DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

Internet: www.cms.gov/PRRBReview

FAX: 410-786-5298
Phone: 410-786-2671

Refer to: 03-0419G

APR 02 2014

CERTIFIED MAIL

Blumberg Ribner, Inc.
Isaac Blumberg
Chief Operating Officer
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

Cahaba Safeguard Administrators, LLC
James Lowe
2803 Slater Road, Suite 215
Morrisville, NC 27560

RE: Jurisdictional Decision – Norman Regional Hospital
Provider No.: 37-0008
FYE: 6/30/1999
PRRB Case No.: 03-0419G

Dear Isaac Blumberg and James Lowe,

The Provider Reimbursement Review Board (Board) has reviewed the documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Norman Regional Hospital received a revised Notice of Program Reimbursement (NPR) for FYE 6/30/1999 on October 7, 2005. On March 28, 2006, the Board received the Provider's appeal request in which it appealed two issues: SSI% and Dual Eligible Days. The Dual Eligible Days issue was subsequently transferred to this group appeal by way of a transfer request dated May 16, 2011.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the receipt of the final determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this appeal because the Provider appealed from a revised NPR in which the issue in this appeal, Dual Eligible Days, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2012) provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

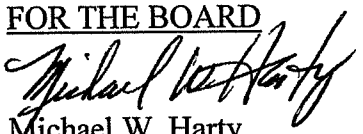
> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Here, the Provider's audit adjustment report associated with the October 7, 2005 revised NPR shows that DSH was adjusted in order to include Medicaid Eligible Days (those days when a patient is eligible for Medicaid and not eligible for Medicare which are specifically excluded by regulation) and to adjust the SSI%. Because the revised NPR did not specifically adjust Dual Eligible Days (days for which a patient is eligible for Medicaid and Medicare), the Board finds that it does not have jurisdiction over this Provider as a participant within this group, as its appeal lacks the specificity requirements for a revised NPR. The Board hereby dismisses Norman Regional Hospital from the group appeal.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

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Refer to: 08-2648GC

APR 03 2014

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Toyon Associates, Inc.
Glenn S. Bunting
Vice President - Appeal Services
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

RE: Jurisdictional Determination – UC Davis Medical Center as part of UC 1995 DSH SSI Ratio
CIRP Group
Provider No.: 05-0599
FYE: 6/30/1995
PRRB Case No.: 08-2648GC

Dear Mr. Bunting and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

UC Davis Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 6/30/1995 on January 21, 2005. On July 7, 2005, the Provider filed an appeal request with the Board appealing the following issue: accuracy of the SSI% provided by CMS and used by the Intermediary for calculating the Disproportionate Share Hospital (DSH) amounts. On July 29, 2005, the Provider requested to transfer the issue from its individual appeal to the group appeal in case number 04-2012G. Finally, on April 21, 2010, the Provider requested to transfer the SSI% issue to the group appeal in case number 08-2648GC.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date the notice of the Intermediary's determination was mailed to the provider.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this Provider's appeal because the Provider appealed from a revised

NPR in which the only issue on appeal, the SSI%, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2002) provides in relevant part:

> (a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

In accordance with 42 C.F.R. § 405.1889, a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

Monmouth: Notice of Reopening

The Intermediary issued a Notice of Reopening (NOR) to UC Davis Medical Center on February 12, 2004, in response to the court's finding in *Monmouth Medical Center v. Thompson*, 257 F.3d 807 (D.C. Cir. 2001), that the Provider was entitled to mandamus relief. Per the Monmouth decision and settlement agreement, the Intermediary issued a revised NPR on January 21, 2005, to UC Davis Medical Center (PN 05-0599) in order to apply HCFAR 97-2.

The *Monmouth* case involved the agency's application of HCFAR 97-2 (February 27, 1997). The court's decision in *Monmouth* and the subsequent settlement agreements that followed the litigation, instructed the Intermediary to issue a NOR to applicable Providers for the purpose of applying HCFAR 97-2 retrospectively. The NORs indicate that the basis of the reopening was a Settlement Agreement with CMS, which allowed a NOR to be issued well after the three year reopening period set forth in 42 C.F.R. § 405.1885.

The settlement agreement afforded the hospitals the right to submit to the Intermediary "one listing of *Medicaid eligible unpaid days* that it believes should be included in the determination of its DSH payment under HCFAR 97-2." HCFAR 97-2 dealt solely with days related to unpaid Title XIX Medicaid Days that were not entitled to Medicare Part A. Any other type of day not referenced in HCFAR 97-2 would not have been the subject of this reopening, nor would the SSI% and therefore, would not be appealable to the Board from the revised NPR.

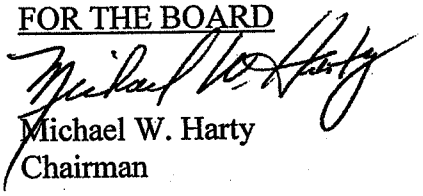
Since this appeal was filed from a revised NPR specific to the Monmouth reopening and there is no evidence the SSI % was adjusted in the revised NPR since that issue does not fall under HCFAR 97-2, the Board finds that it does not have jurisdiction over this Provider pursuant to 42 C.F.R. § 405.1889(b)(1).

The Board finds that it lacks jurisdiction over this Provider, UC Davis Medical Center, because it appealed from a revised NPR that did not specifically adjust the SSI% issue. This Provider is hereby dismissed from case number 08-2648GC.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the case.

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

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Refer to: 06-2092GC

APR 0 3 2014

CERTIFIED MAIL

Toyon Associates, Inc.
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Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

RE: Jurisdictional Determination – Marian Medical Center and Mercy General Hospital as part of "CHW 1994 DSH SSI Ratio CIRP Group"
Provider Nos.: 05-0107 and 05-0017
FYE: Various 1994
PRRB Case No.: 06-2092GC

Dear Mr. Knight and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The jurisdictional decision of the Board with respect to Marian Medical Center (Provider number 05-0107, FYE 11/30/1994) and Mercy General Hospital (Provider number 05-0017, FYE 3/31/1994) is set forth below.

Background

On May 26, 2004, a revised Notice of Program Reimbursement (NPR) was issued to Marian Medical Center, Provider 05-0107, for the fiscal year ending (FYE) November 30, 1994. On June 21, 2004, the Provider filed an appeal request challenging the Disproportionate Share Hospital (DSH) Medi-Cal days and Code 2 days. The Board assigned case number 04-1830 to the case. On July 17, 2006, the Provider requested to add the following issues to the appeal: SSI ratio, dual eligible days, General Assistance Days, and Code 2 and 3 days. On August 21, 2006, the Provider requested to transfer the SSI ratio issue from case number 04-1830 to the group appeal in case number 06-2092GC.

On May 4, 2006, a revised NPR was issued to Mercy General Hospital, Provider number 05-0017, for FYE March 31, 1994. On October 23, 2006, the Provider filed an appeal request challenging the DSH Medicaid Eligible Days, Labor Room Days, Dual Eligible Days, Medi-Cal Code 2 and 3 Days, SSI ratio, and General Assistance Days. The Board assigned case number 07-0312 to the case. On October 23, 2006, the Provider requested to transfer the SSI ratio issue from case number 07-0312 to the group appeal in case number 06-2092GC.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) (2004) and 42 C.F.R. §§ 405.1835-405.1841 (2004), a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 or more for a group appeal), and the request for hearing is received by the Board within 180 days of the date the notice of the Intermediary's determination was mailed to the provider.

The Board finds that it does not have jurisdiction over Marian Medical Center (Provider 05-0107, FYE November, 30, 1994) and Mercy General Hospital (Provider number 05-0017, FYE March 31, 1994) because the Providers appealed from revised NPRs in which the only issue on appeal, the SSI percentage, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2004) provides in relevant part:

> (a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be, either on motion of such intermediary officer or panel of hearing officers, Board, or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

In accordance with 42 C.F.R. § 405.1889 (2004), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

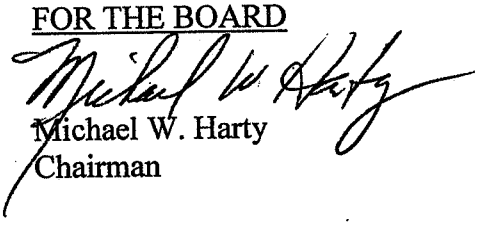
In the instant case, Marian Medical Center, Provider number 05-0107, audit adjustment report associated with the May 26, 2004 revised NPR shows that DSH was adjusted generally. The Provider did not submit any documentation to establish that that the SSI percentage was specifically adjusted. Mercy General Hospital, Provider number 05-0017, audit adjustment report associated with the May 4, 2006 revised NPR shows that some DSH components were adjusted, but there was no evidence to establish that the SSI percentage was specifically adjusted. As the Providers appealed from revised NPRs and the SSI percentage was not specifically adjusted in either of the revised NPRs, the Board finds that it does not have jurisdiction over Marian

Medical Center (Provider 05-0107, FYE November, 30, 1994) and Mercy General Hospital (Provider number 05-0017, FYE March 31, 1994). These Providers are hereby dismissed from case number 06-2092GC.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

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Refer to: 09-0943

APR 03 2014

CERTIFIED MAIL

Healthcare Recovery Services, LLC
Chris Mahne
Vice-President
1221 Brickell Avenue
Suite 900
Miami, FL 33131

Novitas Solutions, Inc.
Bruce Snyder
JL Provider Audit Manager
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 19219

RE: Jurisdictional Decision – Jameson Memorial Hospital
Provider No.: 39-0016
FYE: 6/30/2006
PRRB Case No.: 09-0943

Dear Mr. Mahne and Mr. Snyder,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

The Intermediary issued a Notice of Program Reimbursement (NPR) for FYE 6/30/2006 on August 22, 2008. On February 26, 2009, the Provider submitted an Appeal Request to the Board where it appealed the following issue: SSI Realignment in which the Provider claims that it may exercise its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period once it obtains and reconciles the underlying data.

Board's Decision

The Board has chosen to review whether it has jurisdiction over the SSI realignment issue in this appeal on its own motion and finds that it does not have jurisdiction as the appeal is premature. 42 C.F.R. § 405.1835 (2005) states:

> "The provider… has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if…[a]n intermediary determination has been made with respect to the provider."

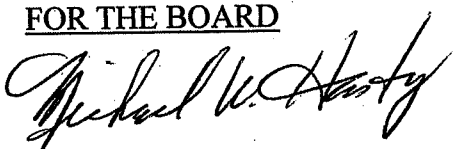
In this case, there was no final determination made by the Intermediary and the Provider has not yet decided whether it will request realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. Therefore, the SSI realignment issue is hereby dismissed. Since the SSI Realignment Issue was the sole remaining issue in the appeal,

case number 09-0934 is hereby closed.

Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

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Refer to:

CERTIFIED MAIL

APR 07 2014

Strategic Reimbursement, Inc.
Nick Putnam
360 W. Butterfield, Suite 310
Elmhurst, IL 60126

RE: SRI 2003 DSH Dual Eligible Days CIRP Group
Specifically St. Francis Hospital (14-0080) and Westlake Hospital (14-0240) as participants in PRRB Case No. 09-1712GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned group appeal which is subject to CMS Ruling 1498-R. The background and pertinent facts of the case as well as the Board's jurisdictional determination are set forth below.

Background:

The Representative filed a request for a Dual Eligible Days group appeal on May 21, 2009 for three participants. Although the Board has never been advised that the group is complete, there have been no additions of Providers since the initial filing. The case is being reviewed for a standard remand.

