only: FYs 2006, 2007, 2008.[66]
4. New Jersey: FYs 2006, 2007, 2008, 2009, 2010[67]

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[58] Providers' Final Position Paper at 36; Provider Exhibit P-35.
[59] Providers' Final Position Paper at 36; Provider Exhibit P-35.
[60] *See* Provider Exhibits P-26, P-27, P-28, P-29.
[61] PRM 15-1 Chapter 3 § 312.
[62] Tr. at 67:12-70:2.
[63] Tr. at 104:1-12.
[64] Provider Exhibit P-100 at 1.
[65] Provider Exhibit P-16 at 1; Provider Exhibit P-100 at 16.
[66] The CON for the LTCH in Gulf Port, Harrison County, Mississippi had a CON that prohibited it from participating in Mississippi's state Medicaid program in accordance with Mississippi Code 41-7-191(6). Provider Exhibit P-100 at 68, 82.

5. North Carolina: FYs 2007, 2008, 2009[68]
6. Pennsylvania: FYs 2006, 2007, 2008, 2009, 2010[69]

The Board will refer to these states as the "States Not Allowing LTCH Enrollment."

Based on the above, the Board finds that the States Not Allowing LTCH Enrollment do not recognize nor reimburse LTCHs, including but not limited to the Select LTCHs. This is similar to the exception to the must bill policy that CMS recognized for CMHCs in the *Monterey* case.

Moreover, the Select LTCHs clearly appears to be caught in a "Catch-22" as identified by the D.C. District Court in 2012 in *Cove Assocs. Jt. Venture v. Sebelius ("Cove")*.[70] Like the LTCHs in *Cove*, the Select LTCHs were told to comply with the Medicare "must bill" policy even though they were unable to do so because billing privileges for these state Medicaid programs were contingent on enrollment in those programs and, as LTCHs, they could not enroll in the relevant state Medicaid programs. As the *Cove* Court stated, the Select LTCHs "are left in the untenable position of either refusing to treat dual-eligible patients or absorbing the bad debt associated with those patients."[71]

In *Cove*, the Secretary's position was that "states are required to issue RAs (regardless of a provider's participation status)" although the agency's counsel conceded "it was in a better position than the providers to ensure that the states comply." However, the *Cove* Court was "not willing to place a stamp of judicial approval on a policy that would put non-participating providers in the position of not being paid due to the delinquency of federally-funded state programs."[72]

Based on *Cove*, the Board finds that the Medicare Contractors improperly disallowed bad debt reimbursement for the claims at issue involving the States Not Allowing LTCH Enrolment. Accordingly, the Board remands to Medicare Contractors to determine the appropriate amount of bad debt reimbursement for those claims.

DECISION AND ORDER:

After considering the law and program instructions, the evidence presented, and the parties' contentions, the Board has determined that the long term care hospitals ("LTCHs") in this consolidated group appeal:

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[67] Provider Exhibit P-25 at 2, 10.
[68] Provider Exhibit P-28 at 1; Provider Exhibit P-100 at 108. However, "re" enrollment was approved as of Feb. 1, 2010. *See* Provider Exhibit P-100 at 109.
[69] Provider Exhibit P-100 at 114. LTCH approved as a Medicaid provider as of Dec. 11, 2011. *See* Provider Exhibit P-100 at 123.
[70] 848 F. Supp. 2d 13 (D.D.C. 2012).
[71] *Id*. at 24.
[72] *Id*. at 28.

(1) Were unable to participate in the state Medicaid program because the state Medicaid program did not and would not enroll that *type* of provider; or

(2) Could have enrolled and participated in the state Medicaid program but the provider made a business decision not to do so.

The Board affirms the Medicare Contractors' dual eligible bad debt adjustments for those providers that chose not to enroll in the state Medicaid program. The Board reverses the Medicare Contractors' dual eligible bad debt adjustments for those providers in states where the Medicaid program would not enroll LTCHs and remands those providers back to the Medicare Contractors to determine the appropriate amount of bad debt reimbursement.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson C.P.A.
John Ahern, MBA

FOR THE BOARD:

/s/
Michael W. Harty
Chairman

DATE: September 27, 2016

APPENDIX I
SUMMARY OF THE PROVIDERS BY GROUP APPEAL

Schedule of Providers in Group

Case No.: 08-0252GC
Group Name: Select Medical 2006 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
1	45-2078	Select Specialty Hospital - South Dallas Desoto, Dallas, Texas	03/31/2006	WPS*	08/01/2007	11/16/2007	107	11	269,931		
2	23-2031	Select Specialty Hospital - Wyandotte Taylor, Wayne, Michigan	04/30/2006	WPS	06/18/2007	11/16/2007	151	10	24,777		
3	39-2031	Select Specialty Hospital - Johnstown Johnstown, Cambria, Pennsylvania	04/30/2006	WPS	07/24/2007	11/16/2007	115	10	100,075		
4	44-2011	Select Specialty Hospital - Nashville Nashville, Davidson, Tennessee	04/30/2006	WPS	08/01/2007	11/16/2007	107	13	122,784		
5	04-2007	Select Specialty Hospital - Pine Bluff Pine Bluff, Jefferson, Arkansas	05/31/2006	WPS	07/30/2007	11/16/2007	109	8	154,347		
6	23-2028	Select Specialty Hospital - Battle Creek Battle Creek, Calhoun, Michigan	06/30/2006	WPS	06/22/2007	11/16/2007	147	10	60,722		
7	04-2005	Select Specialty Hospital - Little Rock Little Rock, Pulaski, Arkansas	06/30/2006	WPS	08/30/2007	11/16/2007	78	13	129,013		
8	28-2001	Select Specialty Hospital - Omaha Omaha, Douglas, Nebraska	06/30/2006	WPS	10/26/2007	11/16/2007	21	14	137,327		
9	15-2016	Select Specialty Hospital - Fort Wayne Fort Wayne, Allen, Indiana	06/30/2006	WPS	10/29/2007	11/16/2007	18	13	156,243		
10	45-2084	Select Specialty Hospital - Midland Midland, Midland, Texas	07/31/2006	WPS	06/12/2007	11/16/2007	157	11	16,500		
11	15-2012	Select Specialty Hospital - Northwest Indiana Hammond, Lake, Indiana	07/31/2006	WPS	10/19/2007	11/16/2007	28	12	210,405		
12	39-2045	Select Specialty Hospital - McKeesport McKeesport, Allegheny, Pennsylvania	08/31/2006	WPS	10/30/2007	11/16/2007	17	10	70,674		
13	06-2015	Select Specialty Hospital - Denver Denver, Denver, Colorado	09/30/2006	WPS	09/27/2007	11/16/2007	50	10	95,335		
14	11-2008	Select Specialty Hospital - Augusta	10/31/2006	WPS	11/16/2007	01/31/2008	76	11	140,258	Direct Add	01/31/2008

Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	A Date of Final Determination	B Date of Hearing Request / Add Issue Request	C No. of Days	D Audit Adj. No.	E Amount in Controversy	F Prior Case Number(s)	G Date of Direct Add / Transfer(s) to Group
		Augusta, Richmond, Georgia									
15	44-2012	Select Specialty Hospital - Knoxville	07/31/2006	WPS	11/26/2007	01/31/2008	66	13	371,560	Direct Add	01/31/2008
		Knoxville, Knox, Tennessee									
16	08-2000	Select Specialty Hospital - Wilimington	07/31/2006	WPS	11/26/2007	01/31/2008	66	7	18,437	Direct Add	01/31/2008
		Wilmington, Newcastle, Delaware									
17	15-2014	Select Specialty Hospital - Evansville	12/31/2006	WPS	11/27/2007	01/31/2008	65	10, 11	16,213	Direct Add	01/31/2008
		Evansville, Vanderburgh, Indiana									
18	04-2006	Select Specialty Hospital - Fort Smith	08/31/2006	WPS	11/28/2007	01/31/2008	64	12	184,141	Direct Add	01/31/2008
		Fort Smith, Sebastian, Arkansas									
19	10-2017	Select Specialty Hospital - Panama City	07/31/2006	WPS	11/30/2007	01/31/2008	62	15	19,149	Direct Add	01/31/2008
		Panama City, Bay, Florida									
20	23-2032	Select Specialty Hospital - Northwest Detroit	08/31/2006	WPS	12/11/2007	01/31/2008	51	14	395,931	Direct Add	01/31/2008
		Detroit, Wayne, Michigan									
21	01-2008	Select Specialty Hospital - Birmingham	08/31/2006	WPS	12/12/2007	01/31/2008	50	9	188,161	Direct Add	01/31/2008
		Birmingham, Jefferson, Alabama									
22	44-2016	Select Specialty Hospital - TriCities	10/31/2006	WPS	12/20/2007	01/31/2008	42	13	90,639	Direct Add	01/31/2008
		Bristol, Sullivan, Tennessee									
23	45-2022	Select Specialty Hospital - Dallas	12/31/2006	WPS	12/21/2007	01/31/2008	41	13	80,415	Direct Add	01/31/2008
		Carrolton, Dallas, Texas									
24	19-2030	Select Specialty Hospital - Jefferson Parish	08/31/2006	WPS	12/21/2007	01/31/2008	41	12	113,280	Direct Add	01/31/2008
		Metairie, Jefferson Parish, Louisiana									
25	44-2015	Select Specialty Hospital - North Knoxville	12/31/2006	WPS	12/26/2007	01/31/2008	36	10	69,590	Direct Add	01/31/2008
		Knoxville, Knox, Tennessee									
26	23-2035	Select Specialty Hospital - Kalamazoo	05/31/2006	WPS	10/30/2007	02/15/2008	108	12	184,912	Direct Add	02/15/2008
		Kalamazoo, Kalamazoo, Michigan									
27	26-2014	Select Specialty Hospital - Western Missouri	02/28/2006	WPS	08/21/2007	02/15/2008	178	16	1,915	Direct Add	02/15/2008
		Kansas City, Jackson, Missouri									
28	19-2044	Select Specialty Hospital - Baton Rouge	10/31/06 term	WPS	01/29/2008	02/15/2008	17	9	12,704	Direct Add	02/15/2008
		Baton Rouge, East Baton Rouge Parish, Louisiana									
29	51-2002	Select Specialty Hospital - Charleston	08/31/2006	WPS	02/01/2008	02/15/2008	14	16	175,750	Direct Add	02/15/2008
		Charleston, Kanawha, West Virginia									
30	37-2006	Select Specialty Hospital - Tulsa	08/31/2006	WPS	02/15/2008	06/30/2008	136	13	51,512	Direct Add	06/30/2008
		Tulsa, Tulsa, Oklahoma									
31	44-2014	Select Specialty Hospital - Memphis	11/30/2006	WPS	03/28/2008	06/30/2008	94	13	238,798	Direct Add	06/30/2008

Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	A Date of Final Determination	B Date of Hearing Request / Add Issue Request	C No. of Days	D Audit Adj. No.	E Amount in Controversy	F Prior Case Number(s)	G Date of Direct Add / Transfer(s) to Group
		Memphis, Shelby, Tennessee									
32	15-2010	Select Specialty Hospital - Indianapolis Greenwood, Johnson, Indiana	11/30/2006	WPS	04/09/2008	06/30/2008	82	15	227,532	Direct Add	06/30/2008
33	23-2023	Select Specialty Hospital - Macomb County Mount Clemens, Macomb, Michigan	12/31/2006	WPS	05/29/2008	06/30/2008	32	15	5,392	Direct Add	06/30/2008
34	25-2005	Select Specialty Hospital - Gulf Coast Gulfport, Harrison, Mississippi	12/31/2006	WPS	09/27/2011	11/26/2008	**	11	202,357	Direct Add	11/26/2008
35	31-2019	Select Specialty Hospital - Northeast New Jersey Rochelle Park, Bergen, New Jersey	10/31/2006	WPS	09/28/2011	11/26/2008	**	13	118,719	Direct Add	11/26/2008

* Wisconsin Physicians Service (formerly Mutual of Omaha). WPS confirmed that they transitioned responsibility for these cost reports to Novitas Solutions, Inc. in February 2011 under the J12 MAC transition.

** Providers that were added to group on 11/26/2008 but did not receive an NPR due to an unrelated issue (outlier reconciliation). NPRs were withheld by the intermediary per instructions from CMS. *See* CMS Pub 100-04, Ch. 3, sec. 20.1.2.5 ("The NPR cannot be issued nor can the cost report be finalized until outlier reconciliation is complete.")

Schedule of Providers in Group

Case No.: 08-1945G
Group Name: Select Medical 2007 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
1	11-2013	Select Specialty Hospital - Augusta Augusta, Richmond, Georgia	03/31/2007	WPS*	03/19/2008	05/02/2008	44	12	166,451		
2	23-2024	Select Specialty Hospital - Ann Arbor Ypsilanti, Washtenaw, Michigan	04/30/2007	WPS	04/25/2008	05/02/2008	7	13	65,148		
3	23-2012	Select Specialty Hospital - Flint Flint, Genesee, Michigan	01/31/2007	WPS	03/28/2008	05/02/2008	35	12	100,605		
4	23-2035	Select Specialty Hospital - Kalamazoo Kalamazoo, Kalamazoo, Michigan	05/31/2007	WPS	04/17/2008	05/02/2008	15	12	128,509		
5	39-2040	Select Specialty Hospital - Lancaster Lancaster, Lancaster, Pennsylvania	1/18/2007 term	WPS	12/28/2007	05/02/2008	126	10	54,270		
6	06-2016	Select Specialty Hospital - Colorado Springs Colorado Springs, El Paso, Colorado	01/31/2007	WPS	06/17/2008	06/30/2008	13	10	110,419	Direct Add	06/30/2008
7	11-2011	Select Specialty Hospital - Savannah Savannah, Chatham, Georgia	04/30/2007	WPS	06/02/2008	06/30/2008	28	4	140,490	Direct Add	06/30/2008
8	23-2030	Select Specialty Hospital - Pontiac Pontiac, Oakland, Michigan	01/31/2007	WPS	04/30/2008	06/30/2008	61	11	16,652	Direct Add	06/30/2008
9	25-2007	Select Specialty Hospital - Jackson Jackson, Hinds, Mississippi	02/28/2007	WPS	05/12/2008	06/30/2008	49	4	410,383	Direct Add	06/30/2008
10	34-2018	Select Specialty Hospital - Durham Durham, Durham, North Carolina	01/31/2007	WPS	06/13/2008	06/30/2008	17	10	136,224	Direct Add	06/30/2008
11	39-2039	Select Specialty Hospital - Central Pennsylvania Camp Hill, Cumberland, Pennsylvania	01/31/2007	WPS	05/09/2008	06/30/2008	52	11	28,983	Direct Add	06/30/2008
12	39-2037	Select Specialty Hospital - Erie Erie, Erie, Pennsylvania	05/31/2007	WPS	06/02/2008	06/30/2008	28	4	40,155	Direct Add	06/30/2008
13	39-2031	Select Specialty Hospital - Johnstown Johnstown, Cambria, Pennsylvania	04/30/2007	WPS	06/02/2008	06/30/2008	28	10	30,304	Direct Add	06/30/2008
14	39-2036	Select Specialty Hospital - Laurel Highlands Latrobe, Westmoreland, Pennyslvania	03/31/2007	WPS	05/16/2008	06/30/2008	45	4	37,184	Direct Add	06/30/2008