Pertinent Facts:

Only St. Joseph Hospital (Participant #2) included the Dual Eligible Days issue in its individual appeal. St. Francis Hospital (Participant #1) and Westlake Hospital (Participant #3) added an issue referred to as "Dual Eligible Days" in their final position papers which were filed prior in 2006. Upon review of the arguments in the position papers, however, the issue briefed actually involves Medicare Part C Days, which is not subject to the Ruling. In the position papers, the Providers also indicate they will be transferring the Dual Eligible Patient Days issue to the SRI Medicare ***Part C*** Days 2003 DSH Group.[1]

The Board notes that both St. Joseph Hospital and Westlake Hospital attempted to expand the Medicaid Eligible Days issue to include the Dual Eligible Days issue when they requested to be transferred from their individual appeals to the group appeal on May 20, 2009. Since the Dual Eligible Days issue was not timely added to the individual appeals prior to the issuance of the Board's August 2008 Rules and the timeframe for adding issues to (or clarifying issues in) pending appeals expired in October 2008, the request to add/clarify is untimely.

[1] The Board has never established a group for the SRI Part C Days issue for FYE 2003

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a)(2004) and 42 C.F.R. §§ 405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of the NPR.

The Board finds that neither St. Francis Hospital or Westlake Hospital timely added the Dual Eligible Days issue to their individual appeals. Consequently, the Dual Eligible Days issue could not have been transferred to the subject group. The issue covered in the Providers' position papers appears to cover Medicare Part C Days, which is not the subject of this group appeal and which is not covered by Ruling 1498-R. Therefore, the Board hereby dismisses St. Francis Hospital or Westlake Hospital from the group appeal.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Enclosed, please find a Standard Remand for the Dual Eligible Days issue for the only remaining participant in the group, St. Joseph Hospital.

Board Members Participating:
Keith E. Braganza, CPA
John Gary Bowers, CPA
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877
Standard Remand for Dual Eligible Days with Schedule of Providers

cc: National Government Services, Inc. (w/enclosures)
Danene L. Hartley, Appeals Coordinator
MP INA101-AF42
P.O. Box 6474
Indianapolis, IN 46206 6474

Kevin D. Shanklin, Executive Director, Blue Cross Blue Shield Association (w/enclosures)

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Refer to: 13-3625

APR 07 2014

CERTIFIED MAIL

Quality Reimbursement Services, Inc.
J.C. Ravindran
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Arcadia, CA 91006

Palmetto GBA
Cecile Huggins
Supervisor
Provider Audit – Mail Code AG-380
2300 Springdale Drive – Bldg. ONE
Camden, SC 29020-1728

RE: Jurisdictional Determination – Roper Hospital, Inc.
Provider No.: 42-0087
FYE: 12/31/2006
PRRB Case No.: 13-3625

Dear Mr. Ravindran and Ms. Huggins,

The Provider Reimbursement Review Board (Board) has reviewed the documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Roper Hospital, Inc. was issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2006 on March 6, 2013. On September 3, 2013, the Board received the Provider's appeal request in which it appealed one issue: the Rural Floor Budget Neutrality Adjustment (RFBNA).

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date the notice of the Intermediary's determination was mailed to the provider.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over the Provider's appeal from a revised NPR because the only issue on appeal, the RFBNA, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (effective August 21, 2008) provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for

> findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

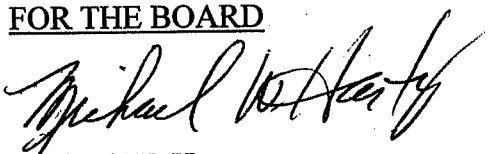
Here, the Provider's audit adjustment report associated with the March 6, 2013 revised NPR shows that the SSI% used in calculating DSH was adjusted. There was no adjustment made to the RFBNA, therefore the Board does not have jurisdiction because the appeal does not meet the specificity requirements for a revised NPR appeal.

Because the RFBNA was not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over this Provider's appeal. Case number 13-3625 is hereby closed.

Review of this determination is available under the provisions of 42 U.S.C. § 395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
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FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview **Phone: 410-786-2671**

Refer to: 13-3623

APR 07 2014

CERTIFIED MAIL

Healthcare Reimbursement Services, Inc.
Corinna Goron
President
17101 Preston Road
Suite 220
Dallas, TX 75248-1372

Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 19219

RE: Jurisdictional Determination – Baton Rouge General Medical Center
Provider No.: 19-0065
FYE: 9/30/2006
PRRB Case No.: 13-3623

Dear Ms. Goron and Mr. LeJeune,

The Provider Reimbursement Review Board (Board) has reviewed the documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Baton Rouge General Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 9/30/2006 on March 5, 2013. On September 3, 2013, the Board received the Provider's appeal request in which it appealed one issue: the Rural Floor Budget Neutrality Adjustment (RFBNA).

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date the notice of the Intermediary's determination was mailed to the provider.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this Provider's appeal because the Provider appealed from a revised NPR in which the only issue on appeal, the RFBNA, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (effective August 21, 2008) provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

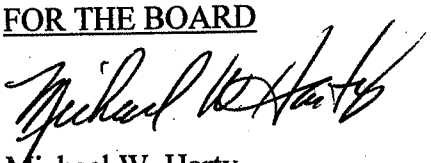
> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Here, the Provider's audit adjustment report identifies that the March 6, 2013 revised NPR was issued specifically to compare the SSI% claimed on the cost report to the updated SSI%. There was no specific adjustment related to the RFBNA, and the provider identifies in the appeal request that the additional reimbuersment for RFBNA was self-disallowed. As a specific adjustment is required for the Board to have jurisdiction from a revised NPR, and the RFBNA was not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over this Provider's appeal. Case number 13-3623 is hereby closed.

Review of this determination is available under the provisions of 42 U.S.C. § 395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-0139

APR 07 2014

CERTIFIED MAIL

Quality Reimbursement Services, Inc.
J.C. Ravindran
President
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Palmetto GBA
Cecile Huggins
Provider Audit - Mail Code AG-380
2300 Springdale Drive - Bldg. ONE
Camden, SC 29020

RE: Jurisdictional Challenge – Durham Regional Hospital
Provider No.: 34-0155
FYE: 6/30/2002
PRRB Case No.: 14-0139

Dear Mr. Ravindran and Ms. Huggins,

The Provider Reimbursement Review Board (PRRB or the Board) has reviewed the jurisdictional documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Durham Regional Hospital was issued a revised Notice of Program Reimbursement (NPR) for FYE 6/30/2002 on April 3, 2013 to include Labor and Delivery days per the PRRB Remand Order in case number 08-2863GC.[1] On October 17, 2013, the Provider filed an appeal request with the Board appealing the following two issues: the Rural Floor Budget Neutrality adjustment (RFBNA), and the Disproportionate Share Payment understatement due to RFBNA diagnostic-related groups (DRGs).

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date of receipt of the intermediary's final determination. However, before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

The Board finds that it does not have jurisdiction over this appeal because the Provider appealed from a revised NPR in which the only issues on appeal, RFBNA and DRGs, were not adjusted. The

1 Provider Appeal Request, Tab 1.

Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2012) provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Here, the April 3, 2013 revised NPR and the Provider's audit adjustment report associated with the revised NPR show an adjustment to Labor and Delivery days on S-3 and the corresponding increase to the allowable DSH percentage due to the increase in Labor and Delivery days. Because neither the RFBNA nor DRGs were specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over this Provider's appeal as it lacks the specificity requirements for a revised NPR. As RFBNA and DRGs were the only issues in the appeal, case number 14-0139 is hereby dismissed.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-0136

APR 07 2014

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Quality Reimbursement Services, Inc.
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150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

Palmetto GBA
Cecile Huggins
Provider Audit - Mail Code AG-380
2300 Springdale Drive - Bldg. ONE
Camden, SC 29020

RE: Jurisdictional Challenge – Durham Regional Hospital
Provider No.: 34-0155
FYE: 6/30/2003
PRRB Case No.: 14-0136

Dear Mr. Ravindran and Ms. Huggins,

The Provider Reimbursement Review Board (PRRB or the Board) has reviewed the jurisdictional documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Durham Regional Hospital was issued a revised Notice of Program Reimbursement (NPR) for FYE 6/30/2003 on April 9, 2013 to include Labor and Delivery days per the PRRB Remand Order in case number 08-2860GC.[1] On October 17, 2013, the Provider filed an appeal request with the Board appealing the following two issues: the Rural Floor Budget Neutrality adjustment (RFBNA), and the Disproportionate Share Payment understatement due to RFBNA diagnostic-related groups (DRGs).

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date of receipt of the intermediary's final determination. However, before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

The Board finds that it does not have jurisdiction over this appeal because the Provider appealed from a revised NPR in which the only issues on appeal, RFBNA and DRGs, were not adjusted. The

1 Provider Appeal Request, Tab 1.

Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2012) provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Here, the April 9, 2013 revised NPR and the Provider's audit adjustment report associated with the revised NPR show an adjustment to Labor and Delivery days on S-3 and the corresponding increase to the allowable DSH percentage due to the increase in Labor and Delivery days. Because neither the RFBNA nor DRGs were specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over this Provider's appeal as it lacks the specificity requirements for a revised NPR. As RFBNA and DRGs were the only issues in the appeal, case number 14-0136 is hereby dismissed.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

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Refer to:
14-0310

APR 08 2014

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Cecile Huggins
Supervisor
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Camden, SC 29020-1728

Quality Reimbursement Services
J.C. Ravindran
President
150 N. Santa Anita Avenue.,
Suite 570A
Arcadia, CA 91006

RE: Duke University Hospital
Provider No.: 34-0030
FYE: 6/30/2004
PRRB Case No.: 14-0310

Dear Ms. Huggins and Mr. Ravindran,

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdiction documentation submitted in the above-captioned case. The Board's jurisdiction decision is set forth below.

Pertinent Facts

On May 10, 2013 the Provider was issued a revised Notice of Program Reimbursement ("NPR") for FYE 6/30/2004. The revised NPR specifically stated that the revision was as a result of including labor and delivery days per the remand order issued by the Board in the Appeal Case Number 09-1895GC. The Intermediary's review did not include any adjustment related to the Rural Floor Budget Neutrality Adjustment ("RFBNA"). The Provider appealed from the revised NPR on October 23, 2013, appealing the following two issues: Rural Floor Budget Neutrality Adjustment and Medicare DSH payment due to RFBNA Adjustment.

Board's Decision

The Board finds that it does not have jurisdiction over Duke University Hospital because it is appealing from a revised NPR which does not adjust RFBNA.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect

> to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Board finds that it does not have jurisdiction over Duke University Hospital because the revised NPR solely adjusted Labor and Delivery room days with the corresponding adjustment to the DSH payment. RFBNA was clearly not considered or revised in the revised NPR, and is therefore outside the scope of the appeal from a revised NPR. The appeal is hereby closed and removed from the Board's docket.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-0132

APR 08 2014

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Camden, SC 29020-1728

Quality Reimbursement Services
J.C. Ravindran
President
150 N. Santa Anita Avenue.,
Suite 570A
Arcadia, CA 91006

RE: Duke University Hospital
Provider No.: 34-0030
FYE: 6/30/2002
PRRB Case No.: 14-0132

Dear Ms. Huggins and Mr. Ravindran,

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdiction documentation submitted in the above-captioned case. The Board's jurisdiction decision is set forth below.

Pertinent Facts

On April 3, 2013 the Provider was issued a revised Notice of Program Reimbursement ("NPR") for FYE 6/30/2002. The revised NPR specifically stated that the revision was as a result of including labor and delivery days per the remand order issued by the Board in the Appeal Case Number 08-2863GC. The Intermediary's review did not include any adjustment related to the Rural Floor Budget Neutrality Adjustment ("RFBNA"). The Provider appealed from the revised NPR on October 11, 2013, appealing the following two issues: Rural Floor Budget Neutrality Adjustment and Medicare DSH payment due to RFBNA Adjustment.

The Intermediary did not identify any jurisdictional impediments in this CIRP group appeal.

Board's Decision

The Board finds that it does not have jurisdiction over Duke University Hospital because it is appealing from a revised NPR which does not adjust RFBNA.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Board finds that it does not have jurisdiction over Duke University Hospital because the revised NPR solely adjusted Labor and Delivery room days with the corresponding adjustment to the DSH payment. RFBNA was clearly not considered or revised in the revised NPR, and is therefore outside the scope of the appeal from a revised NPR. The appeal is hereby closed and removed from the Board's docket.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-0131

APR 08 2014

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Quality Reimbursement Services
J.C. Ravindran
President
150 N. Santa Anita Avenue.,
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Arcadia, CA 91006

RE: Duke University Hospital
Provider No.: 34-0030
FYE: 6/30/2003
PRRB Case No.: 14-0131

Dear Ms. Huggins and Mr. Ravindran,

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdiction documentation submitted in the above-captioned case. The Board's jurisdiction decision is set forth below.

Pertinent Facts

On April 9, 2013 the Provider was issued a revised Notice of Program Reimbursement ("NPR") for FYE 6/30/2003. The revised NPR specifically stated that the revision was as a result of including labor and delivery days per the remand order issued by the Board in the Appeal Case Number 08-2860GC. The Intermediary's review did not include any adjustment related to the Rural Floor Budget Neutrality Adjustment ("RFBNA"). The Provider appealed from the revised NPR on October 11, 2013, appealing the following two issues: Rural Floor Budget Neutrality Adjustment and Medicare DSH payment due to RFBNA Adjustment.

The Intermediary did not identify any jurisdictional impediments in this CIRP group appeal.

Board's Decision

The Board finds that it does not have jurisdiction over Duke University Hospital because it is appealing from a revised NPR which does not adjust RFBNA.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
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> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Board finds that it does not have jurisdiction over Duke University Hospital because the revised NPR solely adjusted Labor and Delivery room days with the corresponding adjustment to the DSH payment. RFBNA was clearly not considered or revised in the revised NPR, and is therefore outside the scope of the appeal from a revised NPR. The appeal is hereby closed and removed from the Board's docket.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-0309

CERTIFIED MAIL

APR 08 2014

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Quality Reimbursement Services
J.C. Ravindran
President
150 N. Santa Anita Avenue.,
Suite 570A
Arcadia, CA 91006

RE: Duke University Hospital
Provider No.: 34-0030
FYE: 6/30/2005
PRRB Case No.: 14-0309

Dear Ms. Huggins and Mr. Ravindran,

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdiction documentation submitted in the above-captioned case. The Board's jurisdiction decision is set forth below.

Pertinent Facts

On May 23, 2013 the Provider was issued a revised Notice of Program Reimbursement ("NPR") for FYE 6/30/2005. The revised NPR specifically stated that the revision was as a result of including labor and delivery days per the remand order issued by the Board in the Appeal Case Number 10-0122GC. The Intermediary's review did not include any adjustment related to the Rural Floor Budget Neutrality Adjustment ("RFBNA"). The Provider appealed from the revised NPR on October 25, 2013, appealing the following two issues: Rural Floor Budget Neutrality Adjustment and Medicare DSH payment due to RFBNA Adjustment.

The Intermediary did not identify any jurisdictional impediments in this CIRP group appeal.

Board's Decision

The Board finds that it does not have jurisdiction over Duke University Hospital because it is appealing from a revised NPR which does not adjust RFBNA.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened, for findings on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the intermediary (with respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

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> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

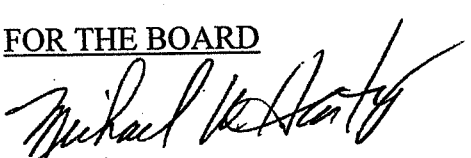
This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Board finds that it does not have jurisdiction over Duke University Hospital because the revised NPR solely adjusted Labor and Delivery room days with the corresponding adjustment to the DSH payment. RFBNA was clearly not considered or revised in the revised NPR, and is therefore outside the scope of the appeal from a revised NPR. The appeal is hereby closed and removed from the Board's docket.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-1961GC
Certified Mail

APR 10 2014

Russell Kramer
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave.
Suite 570A
Arcadia, CA 91006

RE: QRS CVC FY 2014 2-Midnight Rule Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-1961GC

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 27, 2014 request for hearing appealing the August 19, 2013 Federal Register[1] and January 27, 2014 request for expedited judicial review (EJR) (both documents were received on January 28, 2014), as well as the Provider's March 19, 2014 response to the Board's request for addition information (received March 24, 2014). The Board's determination with respect to the request for EJR is set forth below.

Issue

In this case, the Providers are challenging the validity of the Secretary's 0.2% reduction to the IPPS rates. The issue contained in the hearing request and request for EJR is:

> Whether the provision in the Fiscal Year 2014 Inpatient Prospective Payment System ("IPPS") Final Rule ("Final Rule") that imposes that imposes a .2 percent decrease in the IPPS rates for all IPPS hospitals for each of the FYs 2014-2018 is procedurally invalid, arbitrary and capricious, and outside the statutory authority of the Centers for Medicare & Medicaid Services ("CMS").

Providers' January 27, 2014 Hearing Request, Ex. 2.

[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary[2] indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[6]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and

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[2] of the Department of Health and Human Services.
[3] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).
[4] *78 Fed. Reg.* at 50907.
[5] *Id.*
[6] *Id.*
[7] Chapter 6, § 20.6 and Chapter 1, §10.

necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[8]

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decision effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[12] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[13] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not

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[8] 78 Fed. Reg. at 50907-08.
[9] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[10] 78 Fed. Reg. 50908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[13] 78 Fed. Reg. at 50909.

creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[14]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized[18] amount was reduced by 0.2 percent.[19]

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[14] *Id.* at 50927.
[15] *Id.* at 50944.
[16] *Id.*
[17] *Id.* at 50945.
[18] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on

The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[20]

Providers' Request for EJR

The Providers believe EJR is appropriate because the Board lacks the power to reverse the 0.2% reduction. The Providers note that in the final IPPS rule, published in the August 19, 2013 Federal Register, the Secretary instituted the 2-midnight policy whereby a hospital stay would be deemed to be inpatient-appropriate if the ordering physician reasonably expects the patient to be in the hospital at least 2 midnights. They believe that if a patient is in the hospital past 2 midnights, CMS contractors will presume that the stay is an appropriate inpatient stay and [be less likely] to audit the hospitals records. Conversely, the Providers contend that a one-night stays are per se not inpatient appropriate unless the patient received a procedure on the "inpatient-only" list of procedures. Further, the Providers point out the Secretary estimates that her 2-midnight policy would increase IPPS operating and capital expenditures by approximately $220 million. In order to offset this amount the Secretary, using the authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(1) and 1395ww(g) to offset the $220 million by applying at 0.2 percent reduction to the operating IPPS standardized amount, the hospital specific rates and the Puerto Rico-specific standardized amount, and a 0.2 percent reduction for capital IPPS.

The Providers believe the 0.2 percent reduction is susceptible to challenge on the following grounds

> The decision to impose a $220 million (more correctly 0.2 percent reduction) is arbitrary and capricious because:
>
> (1) it relies on faulty assumptions and is not adequately explained;
>
> (2) It does not adequately take into account the payment reductions made by the Part B inpatient policy; and
>
> (3) It does not provide any mechanisms for making adjustments to, or reversing the effects of the payment cut if the [Secretary's] estimate is incorrect

Faulty Assumptions

The final IPPS rule states that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, resulting in a net gain of 40,000 inpatient stays. The Providers maintain that the final rule does

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whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* "Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated" (CMS Office of the Inspector General Report OEI-09-00-00200, August 2001) on the internet at http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[19] *Id.* at 50952-53.

[20] *Id.* at 50990.

not give much detail regarding how the estimate of a net gain of 40,000 inpatient stays was calculated other than the Secretary's actuaries based their estimate on FY 2011 claims data. The final rule does not explain the number of claims that were examined or how the data was used. Instead it states that:

> In determining the estimate of the number of encounters that would shift from outpatient to inpatient, our actuaries examined outpatient claims for observation or a major procedure. Claims not containing observation or a major procedure were excluded. The number of claims spanning 2 or more midnights based on the dates of service that were expected to become inpatient was approximately 400,000. This estimate did not include any assumption about outpatient encounters shorter than 2 midnights potentially becoming inpatient encounters.
>
> In determining the estimate of the number of encounters that would shift from inpatient to outpatient, our actuaries examined inpatient claims containing a surgical MS–DRG. Claims containing medical MS–DRGs were excluded. The number of claims spanning less than 2 midnights based on the length of stay that were expected to become outpatient, after excluding encounters that resulted in death or transfers, was approximately 360,000.

78 Fed. Reg. at 50953.

The Providers believe that this indicates that the Secretary is assuming that any claims for which the time in the hospital spanned 2 or more midnights would become inpatient claims under the 2-midnight policy and any claims for which the time in the hospital did not span two midnights would be outpatient claims. These assumptions were not justified by the Secretary.

In particular the Providers asserts, these assumptions will not prove to be valid in light of the Medicare "Part B Inpatient" policy announced in the August 19, 2013 final IPPS rule.[21] This rule provides that if a hospital bills a hospital encounter as an inpatient stay, and the RAC or other Medicare contractor subsequently determines that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated on an outpatient basis instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. As a practical matter, following reopening by a RAC or other contractor, hospitals will never or almost never be able to re-bill under Part B because the reopenings almost always occur more than 12 months after the patient is discharged. The Providers are concerned that short stays, including

[21] *See generally* 78 Fed. Reg. at 50914-50938.

stays spanning 2 midnights, will denied under Medicare Part A and they will be unable to rebill under Part B within the 12-month window for filing claims. As a result, they may bill some of the stays exceeding 2 midnights under Part B initially. In addition, claims spanning 2 midnights may be billed under Part B even through the patient was admitted because of lack of documentation to support billing under Part A even though the patient stay was expected to span 2 midnights. In addition, some stays lasting less than 2 midnights will be billed under Part A. Some of these stays will be allowed under audit (or not audited and paid), but others will denied because the physician's assumption that the patient stay would exceed 2 midnights was not reasonable or sufficiently documented.

In addition, the Providers contend that there may be other fault assumptions upon which the Secretary relied but they cannot be identified because there were not sufficient details about the estimation outlined in the final IPPS rule. For example, the Providers do not know if the actuaries included claims denied on reopening and what adjustment, if any, was made for the fact that some FY 2011 claims where still within the 3-year reopening period. The Providers do not know if the Secretary assumed that the same rate of allowance/denials that occurred in previous years under different policies for inpatient admissions and rebilling under Part B would apply or some other rate was used.

Reductions Made as the Result of Part B Inpatient Policy

The Providers assert that even if the 2 midnight policy does result in an increase in Part A payments of $220 million per year, the Secretary projects that the closely related Inpatient Part B policy reduces Medicare payments by almost a billion dollars a year. However, there is no increase in payment to take into account the reduced Part B payments (estimated at $4.8 billion in the Part or 4.6 billion over 5 years[22]). The Providers believe the Secretary should also increase Part B rates to account for this decrease in payments, but the Secretary indicated that the reduction in Part B payments would be offset by the cost of ALJ decisions and CMS Ruling 1455-R which allows appeals outside the timely filing period which would be approximately $1.260 billion over calendar years 2013 to 2017.[23] The Providers find this calculation odd because the Ruling applies only for denials of service furnished before October 1, 2013 (NOTE: given the RAC and other contractors have 3 or 4 years to reopen the Part A claims and then the Providers must appeal it could easily take this long to bill Part B, potentially longer since the ALJs have said they have too many Part A appeals to process and were staying the process). The Providers note that the Secretary provides no explanation as to the number of existing appeals to which the Ruling would apply or the number of determinations that would be made that allowed Providers to rebill. The Providers assert that the Part B policy is saving Medicare $4.6 billion over the next 5 years that it otherwise would have spent regardless of the effect of alleged offsets.

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[22] 78 Fed. Reg. 16632, 16633 (March 13, 2013) (we estimate the final [Part B, Inpatient] policy will result in approximately $4.8 billion decrease in Medicare program expenditures over 5 years) and 78 Fed. Reg. at 505007 (Aug. 19, 2013) (with respect to Part B Hospital Inpatient Payment Policy following the denial of Part A claims and subsequent billing to Part B, we estimate that the final Medicare expenditures will be reduced by $4.6 billion over 5 years).