Schedule of Providers in Group

Case No.: 08-1945G
Group Name: Select Medical 2007 Dual Eligible (DE) Bad Debt CIRP Group
Group Representative: Jason M. Healy
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Date Prepared: 03/04/2013

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#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
15	45-2073	Select Specialty Hospital - San Antonio San Antonio, Bexar, Texas	04/30/2007	WPS	06/03/2008	06/30/2008	27	3	114,755	Direct Add	06/30/2008
16	04-2000	Select Specialty Hospital - Little Rock Little Rock, Pulaski, Arkansas	02/28/2007	WPS	07/03/2008	11/07/2008	127	5	191,749	Direct Add	11/07/2008
17	08-2000	Select Specialty Hospital - Wilmington Wilmington, New Castle, Delaware	07/31/2007	WPS	06/30/2008	11/07/2008	130	7	40,130	Direct Add	11/07/2008
18	23-2031	Select Specialty Hospital - Downriver Taylor, Wayne, Michigan	04/30/2007	WPS	07/16/2008	11/07/2008	114	8	80,233	Direct Add	11/07/2008
19	23-2033	Select Specialty Hospital - Saginaw Saginaw, Saginaw, Michigan	02/28/2007	WPS	08/08/2008	11/07/2008	91	12	72,689	Direct Add	11/07/2008
20	28-2001	Select Specialty Hospital - Omaha Omaha, Douglas, Nebraska	06/30/2007	WPS	09/08/2008	11/07/2008	60	12	142,880	Direct Add	11/07/2008
21	39-2044	Select Specialty Hospital - Pittsburgh/UPMC Pittsburgh, Allegheny, Pennsylvania	06/30/2007	WPS	10/08/2008	11/07/2008	30	11	2,934	Direct Add	11/07/2008
22	44-2011	Select Specialty Hospital - Nashville Nashville, Davidson, Tennessee	04/30/2007	WPS	06/20/2008	11/07/2008	140	8	157,548	Direct Add	11/07/2008
23	45-2089	Select Specialty Hospital - Conroe Conroe, Montgomery, Texas	02/28/2007	WPS	07/25/2008	11/07/2008	105	11	108,373	Direct Add	11/07/2008
24	45-2078	Select Specialty Hospital - South Dallas Desoto, Dallas, Texas	03/31/2007	WPS	07/01/2008	11/07/2008	129	12	258,700	Direct Add	11/07/2008
25	01-2008	Select Specialty Hospital - Birmingham Birmingham, Jefferson, Alabama	08/31/2007	WPS	12/29/2008	02/12/2009	45	8	56,445	Direct Add	02/12/2009
26	04-2006	Select Specialty Hospital - Fort Smith Fort Smith, Sebastian, Arkansas	08/31/2007	WPS	12/24/2008	02/12/2009	50	9	181,908	Direct Add	02/12/2009
27	04-2005	Select Specialty Hospital - Little Rock Little Rock, Pulaski, Arkansas	06/30/2007	WPS	11/20/2008	02/12/2009	84	5	96,184	Direct Add	02/12/2009
28	06-2015	Select Specialty Hospital - Denver Denver, Denver, Colorado	09/30/2007	WPS	01/02/2009	02/12/2009	41	9	143,107	Direct Add	02/12/2009
29	15-2013	Select Specialty Hospital - Beechgrove	08/31/2007	WPS	12/23/2008	02/12/2009	51	13	33,657	Direct Add	02/12/2009

Schedule of Providers in Group

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					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
		Beech Grove, Marion, Indiana									
30	15-2019	Select Specialty Hospital - Bloomington	07/31/2007	WPS	12/29/2008	02/12/2009	45	12	12,356	Direct Add	02/12/2009
		Bloomington, Monroe, Indiana									
31	15-2016	Select Specialty Hospital - Fort Wayne	06/30/2007	WPS	11/26/2008	02/12/2009	78	11	69,735	Direct Add	02/12/2009
		Fort Wayne, Allen, Indiana									
32	15-2012	Select Specialty Hospital - Northwest Indiana	07/31/2007	WPS	12/08/2008	02/12/2009	66	12	211,943	Direct Add	02/12/2009
		Hammond, Lake, Indiana									
33	23-2028	Select Specialty Hospital - Battle Creek	06/30/2007	WPS	11/26/2008	02/12/2009	78	10	45,504	Direct Add	02/12/2009
		Battle Creek, Calhoun, Michigan									
34	23-2038	Select Specialty Hospital - Grosse Pointe	12/31/2007	WPS	12/22/2008	02/12/2009	52	4	37,330	Direct Add	02/12/2009
		Grosse Pointe, Wayne, Michigan									
35	23-2032	Select Specialty Hospital - Northwest Detroit	08/31/2007	WPS	12/05/2008	02/12/2009	69	10	248,507	Direct Add	02/12/2009
		Detroit, Wayne, Michigan									
36	37-2006	Select Specialty Hospital - Tulsa	08/31/2007	WPS	11/26/2008	02/12/2009	78	8	6,887	Direct Add	02/12/2009
		Tulsa, Tulsa, Oklahoma									
37	39-2045	Select Specialty Hospital - McKeesport	08/31/2007	WPS	12/29/2008	02/12/2009	45	11	8,043	Direct Add	02/12/2009
		McKeesport, Allegheny, Pennsylvania									
38	44-2012	Select Specialty Hospital - Knoxville	07/31/2007	WPS	12/24/2008	02/12/2009	50	12	223,552	Direct Add	02/12/2009
		Knoxville, Knox, Tennessee									
39	44-2015	Select Specialty Hospital - North Knoxville	12/31/2007	WPS	12/29/2008	02/12/2009	45	4	55,554	Direct Add	02/12/2009
		Knoxville, Knox, Tennessee									
40	45-2084	Select Specialty Hospital - Midland	07/31/2007	WPS	12/01/2008	02/12/2009	73	9	13,852	Direct Add	02/12/2009
		Midland, Midland, Texas									
41	51-2002	Select Specialty Hospital - Charleston	08/31/2007	WPS	12/29/2008	02/12/2009	45	13	110,261	Direct Add	02/12/2009
		Charleston, Kanawha, West Virginia									
42	15-2010	Select Specialty Hospital - Indianapolis	11/30/2007	WPS	03/10/2009	03/31/2009	21	12	208,950	Direct Add	03/31/2009
		Greenwood, Johnson, Indiana									
43	34-2016	Select Specialty Hospital - Winston Salem	07/31/2007	WPS	10/15/2008	03/31/2009	167	10	48,339	Direct Add	03/31/2009
		Winston-Salem, Forsyth, North Carolina									