[23] 78 Fed. Reg. at 50954.

No Mechanism for Making Adjustments to or Reversing the Effects of Payments if the Estimate is Incorrect

The Providers believe that the estimate of an additional $220 million of IPPS expenditures is highly speculative because the Secretary acknowledged that the estimate is subject to a variety of factors. The Secretary noted that the actual costs or savings would depend substantially on possible changes in unanticipated changes in hospital behavior and changes in inpatient and outpatient utilization.

The Providers believe that the Board lacks the authority to declare the 0.2 percent decrease in IPPS rates invalid, consequently EJR is appropriate.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $50,000, as required for a group appeal. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amountis valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of

this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Blowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1877 and 405.1877
Schedule of Providers

cc: Donna Kalafut, Noridian Healthcare Solutions (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to: 14-1990GC

Certified Mail

APR 10 2014

Corinna Goron
Healthcare Reimbursement Services
17101 Preston Road
Suite 220
Dallas, TX 75248

RE: HRS UHHS FY 2014 2-Midnight Rule Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-1990GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 28, 2014 request for hearing appealing the August 19, 2013 Federal Register[1] and January 28, 2014 request for expedited judicial review (EJR) (both documents were received on January 29, 2014), as well as the Provider's March 21, 2014 response to the Board's request for addition information (received March 24, 2014). The Board's determination with respect to the request for EJR is set forth below.

Issue

In this case, the Providers are challenging the validity of the Secretary's 0.2% reduction to the IPPS rates. The issue contained in the hearing request and request for EJR is:

> Whether the provision in the Fiscal Year 2014 Inpatient Prospective Payment System ("IPPS") Final Rule ("Final Rule") that imposes that imposes a .2 percent decrease in the IPPS rates for all IPPS hospitals for each of the FYs 2014-2018 is procedurally invalid, arbitrary and capricious, and outside the statutory authority of the Centers for Medicare & Medicaid Services ("CMS").

Providers' January 28, 2014 Hearing Request, Tab. 2.

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Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary[2] indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

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Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and

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necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[8]

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

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The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized[18] amount was reduced by 0.2 percent.[19]

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[14] *Id.* at 50927.
[15] *Id.* at 50944.
[16] *Id.*
[17] *Id.* at 50945.
[18] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on

The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[20]

Providers' Request for EJR

The Providers believe EJR is appropriate because the Board lacks the power to reverse the 0.2% reduction. The Providers note that in the final IPPS rule, published in the August 19, 2013 Federal Register, the Secretary instituted the 2-midnight policy whereby a hospital stay would be deemed to be inpatient-appropriate if the ordering physician reasonably expects the patient to be in the hospital at least 2 midnights. They believe that if a patient is in the hospital past 2 midnights, CMS contractors will presume that the stay is an appropriate inpatient stay and [be less likely] to audit the hospitals records. Conversely, the Providers contend that a one-night stays are per se not inpatient appropriate unless the patient received a procedure on the "inpatient-only" list of procedures. Further, the Providers point out the Secretary estimates that her 2-midnight policy would increase IPPS operating and capital expenditures by approximately $220 million. In order to offset this amount the Secretary, using the authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(1) and 1395ww(g) to offset the $220 million by applying at 0.2 percent reduction to the operating IPPS standardized amount, the hospital specific rates and the Puerto Rico-specific standardized amount, and a 0.2 percent reduction for capital IPPS.

The Providers believe the 0.2 percent reduction is susceptible to challenge on the following grounds

> The decision to impose a $220 million (more correctly 0.2 percent reduction) is arbitrary and capricious because:
>
> (1) it relies on faulty assumptions and is not adequately explained;
>
> (2) It does not adequately take into account the payment reductions made by the Part B inpatient policy; and
>
> (3) It does not provide any mechanisms for making adjustments to, or reversing the effects of the payment cut if the [Secretary's] estimate is incorrect

Faulty Assumptions

The final IPPS rule states that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, resulting in a net gain of 40,000 inpatient stays. The Providers maintain that the final rule does

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whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* "Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated" (CMS Office of the Inspector General Report OEI-09-00-00200, August 2001) on the internet at http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[19] *Id.* at 50952-53.

[20] *Id.* at 50990.

not give much detail regarding how the estimate of a net gain of 40,000 inpatient stays was calculated other than the Secretary's actuaries based their estimate on FY 2011 claims data. The final rule does not explain the number of claims that were examined or how the data was used. Instead it states that:

> In determining the estimate of the number of encounters that would shift from outpatient to inpatient, our actuaries examined outpatient claims for observation or a major procedure. Claims not containing observation or a major procedure were excluded. The number of claims spanning 2 or more midnights based on the dates of service that were expected to become inpatient was approximately 400,000. This estimate did not include any assumption about outpatient encounters shorter than 2 midnights potentially becoming inpatient encounters.
>
> In determining the estimate of the number of encounters that would shift from inpatient to outpatient, our actuaries examined inpatient claims containing a surgical MS–DRG. Claims containing medical MS–DRGs were excluded. The number of claims spanning less than 2 midnights based on the length of stay that were expected to become outpatient, after excluding encounters that resulted in death or transfers, was approximately 360,000.

78 Fed. Reg. at 50953.

The Providers believe that this indicates that the Secretary is assuming that any claims for which the time in the hospital spanned 2 or more midnights would become inpatient claims under the 2-midnight policy and any claims for which the time in the hospital did not span two midnights would be outpatient claims. These assumptions were not justified by the Secretary.

In particular the Providers assert, these assumptions will not prove to be valid in light of the Medicare "Part B Inpatient" policy announced in the August 19, 2013 final IPPS rule.[21] This rule provides that if a hospital bills a hospital encounter as an inpatient stay, and the RAC or other Medicare contractor subsequently determines that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated on an outpatient basis instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. As a practical matter, following reopening by a RAC or other contractor, hospitals will never or almost never be able to re-bill under Part B because the reopenings almost always occur more than 12 months after the patient is discharged. The Providers are concerned that short stays, including

[21] *See generally* 78 Fed. Reg. at 50914-50938.

stays spanning 2 midnights, will denied under Medicare Part A and they will be unable to rebill under Part B within the 12-month window for filing claims. As a result, they may bill some of the stays exceeding 2 midnights under Part B initially. In addition, claims spanning 2 midnights may be billed under Part B even through the patient was admitted because of lack of documentation to support billing under Part A even though the patient stay was expected to span 2 midnights. In addition, some stays lasting less than 2 midnights will be billed under Part A. Some of these stays will be allowed under audit (or not audited and paid), but others will denied because the physician's assumption that the patient stay would exceed 2 midnights was not reasonable or sufficiently documented.

In addition, the Providers contend that there may be other fault assumptions upon which the Secretary relied but they cannot be identified because there were not sufficient details about the estimation outlined in the final IPPS rule. For example, the Providers do not know if the actuaries included claims denied on reopening and what adjustment, if any, was made for the fact that some FY 2011 claims where still within the 3-year reopening period. The Providers do not know if the Secretary assumed that the same rate of allowance/denials that occurred in previous years under different policies for inpatient admissions and rebilling under Part B would apply or some other rate was used.

Reductions Made as the Result of Part B Inpatient Policy

The Providers assert that even if the 2 midnight policy does result in an increase in Part A payments of $220 million per year, the Secretary projects that the closely related Inpatient Part B policy reduces Medicare payments by almost a billion dollars a year. However, there is no increase in payment to take into account the reduced Part B payments (estimated at $4.8 billion in the Part or 4.6 billion over 5 years[22]). The Providers believe the Secretary should also increase Part B rates to account for this decrease in payments, but the Secretary indicated that the reduction in Part B payments would be offset by the cost of ALJ decisions and CMS Ruling 1455-R which allows appeals outside the timely filing period which would be approximately $1.260 billion over calendar years 2013 to 2017.[23] The Providers find this calculation odd because the Ruling applies only for denials of service furnished before October 1, 2013 (NOTE: given the RAC and other contractors have 3 or 4 years to reopen the Part A claims and then the Providers must appeal it could easily take this long to bill Part B, potentially longer since the ALJs have said they have too many Part A appeals to process and were staying the process). The Providers note that the Secretary provides no explanation as to the number of existing appeals to which the Ruling would apply or the number of determinations that would be made that allowed Providers to rebill. The Providers assert that the Part B policy is saving Medicare $4.6 billion over the next 5 years that it otherwise would have spent regardless of the effect of alleged offsets.

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[22] 78 Fed. Reg. 16632, 16633 (March 13, 2013) (we estimate the final [Part B, Inpatient] policy will result in approximately $4.8 billion decrease in Medicare program expenditures over 5 years) and 78 Fed. Reg. at 505007 (Aug. 19, 2013) (with respect to Part B Hospital Inpatient Payment Policy following the denial of Part A claims and subsequent billing to Part B, we estimate that the final Medicare expenditures will be reduced by $4.6 billion over 5 years).

[23] 78 Fed. Reg. at 50954.

No Mechanism for Making Adjustments to or Reversing the Effects of Payments if the Estimate is Incorrect

The Providers believe that the estimate of an additional $220 million of IPPS expenditures is highly speculative because the Secretary acknowledged that the estimate is subject to a variety of factors. The Secretary noted that the actual costs or savings would depend substantially on possible changes in unanticipated changes in hospital behavior and changes in inpatient and outpatient utilization.

The Providers believe that the Board lacks the authority to declare the 0.2 percent decrease in IPPS rates invalid, consequently EJR is appropriate.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $50,000, as required for a group appeal. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amountis valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of

this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Blowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1877 and 405.1877
Schedule of Providers

cc: Judith Cummings, CGS (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
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Refer to: 14-1989GC

Certified Mail

APR 10 2014

Corinna Goron
Healthcare Reimbursement Services
17101 Preston Road
Suite 220
Dallas, TX 75248

RE: HRS WKHS FY 2014 2-Midnight Rule Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-1989GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 28, 2014 request for hearing appealing the August 19, 2013 Federal Register[1] and January 28, 2014 request for expedited judicial review (EJR) (both documents were received on January 29, 2014), as well as the Provider's March 21, 2014 response to the Board's request for addition information (received March 24, 2014). The Board's determination with respect to the request for EJR is set forth below.

Issue

In this case, the Providers are challenging the validity of the Secretary's 0.2% reduction to the IPPS rates. The issue contained in the hearing request and request for EJR is:

> Whether the provision in the Fiscal Year 2014 Inpatient Prospective Payment System ("IPPS") Final Rule ("Final Rule") that imposes that imposes a .2 percent decrease in the IPPS rates for all IPPS hospitals for each of the FYs 2014-2018 is procedurally invalid, arbitrary and capricious, and outside the statutory authority of the Centers for Medicare & Medicaid Services ("CMS").

Providers' January 28, 2014 Hearing Request, Tab. 2.

[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary[2] indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[6]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and

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[2] of the Department of Health and Human Services.
[3] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).
[4] *78 Fed. Reg.* at 50907.
[5] *Id.*
[6] *Id.*
[7] Chapter 6, § 20.6 and Chapter 1, §10.

necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[8]

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decision effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[12] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[13] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not

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[8] 78 Fed. Reg. at 50907-08.
[9] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[10] 78 Fed. Reg. 50908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[13] 78 Fed. Reg. at 50909.

creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[14]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized[18] amount was reduced by 0.2 percent.[19]

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The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[20]

Providers' Request for EJR

The Providers believe EJR is appropriate because the Board lacks the power to reverse the 0.2% reduction. The Providers note that in the final IPPS rule, published in the August 19, 2013 Federal Register, the Secretary instituted the 2-midnight policy whereby a hospital stay would be deemed to be inpatient-appropriate if the ordering physician reasonably expects the patient to be in the hospital at least 2 midnights. They believe that if a patient is in the hospital past 2 midnights, CMS contractors will presume that the stay is an appropriate inpatient stay and [be less likely] to audit the hospitals records. Conversely, the Providers contend that a one-night stays are per se not inpatient appropriate unless the patient received a procedure on the "inpatient-only" list of procedures. Further, the Providers point out the Secretary estimates that her 2-midnight policy would increase IPPS operating and capital expenditures by approximately $220 million. In order to offset this amount the Secretary, using the authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(1) and 1395ww(g) to offset the $220 million by applying at 0.2 percent reduction to the operating IPPS standardized amount, the hospital specific rates and the Puerto Rico-specific standardized amount, and a 0.2 percent reduction for capital IPPS.

The Providers believe the 0.2 percent reduction is susceptible to challenge on the following grounds

> The decision to impose a $220 million (more correctly 0.2 percent reduction) is arbitrary and capricious because:
>
> (1) it relies on faulty assumptions and is not adequately explained;
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> (2) It does not adequately take into account the payment reductions made by the Part B inpatient policy; and
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not give much detail regarding how the estimate of a net gain of 40,000 inpatient stays was calculated other than the Secretary's actuaries based their estimate on FY 2011 claims data. The final rule does not explain the number of claims that were examined or how the data was used. Instead it states that:

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The Providers believe that this indicates that the Secretary is assuming that any claims for which the time in the hospital spanned 2 or more midnights would become inpatient claims under the 2-midnight policy and any claims for which the time in the hospital did not span two midnights would be outpatient claims. These assumptions were not justified by the Secretary.

In particular the Providers assert, these assumptions will not prove to be valid in light of the Medicare "Part B Inpatient" policy announced in the August 19, 2013 final IPPS rule.[21] This rule provides that if a hospital bills a hospital encounter as an inpatient stay, and the RAC or other Medicare contractor subsequently determines that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated on an outpatient basis instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. As a practical matter, following reopening by a RAC or other contractor, hospitals will never or almost never be able to re-bill under Part B because the reopenings almost always occur more than 12 months after the patient is discharged. The Providers are concerned that short stays, including

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The Providers believe that the estimate of an additional $220 million of IPPS expenditures is highly speculative because the Secretary acknowledged that the estimate is subject to a variety of factors. The Secretary noted that the actual costs or savings would depend substantially on possible changes in unanticipated changes in hospital behavior and changes in inpatient and outpatient utilization.

The Providers believe that the Board lacks the authority to declare the 0.2 percent decrease in IPPS rates invalid, consequently EJR is appropriate.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $50,000, as required for a group appeal. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount there are no findings of fact for resolution by the Board;

3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of

this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Blowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1877 and 405.1877
Schedule of Providers

cc: Timothy LaJune, Novitas (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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Refer to: 13-3755

APR 14 2014

CERTIFIED MAIL

Strategic Reimbursement, Inc.
Nick Putnam
360 W. Butterfield Road
Elmhurst, IL 60126

Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108

RE: St. Joseph Hospital of Orange
Provider No.: 05-0069
FYE: 06/30/2009
PRRB Case No.: 13-3755

Dear Mr. Putnam and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

St. Joseph Hospital of Orange (the Provider) was issued an original Notice of Program Reimbursement (NPR) for FYE 06/30/2009 on February 25, 2013. The Provider was issued a revised Notice of Program Reimbursement on March 26, 2013. On September 20, 2013, the Provider filed an appeal request with the Board appealing various issues, along with an explanation for filing its appeal based on the March 26, 2013 revised NPR date rather than the February 25, 2013 NPR date. The Provider's explanation stated that it had used a tracking mechanism (HCRIS) to monitor the appeal deadline, and that the original NPR dated February 25, 2013 was not published; only the March 26, 2013 revised NPR was published. As a result, the Provider filed its appeal of the original NPR in accordance with the revised NPR date.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the receipt of the final determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not challenge jurisdiction over the issues appealed, the Board nonetheless finds that it does not have jurisdiction over this appeal from the original NPR because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed with the Board no later than 180 days after the provider has received its final determination.
42 C.F.R. § 405.1835(a)(3)(i) states,

> (3) Unless the provider qualifies for a good cause extension[...], the date of the receipt by the Board of the provider's hearing request is-
>
> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

St. Joseph Hospital of Orange was issued its original NPR on February 25, 2013 and presumed to have received it on March 2, 2013. The Provider did not present evidence that the NPR was received later than the five day presumption. In its appeal request, the Provider indicated that it had timely appealed from the revised NPR dated March 26, 2013. However, the final determination it attached to its appeal request was a copy of the original NPR dated February 25, 2013, and the Provider's explanation of the late filing indicates that the original NPR was in fact the final determination from which the Provider intended to appeal. As such, the 180 day window is calculated from the date the Provider was presumed to have received the original NPR. An appeal request from this original NPR was delivered by FedEx and received by the Board on September 20, 2013. Thus, the date of filing was 202 days after the presumed date of receipt of the determination from the Intermediary.

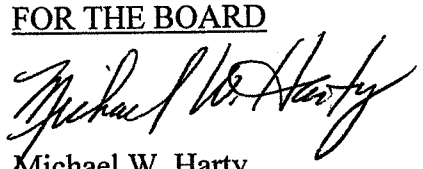
The Board cannot expand the deadline to appeal the original NPR to that of the revised NPR, as the original and revised NPR's are distinct determinations from which appeal rights are significantly different. French Hospital vs. Shalala discussed the distinction between an original NPR appeal and a revised NPR appeal, "Section 405.1889'sdistinction between revised and original NPRs has two effects. The regulation, read in tandem with the regulations prescribing various routes of appeal, creates a separate right of appeal for providers to challenge revised NPRs. At the same time, however, § 405.1889 limits the scope of review of revised NPRs because it mandates that they be considered "separate and distinct" for purposes of appeal. 42 C.F.R. § 405.1889 bifurcates the revised NPR from the initial NPR, thereby limiting the scope of review to issues addressed in that revised NPR."

Because the appeal request of the original NPR was not received by the Board within 180 days of its issuance as required by 42 C.F.R. § 405.1835, the Board finds that it was not timely filed. The Board hereby dismisses the appeal and case number 13-3755 is closed.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

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Refer to: 13-0441

APR 15 2014

CERTIFIED MAIL

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Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

RE: Jurisdictional Decision – Renown Regional Medical Center
Provider No.: 29-0001
FYE: 6/30/2007
PRRB Case No.: 13-0441

Dear Mr. Blumberg and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Renown Regional Medical Center received a revised Notice of Program Reimbursement (NPR) for FYE 6/30/2007 on July 18, 2012. On January 18, 2013, the Board received the Provider's appeal request in which it appealed three issues: Medicare SSI Percentage, Medicaid HMO Days (Part C Days), and the Rural Floor Budget Neutrality Adjustment (RFBNA).

Intermediary's Contentions

The Intermediary filed a jurisdictional challenge on November 12, 2013, contending that the Board lacks jurisdiction over the RFBNA issue because the Provider is appealing from a revised NPR in which the relevant issue was not specifically revised. Specifically, the Intermediary contends that, although the revised NPR incorporated six adjustments, none of the adjustments were related to RFBNA.

Provider's Contentions

The Provider filed a response to the Intermediary's jurisdictional challenge on December 12, 2013, contending that the Board does have jurisdiction over the RFBNA issue because the Provider met the statutory requirements for a Board hearing; the RFBNA issue was encompassed by the Intermediary's determination; the Intermediary made an audit adjustment relating to the RFBNA issue; an audit adjustment is not a prerequisite for Board jurisdiction; and the Provider

was not required to follow protest procedures to preserve its appeal rights on the RFBNA issue.[1] The Provider further notes that its attorneys have been in contact with counsel for DHHS about settlement of this issue, and have submitted supporting documentation as requested by HHS. The Provider's attorneys were advised by HHS counsel that HHS is planning to settle the cases as expeditiously as possible. Accordingly, the Provider requests that the Board defer ruling on the Intermediary's jurisdictional challenge pending the outcome of these settlement discussions.[2]

The Provider maintains that it has met the jurisdictional prerequisites in 42 U.S.C. § 1395oo(a) as the appeal was filed on January 17, 2013, which was within 180 days of receipt of the NPR; the estimated amount in controversy is $723,000, which is well over the $10,000 requirement; and it expressed dissatisfaction with the total amount of program reimbursement.[3]

The Provider further contends that the RFBNA issue is reflected in the Intermediary's final determination. The Provider argues that an improperly deflated standardized amount was incorporated in the DRG payments reflected on Worksheet E, Part A, line 1 of the cost report and was reflected in the Intermediary's final determination for FY 2007. By deflating the DRG payment, the Provider's DSH payment was also negatively impacted. Also, the disputed change in the SSI% has reduced the DSH payment, which has flowed through to the Provider's Rural Floor Payment and lowered the DRG payment. The Provider contends as the Intermediary acknowledges it made an audit adjustment to the Provider's DRG payments when it issued the revised NPR; with that the Intermediary determined that DRG payments computed based on the erroneous standardized amount were included in the Provider's FY 2007 cost report. Thus, the Intermediary made a "determination" that incorporated the RFBNA errors in the Provider's cost report.[4]

The Provider argues no audit adjustment is necessary for the Board to have jurisdiction over this appeal.[5] The Provider maintains that, pursuant to *Bethesda*, the Board has power to review and revise cost reports with respect to an issue that was not considered or adjusted by the Intermediary, so long as the issue was covered by the cost report. The Provider further contends that, pursuant to *Mayo Regional Hosp. v. Blue Cross & Blue Shield Ass'n/Associated Hosp. Servs. Of Maine*, PRRB Dec. No. 2002-D15 [2002-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 80,803 (Mar. 27, 2002), the Board has the power to decide an issue even if it was not first raised with the Intermediary at the time the cost report was filed and the Intermediary did not make an audit adjustment, and that pursuant to *Sacred Heart Med. Ctr. (Spokane Wash.) v. Blue Cross & Blue Shield Ass'n/Blue Cross of Wash. & Alaska*, PRRB Dec. No. 99-D2 [1998-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 80,085 (Oct. 16, 1998), *aff'd on other grounds* [1999-1 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 80,154 (Admin. Dec. 21, 1998), the inclusion of a "disputed statistic" in a cost report suffices to establish Board jurisdiction even in the absence of an audit adjustment. The Provider maintains that the RFBNA was covered by the cost report because the Provider claimed DRG payments on the cost report and the DRG payments were tainted by the erroneous application of RFBNA. As such, the

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1 Provider's Reply to Intermediary's Jurisdictional Challenge at 1.
2 *Id.* at 2.
3 *Id.* at 5-6.
4 *Id.* at 6-7.
5 *Id.*

Provider contends that the Board has jurisdiction over this case based on the existing case law and the Medicare statute and regulations.[6]

The Provider maintains that it is not required to follow protest procedures to preserve its appeal rights on the RFBNA issue. The protest item procedure is not intended to address issues such as the RFBNA issue because the RFBNA issue does not involve a "non-allowable" item or challenge to a regulation, manual provision, or CMS Ruling; rather, it stems from computational errors made by CMS in applying the RFBNA, which CMS has acknowledged and corrected prospectively.[7] The Provider contends that interpretation of the 2008 regulatory change as requiring the use of protest procedures for the RFBNA issue would be contrary to the Medicare statute as interpreted by the Supreme Court in *Bethesda*.[8]

Board's Decision

A Provider has a right to a hearing before the Board, as a single Provider appeal, with respect to a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the Intermediary, the amount in controversy is $10,000 or more, and the request for a hearing is filed within 180 days of the NPR.[9]

Jurisdiction for reopening an Intermediary determination rests exclusively with the Intermediary (or successor Intermediary) that rendered the determination.[10] 42 C.F.R. § 405.1885(a)(6) (2012) states that "[a] determination or decision to reopen or not to reopen a determination or decision is not a final determination or decision within the meaning of [Subpart R of Title 42] and is not subject to further administrative review or judicial review."[11]

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that

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6 *Id.* At 7-9.
7 *Id.* at 9-11.
8 *Id.* at 10.
9 42 U.S.C. § 1395oo(a) (2012); 42 C.F.R. §§ 405.1835-1841 (2012).
10 42 C.F.R. § 405.1885(c) (2012).
11 *See* Your Home Visiting Nurse Services, Inc. v. Shalala, 525 U.S. 449 (1999).

was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The MAC, with its jurisdictional challenge, supplied the Notice of Reopening that was issued to this provider. The cost report was reopened "To revise the Medicare-SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS". The Provider's audit adjustment report associated with the July 18, 2012 revised NPR identified six audit adjustments; three software type adjustments, two adjustments to revise the SSI%, and an adjustment to include all tentative payments on the cost report. None of these adjustments were related to the RFBNA nor DRGs, which the provider has appealed from the RNPR and claims is the basis for the appealed underpayment.