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44	36-2024	Select Specialty Hospital - Youngstown Youngstown, Mahoning, Ohio	12/31/2007	WPS	03/10/2009	03/31/2009	21	12	8,680	Direct Add	03/31/2009
45	04-2005	Select Specialty Hospital - Little Rock Little Rock, Pulaski, Arkansas	12/07/2007	WPS	04/02/2009	05/18/2009	46	9	18,759	Direct Add	05/18/2009
46	15-2019	Select Specialty Hospital - Bloomington Bloomington, Monroe, Indiana	9/24/07 term	WPS	02/25/2009	05/18/2009	82	6	694	Direct Add	05/18/2009
47	15-2014	Select Specialty Hospital - Evansville Evansville, Vanderburgh, Indiana	12/31/2007	WPS	03/25/2009	05/18/2009	54	10	18,054	Direct Add	05/18/2009
48	19-2030	Select Specialty Hospital - Jefferson Parish Metairie, Jefferson, Louisiana	08/31/2007	WPS	01/21/2009	05/18/2009	117	10	143,872	Direct Add	05/18/2009
49	31-2019	Select Specialty Hospital - Northeast New Jersey Rochelle Park, Bergen, New Jersey	10/31/2007	WPS	03/30/2009	05/18/2009	49	12	73,892	Direct Add	05/18/2009
50	36-2019	Select Specialty Hospital - Cincinnati Cincinnati, Hamilton, Ohio	07/31/2007	WPS	12/11/2008	05/18/2009	158	9	15,616	Direct Add	05/18/2009
51	44-2014	Select Specialty Hospital - Memphis Memphis, Shelby, Tennessee	11/30/2007	WPS	03/27/2009	05/18/2009	52	9	242,645	Direct Add	05/18/2009
52	44-2016	Select Specialty Hospital - Tri Cities Bristol, Sullivan, Tennessee	10/31/2007	WPS	03/27/2009	05/18/2009	52	6	40,589	Direct Add	05/18/2009
53	45-2087	Select Specialty Hospital - Longview Longview, Gregg, Texas	12/31/2007	WPS	04/17/2009	05/18/2009	31	10	99,861	Direct Add	05/18/2009
54	17-2007	Select Specialty Hospital - Wichita Wichita, Sedgwick, Kansas	12/31/2007	WPS	05/22/2009	08/24/2009	94	12	1,215	Direct Add	08/24/2009
55	23-2028	Select Specialty Hospital - Battle Creek Battle Creek, Calhoun, Michigan	12/31/07 term	WPS	06/30/2009	08/24/2009	55	10	81,880	Direct Add	08/24/2009
56	25-2005	Select Specialty Hospital - Gulfcoast Gulfport, Harrison, Mississippi	12/31/2007	WPS	04/30/2009	08/24/2009	116	12	158,337	Direct Add	08/24/2009
57	45-2022	Select Specialty Hospital - Dallas Carrolton, Dallas, Texas	12/31/2007	WPS	05/15/2009	08/24/2009	101	13	85,275	Direct Add	08/24/2009
58	23-2031	Select Specialty Hospital - Downriver	12/17/07 CHOW	WPS	10/26/2009	01/25/2010	91	11	175,723	Direct Add	01/25/2010

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Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
		Taylor, Wayne, Michigan									
59	11-2008	Select Specialty Hospital - Augusta	3/20/07 term	WPS	04/23/2010	07/12/2010	80	15	88,320	Direct Add	07/12/2010
		Augusta, Richmond, Georgia									
60	39-2047	Select Specialty Hospital - Danville	01/31/2007	Novitas**	09/30/2011	01/10/2012	102	13	66,406	Direct Add	01/10/2012
		Danville, Montour, Pennsylvania									

* Wisconsin Physicians Service (formerly Mutual of Omaha). WPS confirmed that they transitioned responsibility for these cost reports to Novitas Solutions, Inc. in February 2011 under the J12 MAC transition.

** Novitas Solutions, Inc. (formerly Highmark)

Schedule of Providers in Group

Case No.: 09-1473GC
Group Name: Select Medical 2008 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

					A	B'	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
1	11-2013	Select Specialty Hospital - Augusta Augusta, Richmond, Georgia	03/31/2008	WPS*	12/24/2008	04/13/2009	110	12	192,622		
2	16-2001	Select Specialty Hospital - Quad Cities Davenport, Scott, Iowa	01/31/2008	WPS	12/24/2008	04/13/2009	110	4	9,374		
3	15-2016	Select Specialty Hospital - Fort Wayne Fort Wayne, Allen, Indiana	06/30/2008	WPS	03/27/2009	04/13/2009	17	12	52,304		
4	23-2012	Select Specialty Hospital - Flint Flint, Genesee, Michigan	01/31/2008	WPS	12/24/2008	04/13/2009	110	4	84,440		
5	23-2030	Select Specialty Hospital - Pontiac Pontiac, Oakland, Michigan	01/31/2008	WPS	02/24/2009	04/13/2009	48	11	34,920		
6	23-2033	Select Specialty Hospital - Saginaw Saginaw, Saginaw, Michigan	02/29/2008	WPS	03/13/2009	04/13/2009	31	8	112,407		
7	23-2024	Select Specialty Hospital - Ann Arbor Ypsilanti, Washtenaw, Michigan	04/30/2008	WPS	03/26/2009	04/13/2009	18	12	71,296		
8	25-2007	Select Specialty Hospital - Jackson Jackson, Hinds, Mississippi	02/29/2008	WPS	12/29/2008	04/13/2009	105	12	208,667		
9	39-2037	Select Specialty Hospital - Erie Erie, Erie, Pennsylvania	05/31/2008	WPS	12/19/2008	04/13/2009	115	12	24,616		
10	39-2047	Select Specialty Hospital - Danville Danville, Montour, Pennsylvania	01/31/2008	WPS	12/23/2008	04/13/2009	111	9	59,884		
11	39-2039	Select Specialty Hospital - Central Pennsylvania Camp Hill, Cumberland, Pennsylvania	01/31/2008	WPS	04/01/2009	04/13/2009	12	12	36,292		
12	44-2011	Select Specialty Hospital - Nashville Nashville, Davidson, Tennessee	04/30/2008	WPS	03/18/2009	04/13/2009	26	11	82,981		
13	04-2000	Select Specialty Hospital - Little Rock Little Rock, Pulaski, Arkansas	02/29/2008	WPS	06/29/2009	08/24/2009	56	12	107,087	Direct Add	08/24/2009
14	06-2016	Select Specialty Hospital - Colorado Springs	01/31/2008	WPS	05/22/2009	08/24/2009	94	15	92,595	Direct Add	08/24/2009