The Provider cites extensive case law, summarizing that the Board must take jurisdiction over the RFBNA as no adjustment is necessary for Board jurisdiction and the provider was not required to protest items in this specific cost year (prior to 2008 Board Rules and Regulations). What the provider fails to address however, is that the instant case is an appeal from a revised NPR, not from an original NPR appeal as the cited case law is based upon. The Provider failed to identify how this appeal from the RNPR met the criteria put forth in 42 C.F.R. § 405.1889, and how the RFBNA was specically revised in the revised NPR. The regulation is clear that both requirements must be met for Board jurisdiction from a RNPR and the record is clear that the only issue reopened and adjusted was the SSI%. Therefore, the Board finds that it does not have jurisdiction over this issue and dismisses it from the appeal.

Although not specifically challenged by the MAC, the Board also finds that it lacks jurisdiction over the Medicaid HMO Days (Part C Days) based on the same rationale described above. The Medicaid HMO Days are reported on S-3 of the cost report and were not reopened for (see reopening request) nor revised (no adjustments to S-3 Medicaid Days) in the RNPR. Therefore the issue does not meet the requirements of 42 C.F.R. § 405.1889, and cannot be appealed from a RNPR. The Medicaid HMO Days issue is also dismissed from the appeal.

Case number 13-0441 will remain open to resolve the SSI% data match issue which remains pending in this appeal. Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD
Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

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APR 21 2014

Refer to: 13-0076 CERTIFIED MAIL

Michael K. Mckay
President
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CGS Administrators
Judith E. Cummings
Accounting Manager
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

Re: Juris Challenge
Southern Ohio Medical Center
Provider No. 36-0008
FYE 06/30/2004
PRRB Case No. 13-0076

Dear Mr. Mckay and Ms. Cummings

The Provider Reimbursement Review Board (Board) has reviewed the above-captioned appeal. The jurisdictional decision of the Board is set forth below.

Background

The Provider is located in Ohio, in the Sixth Circuit. Following the decision in *Clark Regional Medical Center v. United States Dep't of Health & Human Services.*, 314 F.3d 241(6th Cir. 2002), CMS counted observation days differently in the Disproportionate Share Hospital (DSH) payment calculation for hospitals in the Sixth Circuit than for hospitals in the rest of the country. For hospitals in the Sixth Circuit, a unique cost report worksheet E, part G, was used for the period at issue to calculate the Medicaid fraction, the Medicare Part A/SSI fraction and the DSH adjustment percentages that would then flow into the DSH payment calculation on the standard worksheet E part A.

In this case, the Intermediary failed to incorporate adjustments to worksheet E, part G to reflect the adjustments to the patient days listed on worksheet S-3, and as a result, the adjustments to the patient days listed on worksheet S-3 did not flow through and were not reflected in the DSH payment calculation on worksheet E, part A. As a result, the adjustments made to the patient day statistics reported on worksheet S-3 in the revised Notice of Program Reimbursement (NPR) dated April 9, 2010, had no impact on the DSH payment calculation.

The Provider's final settled cost report was issued on August 16, 2006. The Provider's cost report has been reopened four times. The first reopening was a Provider request to correct the Indirect Medical Education (IME) and Graduate Medical Education (GME) payments for new residency programs. A first Amended NPR was issued on February 2, 2009. The second reopening was a Provider request to include additional Medicaid eligible days, net of labor and

delivery and dual eligible days, in the DSH and Low-income Patient (LIP) calculations. A second Amended NPR was issued on April 9, 2010. The third reopening was Intermediary initiated to correct IME and GME. A third Amended NPR was issued on September 26, 2011. The fourth reopening was a Provider request to update the allowable DSH percentage on Worksheet E, Part A using the additional Medicaid eligible days (after Intermediary review) per the second reopening dated April 9, 2010. A fourth Amended NPR was issued on May 15, 2012.

The Provider filed its appeal request with the PRRB on November 13, 2012, challenging the exclusion of labor and delivery days in the revised NPR at issue. The Intermediary then challenged the PRRB's jurisdiction to hear the DSH Labor and Delivery day's issue, claiming that the appeal request was not timely and there was no final determination relating to the issue appealed. On February 15, 2013, the Provider filed a response to the Intermediary's jurisdictional challenge and on June 17, 2013, the Provider requested a standard remand for the labor and delivery day issue under CMS Ruling 1498-R.

Intermediary's Contentions

The Intermediary contends they did not make an adjustment to remove labor and delivery days during the fourth reopening dated May 15, 2012. In accordance with 42 C.F.R. § 405.1835: "The provider ... has a right to a hearing before the Board about any matter designated in §405.1801(a)(1), if. ..[a]n intermediary determination has been made with respect to the provider." The Provider requested a second reopening on July 25, 2008 to include additional Medicaid eligible days in the DSH and LIP calculations. The Provider self-identified 326 labor and delivery days and 128 dual eligible days. In the Provider's second reopening request, the Intermediary states that the Provider noted they "do not concur that labor days require removal from the Medicaid proxy, [but] effective October 1, 2003, CMS amended the DSH regulation, 42 CFR § 412.106(a)(l)(ii), to exclude from the numerator and the denominator of the Medicaid fraction patient days associated with ancillary labor/delivery services." The Provider also recognized that the 128 dual eligible days should be included in the SSI fraction, but was unable to determine if they had as the Social Security Administration (SSA) had not yet released the data used to calculate the SSI percent. This reopening was granted by the previous Intermediary, National Government Services (NGS), on November 17, 2009 and a second Amended NPR was issued on April 9, 2010. NGS sampled and reviewed the days in question and made the necessary adjustment to allow 207 additional Medicaid days, 44 additional Rehab Medicaid days to reduce total days by 463 self-identified labor and delivery days. NGS made the correct adjustments to the Medicaid days; however, they failed to recalculate the corresponding allowable DSH percentage which resulted in no change to the DSH payment.

Per the Intermediary, in January 2012, the Provider's consultant identified that the allowable DSH percentage was not updated based on the review of additional Medicaid days. On April 26, 2012, the Provider formally requested that the Intermediary reopen the cost report to correct the allowable DSH percentage based on the review of Medicaid days previously performed by NGS (second reopening). The Intermediary reviewed the reopening and granted the Provider's request. The Intermediary recalculated the allowable DSH percentage and issued a fourth Amended NPR on May 15, 2012. The Intermediary contends this reopening was solely limited to the allowable DSH percentage and did not review the Medicaid days on the cost report or any additional days. No adjustment was made to labor and delivery or dual eligible days as these days were removed in the second reopening (dated April 9, 2010) and per the intermediary was outside the scope of fourth reopening (dated May 15, 2012). The only

adjustment to Medicaid days during the fourth reopening was to include the total allowable Medicaid Days and Total Days on Worksheet E Part G, as previously reviewed and adjusted on W/S S-3 Part I, in the second amended NPR.[1]

Provider's Contentions

The Provider contends the May 15, 2012 revised NPR (fourth reopening) was the Provider's first opportunity to appeal the Intermediary's exclusion of labor and delivery room days from the DSH payment calculation. The April 9, 2010 revised NPR (second reopening) adjusted labor and delivery room days in the patient day statistics but made no adjustment at all to the DSH payment calculation. Thus, adjustments to the statistics on worksheet S-3 from the second revised NPR had no reimbursement impact on operating DSH, and the Provider had no ground for appealing that determination.[2]

The Provider also contends the first time that the Intermediary made an adjustment with respect to labor and delivery room days in the DSH calculation was in May 15, 2012 revised NPR (fourth reopening). At that time, the Intermediary made an adjustment (adjustment number 2) to report 207 additional Medicaid eligible days, which was the net number of Medicaid eligible days based on multiple adjustments previously identified in the second reopening NPR dated April 9, 2010. The Provider cites the Intermediary's workpaper at procedure 1, which states that the Intermediary was to "[r]eview the RO2 DSH workpapers to determine the proper number of Medicaid and Total days." The workpaper reflects the adjustment to days by category, including the removal of 326 labor and delivery days within the Medicaid eligible day adjustment. The workpaper also reflected a reduction to the total patient day count for 463 labor and delivery room days. Thus, the Provider contends the Intermediary reviewed and adjusted labor and delivery room days for the purpose of the DSH calculation within the fourth reopening as to the "proper number of Medicaid and Total days." [3]

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of the Notice of Program Reimbursement (NPR).

The Board finds that it has jurisdiction under 42 U.S.C. 1395oo(a) over the Labor and Delivery days' issue since it was the fourth reopening(Fourth Amended NPR) that was final and binding, which the Provider appealed from. Under 42 CFR §§ 405.1807, *Effect of Intermediary determination:* "The determination shall be final and binding on the party or parties to such determination unless (b) The Intermediary determination is revised in accordance with §§ 405.1885." While the Intermediary changed its determination regarding the number of labor and delivery days on the second reopening (Second Amended NPR) but didn't actually recalculate the allowable DSH percentage regarding the effect of this adjustment until the fourth reopening, the determination from the second reopening was not final and binding, since this determination was reopened once again in the fourth reopening to effectuate the decision regarding labor and

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1 *See* Mac's Jurisdictional Challenge dated December 30, 2012.
2 *See* 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(2).
3 *See* Provider's Response to Jurisdictional Challenge dated February 15, 2013.

delivery days.

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

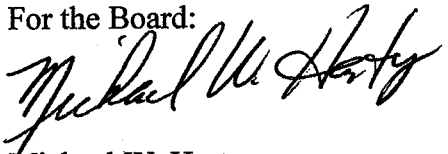
> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Consequently, this issue can be remanded to the Intermediary under the terms of the Centers for Medicare & Medicaid Services (CMS) Ruling CMS-1498-R for recalculation of the DSH payment adjustment. As this was the last remaining issue in Case number 13-0076, the case will also be closed after the remand is processed.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§405.1875 and 405.1877.

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Calyton Nix, ESQ.
L. Sue Andersen, Esq.

For the Board:



Michael W. Harty,
Chairman

Enclosures: 42 U.S.C. §1395oo(f)
42 C.F.R. §§405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, Senior Gov. Initiatives, BCBSA

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Refer to:

14-2385

APR 25 2014

CERTIFIED MAIL

Ms. Tracy A. Jessner, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East
Suite 1600
Los Angeles, CA 90067

RE: Nevada Regional Medical Center
Provider No.: 26-0061
FYE – 09/30/2014
PRRB Case No.: 14-2385

Dear Ms. Jessner:

In a letter dated February 11, 2014, received in the Board's offices on February 14, 2014, the Provider filed a Form A – Individual Appeal Request for the above-captioned Provider and Fiscal Year End ("FYE"). The Board acknowledged receipt of the appeal request by letter dated February 22, 2014 and assigned case number 14-2385.

Upon further review of the appeal request, the Board notes that the Estimated Impact of Amount in Controversy for the .2% Adjustment for Two Midnight Rule is $4,796.00. Pursuant to 42 C.F.R. § 405.1835(a)(2); § .405.1839(a)(1) and Board Rule 6.3, any individual appeal request must have a total amount in controversy of at least $10,000 when the appeal is initially filed.

Since the amount in controversy does not meet the jurisdictional requirements necessary to proceed, the Board hereby closes the subject appeal and removes it from its docket. Therefore, the Provider's request to transfer Nevada Regional Medical Center, Case Number 14-2385 into HLB Independent FFY 2014 Two Midnights 0.2 Percent IPPS Payment Group, Case Number 14-3272G is denied.

The Provider may have appeal rights with the Intermediary pursuant to 42 C.F.R. § 405.1839(a) which advises that the amount in controversy for an Intermediary hearing is at least $1,000 but less than $10,000. The request must meet the requirements for an Intermediary hearing as addressed in 42 C.F.R. § 1809. The Board does not have the authority to transfer the subject appeal to the Intermediary; the Provider must file the appeal directly with the Intermediary.

Board Members Participating:

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

cc: Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
P.O. Box 1604
Omaha, NE 68101

Kevin D. Shanklin
Executive Director
Senior Government Initiatives
BlueCross BlueShield Association
225 North Michigan Ave.
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Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to: 09-2176GC

CERTIFIED MAIL

APR 25 2014

Blumberg Ribner, Inc.
Isaac Blumberg
Chief Operating Officer
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

RE: Jurisdictional Review
Provider No.: Various
FYE: Various
PRRB Case No.: 09-2176GC, MHS 1996-2003 DSH Dual Eligible Days CIRP Group

Dear Mr. Blumberg and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and on its own motion noted a jurisdictional impediment. The jurisdictional decision of the Board is set forth below.

Background

This group appeal was filed on August 26, 2009 and began with four participants for multiple years, from which the Dual Eligible Days issue was transferred to form this group. Upon completion of the group, the Board reviewed the participants since the Dual Eligible Days issue is under the CMS Ruling 1498 remand.

Orange Coast Memorial Medical Center, Provider No. 05-0678, Fiscal Year End 06/30/2000 (participant #5 on the schedule of Providers):

On July 22, 2003, the Provider filed an individual appeal from an original Notice of Program Reimbursement (NPR) dated January 31, 2003 (CN 03-1397). Case No. 03-1397 was withdrawn by the Provider on September 13, 2005. On February 22, 2006, the Provider filed an individual appeal from a Revised NPR dated August 31, 2005 (CN 06-0758). On June 20, 2006, Case No. 06-0758 was closed after the last issue was transferred to Case No. 95-2120G.[1]

The Board received the Schedule of Providers (SOP) and jurisdictional documents for Case No. 09-2176GC on May 17, 2013. It was noted that for participant #5, Orange Coast Memorial

[1] Case No. 95-2120G pertains to the SSI percentage issue and not the Dual Eligible Days issue.

Medical Center, the NPR and appeal request dates correspond to individual Case No. 03-1397 but the SOP list Case No. 06-0758 as the case that the Dual Eligible Days issue was being transferred from.[2]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§405.1835 – 405.1841, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the receipt of a final determination.

The Board hereby **denies** the transfer of the Dual Eligible Days issue for Orange Coast Memorial Medical Center, Provider No. 05-0678, Fiscal Year End 06/30/2000 into the subject appeal since both individual cases were closed prior to the establishment of Case No. 09-2176GC. Therefore, the Board finds that it lacks jurisdiction over Orange Coast Memorial Medical Center, Provider No. 05-0678, Fiscal Year End 06/30/2000 in the subject appeal and hereby **dismisses** it from Case No. 09-2176GC.

Other Participating Providers

Upon review of the supporting documentation there are no jurisdictional problems with the remaining providers included in this appeal.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

[2] Both cases (CN 03-1397 and CN 06-0758) were closed prior to the formation of CN 09-2176GC and as stated previously in Footnote #1, CN 95-2120G issue is SSI% not Dual Eligible Days.

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CERTIFIED MAIL

APR 25 2014

Hooper, Lundy & Bookman, P.C.
Nina Adatia Marsden
1875 Century Park East
Suite 1600
Los Angeles, CA 90067

RE: PH FFY 2014 Two Midnights 0.2 Percent IPPS Payment Reduction CIRP Group
FYE: 09/30/2014, PRRB Case No: 14-2984GC

Dear Ms. Adatia Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed your request that good cause be found for the late filing of the subject appeal. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The FFY 2014 Medicare Inpatient Prospective Payment System (IPPS) Final Rule was published in the Federal Register on August 19, 2013.

The Provider's appeal was dated March 24, 2014 and was received by the Board on March 25, 2014 (218 days after the issuance of the August 19, 2013 Federal Register). In its appeal, the Provider acknowledges that the appeal was filed more than 180 days after the August 19, 2013 Federal Register, but requests good cause be found.

The Provider sites the following reason for missing the deadline:

- The Provider states that, on February 11, 2014, an email was sent to the Chief Legal Counsel ("Counsel") for Palomar Health providing the address information for the parties who were to receive copies of the appeal request.

- This email was forwarded to the Counsel's Executive Assistant to execute delivery of the appeal request. The Executive Assistant followed the email instructions to send copies to Noridian Healthcare Solutions, LLC and Blue Cross Blue Shield Association, but did not note that the intended addressee was Michael Harty at the Board. Therefore, a Federal Express packet was not prepared for delivery to the Board.

- The Provider telephoned the Board on February 26, 2014 to inquire about the status of the appeal. After consulting with Board Staff, the Provider recognized that its appeal was not properly delivered to the Board.

- The Provider maintains that its appeal should be acknowledged as timely filed because it intended to file the appeal with the Board but, due to an administrative oversight, the appeal package was not delivered to the Board appropriately.

- The Provider further requests that, should the Board not acknowledge the appeal as timely filed, the Board exercise its authority to grant an extension to the normal appeal deadline.

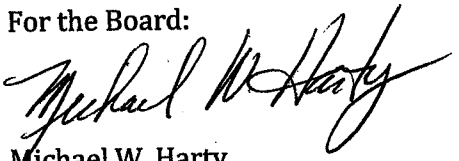
Board Determination:

Pursuant to 42 C.F.R. § 405.1836(b), "[t]he Board may find good cause to extend the time limit only if the Provider demonstrates in writing it can not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire or strike)...". Based on its review, the Board finds that there was nothing outside of the Provider's control to prevent it from timely filing this appeal request. Therefore, this request does not meet the requirements for a good cause extension under the current regulations and the appeal is dismissed.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

Kevin Shanklin, BCBSA

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Refer to:

APR 25 2014

CERTIFIED MAIL

Tenet Healthcare Corporation
John M. Maguire
Manager, Appeals
1445 Ross Avenue, Suite 1400
Dallas, TX 75202 2703

RE: Requests to transfer Providers from:
Metro West Medical Center, Provider No. 22-0175, Case No. 13-0977
St. Vincent Hospital, Provider No. 22-0176, Case No. 13-0941
Arrowhead Hospital, Provider No. 03-0094, Case No. 13-0745 and
Phoenix Baptist Hospital, Provider No. 03-0030, Case No. 13-0643

To: Tenet FY 2009 DSH Dual Eligible Days CIRP Group, Case No. 13-1553GC

Dear Mr. Maguire:

The Provider Reimbursement Review Board (the Board) is in receipt of the Representative's requests to transfer the Dual Eligible Days issue from the subject Providers' individual appeals to the Tenet FY 2009 DSH Dual Eligible Days Common Issue Related Party (CIRP) Group, Case No. 13-1553GC. The pertinent facts and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The Tenet FY 2009 DSH Dual Eligible Days CIRP group appeal was filed on April 8, 2013. The group issue statement described the issue in dispute as "... whether the DSH calculation should include all eligible, including unpaid, Medicaid days, including those days where the patient has exhausted their Medicare Part A eligibility."

In response to a Board request for additional information in the group, the Representative submitted a clarification of the issue statement on April 22, 2013. The clarification discusses the payment of inpatient days for patients who were eligible for both Medicare and Medicaid, but who were not entitled to have payment made under Part A prospective payment system. It includes the exclusion of these days from the numerator of the Medicaid fraction and the inclusion of those days in the SSI fraction.

The Representative also filed group appeals for the Medicare and Medicaid fractions of the Part C Days issue on April 22, 2013. The Board established the following appeals:

- Tenet FY 2009 DSH Medicaid Fraction Part C Days CIRP – Case No. 13-1961GC
- Tenet FY 2009 DSH SSI Fraction Part C Days CIRP – Case No. 13-1962GC

All four of the referenced providers have requested to be transferred into the two Part C Days group appeals (13-1961GC and 13-1962GC), as well as the subject Dual Eligible Days group (13-1553GC).

On January 30, 2014, the Board transferred the Dual Eligible Days, Medicaid Fraction Part C Days and SSI Fraction Part C Days issues for Phoenix Baptist Hospital and Arrowhead Hospital, resulting in the closure of the individual appeals (13-0643 and 13-0745).

On February 18, 2014, the Representative requested the transfer of the Dual Eligible Days, Medicaid Fraction Part C Days and SSI Fraction Part C Days issues for St. Vincent Hospital and Metro West Medical Center and advised that the individual appeals (13-0941 and 13-0977) could be closed upon completion of the transfers to groups.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the Notice of Program Reimbursement (NPR).

The Board finds that the initial group appeal request characterized the issue as "Dual Eligible Days." Specifically, the statement of the group issue indicates:

> The common issue in this group appeal concerns the treatment in the calculation of the Medicare disproportionate share hospital ("DSH") payment of inpatient days for patient who were eligible for Medicare part A and Medicaid, but who were not entitled to have payment made for such days under the Medicare part A prospective payment system (hereinafter referred to as "part A eligible but unpaid" days). These days include days for patients who had exhausted their part A benefits, for whom Medicare was a secondary payer, and other days that were not covered by Medicare part A. The Providers contend that these part A eligible but unpaid days must be counted in the numerator of the Medicaid fraction to the extent that the patient was eligible of Medicaid and that they must be excluded in their entirety from the SSI Fraction . . .

In contrast, the issue statement for each of the Providers requesting to be transferred states:

> The Intermediary improperly included Medicare Advantage (MA) days in the Medicare/SSI fraction and failed to include Medicare Advantage days for the M + C beneficiary who is also eligible for Medicaid in the Medicaid fraction in the calculation of the Medicare disproportionate share hospital ("DSH") adjustment.

Consequently, the dual eligible days issue was not actually appealed in the individual appeals for any of the four Providers.

Therefore, the transfer of the Dual Eligible Days issue for Phoenix Baptist Hospital and Arrowhead Hospital to group case number 13-1553GC, is hereby rescinded since it has now been determined that the Dual Eligible Days issue was not appealed in either individual appeal. The Medicaid Fraction Part C Days and SSI Fraction Part C Days issues were previously transferred from case numbers 13-0643 and 13-0745 to group case numbers 13-1961GC and 13-1962GC, respectively, in accordance with your January 2014 requests. Since there are no other issues in dispute in these appeals, the cases remain closed.

Further, the Board denies the February 14, 2014 requests to transfer the Dual Eligible Days issue for Metro West Medical Center (13-0977) and St. Vincent Hospital (13-0941) to group case number 13-1553GC. The Board grants the transfer of the Medicaid Fraction Part C Days and SSI Fraction Part C Days issues from the individual appeals to group case numbers 13-1961GC and 13-1962GC, respectively, in accordance with your February 14, 2014 requests. Since there are no other issues in dispute in these appeals, case numbers 13-0977 and 13-0941 are hereby closed.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
John Gary Bowers, CPA
Michael W. Harty
Clayton J. Nix, Esq.