Schedule of Providers in Group

Case No.: 09-1473GC
Group Name: Select Medical 2008 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
		Colorado Springs, El Paso, Colorado									
15	08-2000	Select Specialty Hospital - Wilmington	07/31/2008	WPS	08/05/2009	08/24/2009	19	12	37,397	Direct Add	08/24/2009
		Wilmington, Newcastle, Delaware									
16	11-2011	Select Specialty Hospital - Savannah	04/30/2008	WPS	06/18/2009	08/24/2009	67	12	113,354	Direct Add	08/24/2009
		Savannah, Chatham, Georgia									
17	15-2012	Select Specialty Hospital - Northwest Indiana	07/31/2008	WPS	07/16/2009	08/24/2009	39	12	163,243	Direct Add	08/24/2009
		Hammond, Lake, Indiana									
18	23-2035	Select Specialty Hospital - Kalamazoo	05/31/2008	WPS	03/17/2009	08/24/2009	160	11	88,627	Direct Add	08/24/2009
		Kalamazoo, Kalamazoo, Michigan									
19	26-2014	Select Specialty Hospital - Western Missouri	02/29/2008	WPS	04/28/2009	08/24/2009	118	12	521	Direct Add	08/24/2009
		Kansas City, Jackson, Missouri									
20	34-2018	Select Specialty Hospital - Durham	01/31/2008	WPS	04/03/2009	08/24/2009	143	12	24,998	Direct Add	08/24/2009
		Durham, Durham, North Carolina									
21	36-2019	Select Specialty Hospital - Cincinnati	07/31/2008	WPS	07/17/2009	08/24/2009	38	12	1,254	Direct Add	08/24/2009
		Cincinnati, Hamilton, Ohio									
22	39-2031	Select Specialty Hospital - Johnstown	04/30/2008	WPS	05/18/2009	08/24/2009	98	8	8,607	Direct Add	08/24/2009
		Johnstown, Cambria, Pennsylvania									
23	39-2044	Select Specialty Hospital - Pittsburgh/UPMC	06/30/2008	WPS	05/22/2009	08/24/2009	94	12	48,409	Direct Add	08/24/2009
		Pittsburgh, Allegheny, Pennsylvania									
24	39-2036	Select Specialty Hospital - Laurel Highlands	03/31/2008	WPS	07/14/2009	08/24/2009	41	11	13,367	Direct Add	08/24/2009
		Latrobe, Westmoreland, Pennsylvania									
25	45-2089	Select Specialty Hospital - Conroe	02/28/2008	WPS	04/22/2009	08/24/2009	124	12	130,748	Direct Add	08/24/2009
		Conroe, Montgomery, Texas									
26	45-2078	Select Specialty Hospital - South Dallas	03/31/2008	WPS	05/22/2009	08/24/2009	94	12	369,888	Direct Add	08/24/2009
		Desoto, Dallas, Texas									
27	52-2008	Select Specialty Hospital - Madison	05/31/2008	WPS	05/21/2009	08/24/2009	95	11	38,662	Direct Add	08/24/2009
		Madison, Dane, Wisconsin									
28	01-2008	Select Specialty Hospital - Birmingham	08/31/2008	WPS	11/10/2009	01/22/2010	73	12	40,533	Direct Add	01/22/2010

Schedule of Providers in Group

Case No.: 09-1473GC
Group Name: Select Medical 2008 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

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#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
		Birmingham, Jefferson, Alabama									
29	04-2006	Select Specialty Hospital - Fort Smith	08/31/2008	WPS	11/13/2009	01/22/2010	70	9	60,076	Direct Add	01/22/2010
		Fort Smith, Sebastian, Arkansas									
30	15-2013	Select Specialty Hospital - Beechgrove	08/31/2008	WPS	11/25/2009	01/22/2010	58	4	103,726	Direct Add	01/22/2010
		Beech Grove, Marion, Indiana									
31	23-2031	Select Specialty Hospital - Downriver	04/30/2008	WPS	10/26/2009	01/22/2010	88	12	91,472	Direct Add	01/22/2010
		Taylor, Wayne, Michigan									
32	23-2032	Select Specialty Hospital - Northwest Detroit	08/31/2008	WPS	10/27/2009	01/22/2010	87	11	160,269	Direct Add	01/22/2010
		Detroit, Wayne, Michigan									
34	23-2038	Select Specialty Hospital - Grosse Pointe	12/31/2008	WPS	11/25/2009	01/22/2010	58	11	49,437	Direct Add	01/22/2010
		Grosse Pointe, Wayne, Michigan									
35	26-2013	Select Specialty Hospital - St. Louis	10/31/2008	WPS	10/27/2009	01/22/2010	87	12	1,953	Direct Add	01/22/2010
		St. Louis, St. Louis, Missouri									
36	34-2016	Select Specialty Hospital - Winston Salem	07/31/2008	WPS	10/27/2009	01/22/2010	87	12	3,298	Direct Add	01/22/2010
		Winston-Salem, Forsyth, North Carolina									
37	28-2001	Select Specialty Hospital - Omaha	06/30/2008	WPS	09/02/2009	01/22/2010	142	12	31,690	Direct Add	01/22/2010
		Omaha, Douglas, Nebraska									
38	39-2045	Select Specialty Hospital - McKeesport	08/31/2008	WPS	11/25/2009	01/22/2010	58	12	2,330	Direct Add	01/22/2010
		McKeesport, Allegheny, Pennsylvania									
39	44-2012	Select Specialty Hospital - Knoxville	07/31/2008	WPS	10/21/2009	01/22/2010	93	7	59,062	Direct Add	01/22/2010
		Knoxville, Knox, Tennessee									
40	44-2016	Select Specialty Hospital - Tri Cities	10/31/2008	WPS	12/23/2009	01/22/2010	30	7	10,769	Direct Add	01/22/2010
		Bristol, Sullivan, Tennessee									
41	45-2073	Select Specialty Hospital - San Antonio	04/30/2008	WPS	08/21/2009	01/22/2010	154	12	160,434	Direct Add	01/22/2010
		San Antonio, Bexar, Texas									
42	45-2084	Select Specialty Hospital - Midland	07/31/2008	WPS	11/02/2009	01/22/2010	81	10	25,418	Direct Add	01/22/2010
		Midland, Midland, Texas									
43	45-2089	Select Specialty Hospital - Conroe	7/31/08 term	WPS	07/19/2010	01/22/2010	178	12	106,439	Direct Add	01/22/2010

Schedule of Providers in Group

Case No.: 09-1473GC
Group Name: Select Medical 2008 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