For the Board:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and .1877

cc: Byron Lamprecht
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Refer to: 09-0347GC

APR 28 2014

CERTIFIED MAIL

Toyon Associates, Inc.
Glenn S. Bunting
Vice President – Appeal Services
1800 Sutter Street
Suite 600
Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

RE: Jurisdictional Decision – Mercy Medical Center Redding, Provider No. 05-0280
As a participant in the CHW 1995 SSI Ratio CIRP Group
FYE: 6/30/1995
PRRB Case No.: 09-0347GC

Dear Mr. Bunting and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Mercy Medical Center Redding was issued a revised Notice of Program Reimbursement (NPR) for FYE 6/30/1995 on January 23, 2007. The revised NPR specifically stated that a February 17, 2004 Notice of Reopening was issued for the cost report for the following reason: "To reopen the disproportionate share hospital payment in accordance with the Mandamus action – settlement agreement issued by the Office of the General Counsel." On February 12, 2007, the Provider filed an individual appeal request in which it appealed five issues: DSH – SSI Ratio; DSH – Dual Eligible Days; DSH – General Assistance Days; DSH – Code 2 & 3 Eligible Days; and Labor Room Day Group. The Provider subsequently requested to transfer the SSI Ratio issue to the Toyon 1995 SSI Ratio Group Appeal #2 (CN 06-2204G) on June 11, 2007, and then requested to transfer the issue to this case on November 23, 2009. On January 7, 2014, the Providers in this group appeal, case number 09-0347GC, filed a request for remand under the standard procedure.

Board's Decision

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it lacks jurisdiction over Mercy Medical Center Redding as a participant in this group appeal. The Provider appealed from a revised NPR specific to the *Monmouth* reopening, and there is no evidence the SSI % was adjusted since it did not fall under HCFAR 97-2.

A provider has a right to a hearing before the Board, with respect to costs claimed on a timely filed cost report, if: (a) it is dissatisfied with the final determination of the intermediary, (b) the

amount in controversy is $10,000 or more ($50,000 for a group), and (c) the request for a hearing is filed within 180 days of the date of the NPR.[1]

In accordance with 42 C.F.R. § 405.1889 (2007), a revised NPR is considered a separate and distinct determination from which the provider may appeal. At the time the revised NPR was issued, the regulation provided:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

Furthermore, the PRRB Instructions[2] for revised NPRs state that:

> The Board accepts jurisdiction over appeals from a revised Notice of Program Reimbursement (NPR) where the issues(s) in dispute were *specifically adjusted* by that revised NPR. The Board typically follows the courts by limiting the scope of such an appeal to only the revised issue(s). *See Anaheim Memorial Hospital v. Shalala*, 130 F.3d 845 (9th Cir. 1997).[3]

***Monmouth*: Notice of Reopening**

The Intermediary issued a Notice of Reopening ("NOR") to Mercy Medical Center Redding on February 17, 2004, in response to the court's finding in *Monmouth Medical Center v. Thompson;* 257 F.3d 807 (D.C. Cir. 2001)), that the Provider was entitled to mandamus relief. The *Monmouth* case involved the agency's application of HCFAR 97-2 (February 27, 1997). The court's decision in *Monmouth* and the subsequent settlement agreements that followed the litigation, instructed the Intermediary to issue a NOR to applicable Providers for the purpose of applying HCFAR 97-2 retrospectively. The NORs indicate that the basis of the reopening was a Settlement Agreement with CMS, which allowed a NOR to be issued well after the three year reopening period set forth in 42 C.F.R. § 405.1885.

The settlement agreement afforded the hospitals the right to submit to the Intermediary "one listing of *Medicaid eligible unpaid days* that it believes should be included in the determination of its DSH payment under HCFAR 97-2." HCFAR 97-2 dealt solely with days related to unpaid Title XIX Medicaid Days that were not entitled to Medicare Part A. Any other type of day not referenced in HCFAR 97-2 would not have been the subject of this reopening, nor would the SSI% and therefore, would not be appealable to the Board from the revised NPR.

Per the Monmouth decision and settlement agreement, the Intermediary issued a NOR on February 17, 2004, and a revised NPR on January 23, 2007, to Mercy Medical Center Redding (PN 05-0280) in order to apply HCFAR 97-2. The Provider's list of claimed days was not

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[1] 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1841.
[2] PRRB Instructions in effect as of March 1, 2002.
[3] Provider Reimbursement Review Board Instructions (2002), at 3.

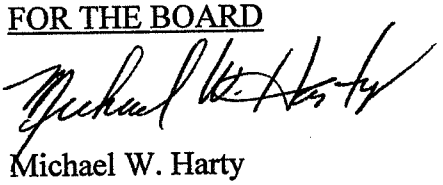
included in the case file, but the list is not necessary for the resolution of this appeal.

The audit adjustment report for the Provider's revised NPR shows that SSI% was not specifically adjusted; rather, the only relevant adjustment was to "adjust DSH payment for settlement." Because this appeal was filed from a revised NPR specific to the *Monmouth* reopening and there is no evidence the SSI % was adjusted on the revised NPR since it did not fall under HCFAR 97-2, the Board finds that it does not have jurisdiction over this participant pursuant to 42 C.F.R. § 405.1889(b)(1) and hereby dismisses the Provider from this appeal. Because this appeal is still pending for the other Providers in the group, case number 09-0347GC will remain open.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA

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Refer to: 08-2012G

APR 30 2014

CERTIFIED MAIL

Blumberg Ribner, Inc.
Isaac Blumberg
Chief Operating Officer
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

National Government Services, Inc,
Kyle Browning
Appeals Lead
MP: INA 102-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Jurisdictional Review
Provider No.: Various
PRRB Case No.: 08-2012G, Blumberg Ribner 2002 Dual Eligible Days Group

Dear Mr. Blumberg and Mr. Browning,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Intermediary's challenge to the Board's jurisdiction for one of the participants, St. Luke's Hospital-Bethlehem ("St. Luke's"), Provider No. 39-0049, Fiscal Year End ("FYE") June 30, 2002. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

Background

St. Luke's filed an individual appeal dated April 2, 2009, to which the Board assigned Case No. 09-1370. This filing was within the 180 day jurisdictional filing requirement from the Provider's revised notice of program reimbursement ("RNPR") dated October 16, 2008. However, it was beyond the 180 day jurisdictional filing requirement from the Provider's original notice of program reimbursement ("NPR") dated August 23, 2004.

The issues included in the original appeal request included: DSH Medicaid Proxy – charity care days and DSH Exhausted Medicare-Dual Eligible Days. The Provider transferred the DSH Exhausted Medicare Dual-Eligible Days issue from Case No. 09-1370 to group appeal 08-2012G on May 6, 2009. On November 30, 2009, the Board closed Case No. 09-1370.

On January 28, 2010, the Intermediary challenged jurisdiction over St. Luke's in Case No. 08-2012G. On March 18, 2011, the Board sent a request to the Blumberg Ribner, Provider Representative ("Representative") to submit its response to the Intermediary's jurisdictional challenge. On April 15, 2011, the Board received the Representative's response to the Intermediary's jurisdictional challenge.

In the Provider's reopening request it states that "patient records meeting the following criteria were discarded from the total count of additional Medicaid Eligible days:

***

2. Dual Medicare Part-A/Medicaid Eligible days…"

In HCA Health Services v. Shalala, 27 F.3d 614 (D.C. Cir. 1994), the court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

Because the RNPR did not adjust the DSH Dual Eligible Days, the Board finds that it lacks jurisdiction over this issue. The Board hereby **denies** the transfer of the Dual Eligible Days issue for St. Luke's, Provider No. 39-0049, FYE June 30, 2002, into the subject appeal since this issue was not reviewed or revised in the RNPR. Therefore, the Board finds that it lacks jurisdiction over St. Luke's, Provider No. 39-0049, FYE June 30, 2002 in the subject appeal and hereby **dismisses** it from Case No. 08-2012G.

Other Participating Providers

Upon review of the supporting documentation there are no jurisdictional problems with the remaining providers included in this appeal.

Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, BCBSA
Bruce Snyder, Novitas Solutions, Inc.

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Refer to:

12-0050GC
CERTIFIED MAIL

APR 30 2014

Stephen P. Nash, Esq.
Patton Boggs, LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: # 1 Abbott Northwest Hospital, Provider No. 24-0057
4 Mercy Hospital, Provider No. 24-0115
5 Owatonna Hospital, Provider No. 24-0069
6 St. Francis Regional Medical Center, Provider No. 24-0104
as participants in the
Patton Boggs/Allina 2009 Medicare Outlier Group
FYE 2009
PRRB Case No. 12-0050GC

Dear Mr. Nash:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' April 9, 2013 request for reconsideration of its March 29, 2013 jurisdictional determination in the above-referenced appeal. The Board's decision with respect to its jurisdictional determination and the appropriateness of expedited judicial review (EJR) for the Providers is set forth below.

The Reconsideration Request

Through correspondence dated February 1, 2013, the Providers in the above-referenced appeal requested the Board grant EJR over the outlier issue. After considering the February 1st request and additional information from the Providers received on March 1, 2013, the Board denied jurisdiction over the four Providers referenced above and granted EJR for the remaining Providers in the appeal. The Board found that it lacked jurisdiction over the Providers above because the evidence submitted with the Schedule of Providers demonstrated that the Providers had not claimed additional outlier reimbursement as a protested amount on their as-filed cost reports as required by 42 C.F.R. § 405.1835(a)(1)(ii). Since the Board concluded that it lacked jurisdiction over the Providers their request for EJR was also denied. *See* 42 C.F.R. § 405.1842(a) (a provider has the right to seek EJR over a legal question if there is jurisdiction over the appeal).

Attached to the Providers' April 9, 2013 request to reinstate were copies of Worksheet E, Part A, Line 30 that appeared to indicate that the Providers had claimed outlier reimbursement as a protested amount on their as-filed cost report. However, the date the cost report pages were prepared was during January of 2013, years after the original fiscal year 2009 cost reports would have been filed with the Medicare Administrative Contractor (MAC). Consequently, the Board asked the MAC to furnish copies of the as-filed cost report pages that were filed in 2010 and verify that outlier reimbursement had been claimed. The Intermediary verified the claim of outlier reimbursement for each of the Providers at the time the as-filed cost report was submitted.

Since it has been established that the Providers did claim outlier reimbursement as a protested amount as required by 42 C.F.R. § 405.1835(a)(1)(ii), the Board finds that it has jurisdiction over the Providers and hereby reinstates them as participants in case number 12-0050GC. The Board is also issuing the determination set forth below with respect to the earlier request for EJR for these Providers.

Background

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permits expedited judicial review where the Board determines that it does not have the authority to decide a question of law, regulation or CMS ruling. In this case, the Providers are challenging the validity of the outlier regulations.[1]

Providers assert that the regulations are invalid as written and enforced in that they are inconsistent with statutory intent and are arbitrary and capricious because, inter alia:

(1) CMS did not use the best available data, and used faulty data when establishing fixed loss outlier thresholds even when admonished by hospitals;

(2) CMS failed to consider important aspects of the problem, such as the regulations, as written, were subject to abuse, e.g. "turbo charging," that led to large increases in outlier payments; and

(3) the fixed loss outlier thresholds established by CMS bear no logical relationship to CMS' published formulas for tracking the rate of increases in hospital charges (and most recently, hospital costs).

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The Intermediary did not oppose the request for EJR. The documentation shows that the estimated amount in controversy exceeds $50,000 threshold for Board jurisdiction over group appeals and the appeals were timely filed.

The Board finds that:

1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the outlier issue, there are no findings of fact for resolution by the Board;

[1] See Provider's February 1, 2013EJR request at footnote 2: "The applicable Medicare Outlier regulations were published in final form on March 29, 1985 at 50 FR commencing at page 12471, and have been subsequently amended 50 FR 35689; 51 FR 31496; 53 FR 38529; 54 FR 36494; 55 FR 15174; 56 FR 43448; 57 FR 39823; 59 FR 45398; 62 FR 45966, 46028; 68 FR 34494, 34515; 71 FR 47870, 48138."

3) it is bound by the regulations; and

4) it is without the authority to decide the legal question of whether the outlier regulations, are valid.

Accordingly, the Board finds that the outlier issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo (f)(1), Schedule of Providers

cc: Danene Hartley, NGS
Kevin Shanklin, BCBSA