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#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
		Conroe, Montgomery, Texas									
44	45-2022	Select Specialty Hospital - Dallas	12/31/2008	WPS	11/13/2009	01/22/2010	70	12	66,858	Direct Add	01/22/2010
		Carrolton, Dallas, Texas									
45	51-2002	Select Specialty Hospital - Charleston	08/31/2008	WPS	12/17/2009	01/22/2010	36	12	118,875	Direct Add	01/22/2010
		Charleston, Kanawha, West Virginia									
46	06-2015	Select Specialty Hospital - Denver	09/30/2008	WPS	01/15/2010	07/02/2010	168	12	68,333	Direct Add	07/02/2010
		Denver, Denver, Colorado									
47	15-2010	Select Specialty Hospital - Indianapolis	11/30/2008	WPS	04/26/2010	07/02/2010	67	13	167,099	Direct Add	07/02/2010
		Greenwood, Johnson, Indiana									
48	15-2014	Select Specialty Hospital - Evansville	12/31/2008	WPS	05/10/2010	07/02/2010	53	11	33,533	Direct Add	07/02/2010
		Evansville, Vanderburgh, Indiana									
49	17-2005	Select Specialty Hospital - Kansas City	10/31/2008	WPS	02/08/2010	07/02/2010	144	13	5,488	Direct Add	07/02/2010
		Kansas City, Wyandotte, Kansas									
50	17-2007	Select Specialty Hospital - Wichita	12/31/2008	WPS	04/21/2010	07/02/2010	72	12	26,361	Direct Add	07/02/2010
		Wichita, Sedwick, Kansas									
51	25-2005	Select Specialty Hospital - Gulfport	12/31/2008	WPS	06/18/2010	07/02/2010	14	15	157,476	Direct Add	07/02/2010
		Gulfport, Harrison, Mississippi									
52	31-2019	Select Specialty Hospital - Northeast New Jersey	10/31/2008	WPS	02/26/2010	07/02/2010	126	14	206,421	Direct Add	07/02/2010
		Rochelle Park, Bergen, New Jersey									
53	36-2024	Select Specialty Hospital - Youngstown	12/31/2008	WPS	04/29/2010	07/02/2010	64	14	14,062	Direct Add	07/02/2010
		Youngstown, Mahoning, Ohio									
54	37-2006	Select Specialty Hospital - Tulsa	08/31/2008	WPS	03/08/2010	07/02/2010	116	13	6,944	Direct Add	07/02/2010
		Tulsa, Tulsa, Oklahoma									
55	44-2014	Select Specialty Hospital - Memphis	11/30/2008	WPS	03/12/2010	07/02/2010	112	14	35,239	Direct Add	07/02/2010
		Memphis, Shelby, Tennessee									
56	44-2015	Select Specialty Hospital - North Knoxville	12/31/2008	WPS	03/23/2010	07/02/2010	101	13	17,674	Direct Add	07/02/2010
		Knoxville, Knox, Tennessee									
57	45-2087	Select Specialty Hospital - Longview	12/31/2008	WPS	05/25/2010	07/02/2010	38	12	97,934	Direct Add	07/02/2010

Schedule of Providers in Group

Case No.: 10-1130GC
Group Name: Select Medical 2009 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
1	23-2030	Select Specialty Hospital - Pontiac Pontiac, Oakland, Michigan	01/31/2009	WPS*	11/12/2009	07/06/2010	40	10	43,728		
2	06-2016	Select Specialty Hospital - Colorado Springs Colorado Springs, El Paso, Colorado	01/31/2009	WPS	02/12/2010	07/06/2010	144	13	49,928		
3	34-2018	Select Specialty Hospital - Durham Durham, Durham, North Carolina	01/31/2009	WPS	03/02/2010	07/06/2010	126	13	84,809		
4	39-2047	Select Specialty Hospital - Danville Danville, Montour, Pennsylvania	01/31/2009	WPS	03/10/2010	07/06/2010	118	4	24,371		
5	23-2035	Select Specialty Hospital - Kalamazoo Kalamazoo, Kalamazoo, Michigan	05/31/2009	WPS	03/17/2010	07/06/2010	111	7	17,203		
6	23-2024	Select Specialty Hospital - Ann Arbor Ypsilanti, Washtenaw, Michigan	04/30/2009	WPS	03/19/2010	07/06/2010	109	12	16,020		
7	25-2007	Select Specialty Hospital - Jackson Jackson, Hinds, Mississippi	02/28/2009	WPS	04/23/2010	07/06/2010	74	13	175,374		
8	39-2039	Select Specialty Hospital - Central Pennsylvania Camp Hill, Cumberland, Pennsylvania	01/31/2009	WPS	04/23/2010	07/06/2010	74	12	39,734		
9	16-2001	Select Specialty Hospital - Quad Cites Davenport, Scott, Iowa	01/31/2009	WPS	05/06/2010	07/06/2010	61	14	34,894		
10	45-2078	Select Specialty Hospital - South Dallas Desoto, Dallas, Texas	03/31/2009	WPS	05/10/2010	07/06/2010	57	10	255,930		
11	39-2036	Select Specialty Hospital - Laurel Highlands Latrobe, Westmoreland, Pennsylvania	03/31/2009	WPS	05/11/2010	07/06/2010	56	10	6,093		
12	23-2012	Select Specialty Hospital - Flint Flint, Genesee, Michigan	01/31/2009	WPS	05/24/2010	07/06/2010	43	8	88,116		
13	44-2011	Select Specialty Hospital - Nashville Nashville, Davidson, Tennessee	04/30/2009	WPS	05/28/2010	07/06/2010	39	12	4,122		
14	39-2037	Select Specialty Hospital - Erie	05/31/2009	WPS	06/01/2010	07/06/2010	35	17	18,327		

Schedule of Providers in Group

Case No.: 10-1130GC
Group Name: Select Medical 2009 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

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#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
		Erie, Erie, Pennsylvania									
15	04-2000	Select Specialty Hospital - Little Rock	02/28/2009	WPS	06/07/2010	07/06/2010	29	12	96,954		
		Little Rock, Pulaski, Arkansas									
16	23-2033	Select Specialty Hospital - Saginaw	02/28/2009	WPS	06/15/2010	07/06/2010	21	9	55,371		
		Saginaw, Saginaw, Michigan									
17	39-2045	Select Specialty Hospital - McKeesport	08/31/2009	WPS	06/16/2010	07/06/2010	20	9	11,842		
		McKeesport, Allegheny, Pennsylvania									
18	10-2020	Select Specialty Hospital - Tallahassee	02/28/2009	WPS	06/18/2010	07/06/2010	18	12	11,234		
		Tallahassee, Leon, Florida									
19	39-2044	Select Specialty Hospital - Pittsburgh/UPMC	06/30/2009	WPS	06/18/2010	07/06/2010	18	5	11,212		
		Pittsburgh, Allegheny, Pennsylvania									
20	43-2002	Select Specialty Hospital - Sioux Falls	02/28/2009	WPS	06/22/2010	07/06/2010	14	7	111		
		Sioux Falls, Minnehaha, South Dakota									
21	18-2003	Select Specialty Hospital - Lexington	05/31/2009	WPS	06/16/2010	11/30/2010	167	9	2,509	Direct Add	11/30/2010
		Lexington, Fayette, Kentucky									
22	11-2013	Select Specialty Hospital - Augusta	03/31/2009	WPS	07/13/2010	11/30/2010	140	16, 17	194,454	Direct Add	11/30/2010
		Augusta, Richmond, Georgia									
23	11-2011	Select Specialty Hospital - Savannah	04/30/2009	WPS	07/14/2010	11/30/2010	139	8	63,188	Direct Add	11/30/2010
		Savannah, Chatham, Georgia									
24	52-2008	Select Specialty Hospital - Madison	05/31/2009	WPS	07/14/2010	11/30/2010	139	12	12,989	Direct Add	11/30/2010
		Madison, Dane, Wisconsin									
25	36-2019	Select Specialty Hospital - Cincinnati	07/31/2009	WPS	07/14/2010	11/30/2010	139	10	10,214	Direct Add	11/30/2010
		Cincinnati, Hamilton, Ohio									
26	28-2001	Select Specialty Hospital - Omaha	06/30/2009	WPS	08/06/2010	11/30/2010	116	14	2,150	Direct Add	11/30/2010
		Omaha, Douglas, Nebraska									
27	15-2016	Select Specialty Hospital - Fort Wayne	06/30/2009	WPS	08/19/2010	11/30/2010	103	11	35,548	Direct Add	11/30/2010
		Fort Wayne, Allen, Indiana									
28	23-2031	Select Specialty Hospital - Downriver	04/30/2009	WPS	08/23/2010	11/30/2010	99	10	111,608	Direct Add	11/30/2010

Schedule of Providers in Group

Case No.: 10-1130GC
Group Name: Select Medical 2009 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

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#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
		Taylor, Wayne, Michigan									
29	39-2031	Select Specialty Hospital - Johnstown	04/30/2009	WPS	09/01/2010	11/30/2010	90	12	17,325	Direct Add	11/30/2010
		Johnstown, Cambria, Pennsylvania									
30	45-2073	Select Specialty Hospital - San Antonio	04/30/2009	WPS	09/03/2010	11/30/2010	88	14	121,234	Direct Add	11/30/2010
		San Antonio, Bexar, Texas									
31	34-2016	Select Specialty Hospital - Winston Salem	07/31/2009	WPS	09/13/2010	11/30/2010	78	15	12,678***	Direct Add	11/30/2010
		Winston-Salem, Forsyth, North Carolina									
32	08-2000	Select Specialty Hospital - Wilmington	07/31/2009	WPS	09/20/2010	11/30/2010	71	11	60,146	Direct Add	11/30/2010
		Wilmington, Newcastle, Delaware									
33	15-2012	Select Specialty Hospital - Northwest Indiana	07/31/2009	WPS	09/22/2010	11/30/2010	69	13	206,266	Direct Add	11/30/2010
		Hammond, Lake, Indiana									
34	44-2014	Select Specialty Hospital - Memphis	11/30/2009	WPS	10/19/2010	11/30/2010	42	13	16,818	Direct Add	11/30/2010
		Memphis, Shelby, Tennessee									
35	51-2002	Select Specialty Hospital - Charleston	08/31/2009	WPS	10/22/2010	11/30/2010	39	11	120,868	Direct Add	11/30/2010
		Charleston, Kanawha, West Virginia									
36	17-2005	Select Specialty Hospital - Kansas City	10/31/2009	WPS	11/02/2010	11/30/2010	28	11	561	Direct Add	11/30/2010
		Kansas City, Wyandotte, Kansas									
37	15-2013	Select Specialty Hospital - Beechgrove	08/31/2009	WPS	11/04/2010	11/30/2010	26	13	105,541	Direct Add	11/30/2010
		Beech Grove, Marion, Indiana									
38	23-2032	Select Specialty Hospital - Northwest Detroit	08/31/2009	WPS	11/05/2010	11/30/2010	25	13	43,030	Direct Add	11/30/2010
		Detroit, Wayne, Michigan									
39	31-2019	Select Specialty Hospital - Northeast New Jersey	10/31/2009	WPS	11/05/2010	11/30/2010	25	13	251,799	Direct Add	11/30/2010
		Rochelle Park, Bergen, New Jersey									
40	15-2014	Select Specialty Hospital - Evansville	12/31/2009	WPS	11/10/2010	11/30/2010	20	13	42,027	Direct Add	11/30/2010
		Evansville, Vanderburgh, Indiana									
41	37-2009	Select Specialty Hospital - Tulsa Midtown	08/31/2009	WPS	11/12/2010	11/30/2010	18	14	236,893	Direct Add	11/30/2010
		Tulsa, Tulsa, Oklahoma									
42	45-2087	Select Specialty Hospital - Longview	12/31/2009	WPS	11/12/2010	11/30/2010	18	10	14,252	Direct Add	11/30/2010

Schedule of Providers in Group

Case No.: 10-1130GC
Group Name: Select Medical 2009 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
		Longview, Gregg, Texas									
43	25-2005	Select Specialty Hospital - Gulfcoast	12/31/2009	WPS	11/12/2010	11/30/2010	18	12	116,680	Direct Add	11/30/2010
		Gulfport, Harrison, Mississippi									
44	01-2008	Select Specialty Hospital - Birmingham	08/31/2009	WPS	11/12/2010	11/30/2010	18	13	62,757	Direct Add	11/30/2010
		Birmingham, Jefferson, Alabama									
45	04-2006	Select Specialty Hospital - Fort Smith	08/31/2009	WPS	11/24/2010	04/29/2011	156	8	34,776	Direct Add	04/29/2011
		Fort Smith, Sebastian, Arkansas									
46	23-2038	Select Specialty Hospital - Gross Pointe	12/31/2009	WPS	12/02/2010	04/29/2011	148	12	538	Direct Add	04/29/2011
		Grosse Pointe, Wayne Michigan									
47	36-2024	Select Specialty Hospital - Youngstown	12/31/2009	WPS	12/10/2010	04/29/2011	140	12	748	Direct Add	04/29/2011
		Youngstown, Mahoning, Ohio									
48	44-2015	Select Specialty Hospital - North Knoxville	12/31/2009	WPS	12/20/2010	04/29/2011	130	12	108	Direct Add	04/29/2011
		Knoxville, Knox, Tennessee									
49	45-2084	Select Specialty Hospital - Midland	07/31/2009	WPS	01/04/2011	04/29/2011	115	11	38,915	Direct Add	04/29/2011
		Midland, Midland, Texas									
50	06-2015	Select Specialty Hospital - Denver	09/30/2009	WPS	01/11/2011	04/29/2011	108	13	103,475	Direct Add	04/29/2011
		Denver, Denver, Colorado									
51	26-2017	Select Specialty Hospital - Springfield	10/31/2009	WPS	07/12/2011	01/10/2012	182	12	6,355	Direct Add	01/10/2012
		Springfield, Green, Missouri									
52	26-2013	Select Specialty Hospital - St. Louis	10/31/2009	Novitas**	09/27/2011	01/10/2012	105	12	9,268	Direct Add	01/10/2012
		St. Louis, St. Louis, Missouri									
53	45-2022	Select Specialty Hospital - Dallas	12/31/2009	Novitas	09/29/2011	01/10/2012	103	14	37,717	Direct Add	01/10/2012
		Carrolton, Dallas, Texas									

** Novitas Solutions, Inc. (formerly Highmark)

***Protested amount on cost report. Intermediary incorrectly noted zero amount on NPR.

Schedule of Providers in Group

Case No.: 11-0590GC
Group Name: Select Medical 2010 Dual Eligible (DE) Bad Debt CIRP Group
Date Prepared: 03/04/2013
Group Representative: Jason M. Healy
Lead Intermediary: Novitas Solutions, Inc.
Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

					A	B	C	D	E	F	G
#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
1	06-2016	Select Specialty Hospital - Colorado Springs Colorado Springs, El Paso, Colorado	01/31/2010	WPS*	11/17/2010	04/28/2011	162	13	35,496		
2	25-2007	Select Specialty Hospital - Jackson Jackson, Hinds, Mississippi	02/28/2010	WPS	11/17/2010	04/28/2011	162	10	16,517		
3	39-2047	Select Specialty Hospital - Danville Danville, Montour, Pennsylvania	01/31/2010	WPS	11/23/2010	04/28/2011	156	7	7,898		
4	16-2001	Select Specialty Hospital - Quad Cites Davenport, Scott, Iowa	01/31/2010	WPS	12/10/2010	04/28/2011	139	12	8,826		
5	10-2020	Select Specialty Hospital - Tallahassee Tallahassee, Leon, Florida	02/28/2010	WPS	12/14/2010	04/28/2011	135	12	68,494		
6	39-2039	Select Specialty Hospital - Central Pennsylvania Camp Hill, Cumberland, Pennsylvania	01/31/2010	WPS	12/15/2010	04/28/2011	134	10	96,423		
7	34-2018	Select Specialty Hospital - Durham Durham, Durham, North Carolina	01/31/2010	Novitas**	09/30/2011	01/10/2012	102	3	221,717	Direct Add	01/10/2012
8	43-2002	Select Specialty Hospital - Sioux Falls Sioux Falls, Minnehaha, South Dakota	02/28/2010	Novitas	08/10/2011	01/10/2012	153	800	76	Direct Add	01/10/2012
9	23-2033	Select Specialty Hospital - Saginaw Saginaw, Saginaw, Michigan	02/28/2010	Novitas	08/10/2011	01/10/2012	153	805	1,552	Direct Add	01/10/2012
10	26-2014	Select Specialty Hospital - Western Missouri Kansas City, Jackson, Missouri	02/28/2010	Novitas	08/11/2011	01/10/2012	152	804	1,682	Direct Add	01/10/2012
11	04-2000	Select Specialty Hospital - Little Rock Little Rock, Pulaski, Arkansas	02/28/2010	Novitas	08/18/2011	01/10/2012	145	803	40,415	Direct Add	01/10/2012
12	11-2013	Select Specialty Hospital - Augusta Augusta, Richmond, Georgia	03/31/2010	Novitas	09/08/2011	01/10/2012	124	807	70,895	Direct Add	01/10/2012
13	39-2036	Select Specialty Hospital - Laurel Highlands Latrobe, Westmoreland, Pennsylvania	03/31/2010	Novitas	09/14/2011	01/10/2012	118	806	15,086	Direct Add	01/10/2012
14	45-2073	Select Specialty Hospital - San Antonio San Antonio, Bexar, Texas	04/30/2010	Novitas	08/30/2011	01/10/2012	133	805	5,638	Direct Add	01/10/2012

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Lead Intermediary: Novitas Solutions, Inc.
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#	Provider Number	Provider Name / Location	FYE	Intermediary / MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case Number(s)	Date of Direct Add / Transfer(s) to Group
15	44-2011	Select Specialty Hospital - Nashville Nashville, Davidson, Tennessee	04/30/2010	Novitas	08/31/2011	01/10/2012	132	800	12,149	Direct Add	01/10/2012
16	39-2031	Select Specialty Hospital - Johnstown Johnstown, Cambria, Pennsylvania	04/30/2010	Novitas	09/13/2011	01/10/2012	119	800	28,228	Direct Add	01/10/2012
17	11-2011	Select Specialty Hospital - Savannah Savannah, Chatham, Georgia	04/30/2010	Novitas	10/06/2011	01/10/2012	96	805	37,213	Direct Add	01/10/2012
18	23-2031	Select Specialty Hospital - Downriver Taylor, Wayne, Michigan	04/30/2010	Novitas	10/31/2011	01/10/2012	71	806	26,438	Direct Add	01/10/2012
19	39-2037	Select Specialty Hospital - Erie Erie, Erie, Pennsylvania	05/31/2010	Novitas	11/16/2011	01/10/2012	55	803	15,579	Direct Add	01/10/2012
20	39-2044	Select Specialty Hospital - Pittsburgh/UPMC Pittsburgh, Allegheny, Pennsylvania	06/30/2010	Novitas	11/23/2011	01/10/2012	48	800	43,098	Direct Add	01/10/2012
21	23-2021	Great Lakes Specialty Hospital - Hackley Muskegon, Muskegon, Michigan	06/30/2010	Novitas	12/09/2011	01/10/2012	32	805	748	Direct Add	01/10/2012
22	15-2016	Select Specialty Hospital - Ft Wayne Fort Wayne, Allen, Indiana	06/30/2010	Novitas	12/07/2011	01/10/2012	34	803	16,073	Direct Add	01/10/2012
23	28-2001	Select Specialty Hospital - Omaha Omaha, Douglas, Nebraska	06/30/2010	Novitas	12/07/2011	01/10/2012	34	804	32,838	Direct Add	01/10/2012
24	44-2012	Select Specialty Hospital - Knoxville Knoxville, Knox, Tennessee	07/31/2010	Novitas	12/15/2011	01/10/2012	26	805	1,891	Direct Add	01/10/2012
25	36-2019	Select Specialty Hospital - Cincinnati Cincinnati, Hamilton, Ohio	07/31/2010	Novitas	12/20/2011	01/10/2012	21	804	7,610	Direct Add	01/10/2012
26	08-2000	Select Specialty Hospital - Wilmington Wilmington, Newcastle, Delaware	07/31/2010	Novitas	12/20/2011	01/10/2012	21	802	46,289	Direct Add	01/10/2012
27	10-2017	Select Specialty Hospital - Panama City Panama City, Bay, Florida	07/31/2010	Novitas	12/22/2011	01/10/2012	19	804	6,203	Direct Add	01/10/2012
28	34-2016	Select Specialty Hospital - Winston Salem Winston-Salem, Forsyth, North Carolina	07/31/2010	Novitas	12/29/2011	01/10/2012	12	***	28,035	Direct Add	01/10/2012
29	42-2009	Regency Hospital - Greenville	07/31/2010	Novitas	01/06/2012	01/10/2012	4	802	13,283	Direct Add	01/10/2012

Schedule of Providers in Group

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Issue: Whether the CMS must-bill policy applies to the Providers' dual-eligible bad debts when the Providers did not participate in a Medicaid program.

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		Greenville, Greenville, South Carolina Knoxville, Knox, Tennessee									
44	17-2007	Select Specialty Hospital - Wichita Wichita, Sedgwick, Kansas	12/31/2010	Novitas	06/07/2012	12/05/2012	181	804	963	Direct Add	12/05/2012
45	25-2005	Select Specialty Hospital - Gulfcoast Gulfport, Harrison, Mississippi	12/31/2010	Novitas	06/08/2012	12/05/2012	180	804	90,789	Direct Add	12/05/2012
46	45-2022	Select Specialty Hospital - Dallas Carrolton, Dallas, Texas	12/31/2010	Novitas	06/08/2012	12/05/2012	180	805	2,503	Direct Add	12/05/2012
47	36-2024	Select Specialty Hospital - Youngstown Youngstown, Mahoning, Ohio	12/31/2010	Novitas	06/22/2012	12/05/2012	166	806	748	Direct Add	12/05/2012
48	10-2001	Select Specialty Hospital - Miami Miami, Miami-Dade, Florida	08/31/2010	Novitas	08/03/2012	12/05/2012	124	800	7,663	Direct Add	12/05/2012
49	11-2009	Select Specialty Hospital - Atlanta Atlanta, Fulton, Georgia	12/31/2010	Novitas	10/29/2012	12/05/2012	37	800	1,155	Direct Add	12/05/2012

* Wisconsin Physicians Service (formerly Mutual of Omaha). WPS confirmed that they transitioned responsibility for these cost reports to Novitas Solutions, Inc. in February 2011 under the J12 MAC transition.

** Novitas Solutions, Inc. (formerly Highmark)

*** Fiscal Intermediary (FI) did not make adjustment to remove protested amount.