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

Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to:

08-1963GC

MAR 03 2015

Certified Mail

King & Spalding
Daniel J. Hettich
1700 Pennsylvania Avenue, NW
Suite 200
Washington D.C. 20006-2706

Wisconsin Physician Services
Byron Lamprecht
P.O. Box 1604
Omaha, NE 68101

RE: Jurisdiction Decision
CHS 2005 DSH SSI Ratio CIRP Group
Provider No.: Various
FYE: Various ending in 2005
PRRB Case No.: 08-1963GC

Dear Mr. Hettich and Mr. Laprecht,

The Provider Reimbursement Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and on its own motion noted jurisdictional impediments for two Providers in this group appeal. The Board finds it lacks jurisdiction over Lake Granbury Medical Center and River Region Medical Center for their 2005 cost report periods.

Background

The Providers filed an initial request for a CIRP group appeal on May 20, 2008. This is a CIRP group appeal with a single issue, DSH SSI percentage, covered under Ruling 1498-R. On July 2, 2014 the Board requested the Provider to supply the Schedule of Providers (SOP) with associated jurisdictional documentation in order to process the remand under the standard procedure. The Group representative submitted the requested documentation and the Board received it on August 18, 2014.

Board's Decision

The Board finds that it does not have jurisdiction over Lake Granbury Medical Center (45-0596, FYE 11/30/2005), and River Region Medical Corporation (25-0031, FYE 06/30/2005) because the Providers are appealing from revised NPRs which did not specifically adjust or consider the SSI %.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. §405.1885 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).

The version of 42 C.F.R. § 405.1889 in effect prior to the August 2008 rule change explains the effect of a cost report revision:

> 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 42 C.F.R. §§ 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. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius,* No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). In this case the Court also held that "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

In the Schedule of Providers at tab 25D, the Lake Granbury Medical Center included a statement indicating that it self-disallowed the SSI Percentage. Self-disallowance, however, is not applicable to appeals from revised NPRs. In the Schedule of Providers at tab 31D, the River Region Medical Corporation included an audit adjustment report that shows a general adjustment to DSH (AA# R1-006) but did not specifically adjust the SSI%, and no work papers were included that showed that the SSI% was considered during the revised NPR process. This is the same scenario as in the *Emanuel* case. Appeals from revised NPRs are limited to the specific matters revised in the revised determination[1]. Therefore, the Board dismisses Lake Granbury Medical Center and River Region Medical Corporation from the group appeal as there was no evidence that the SSI Percentage was actually adjusted.

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 this case.

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[1] 42 C.F.R. § 405.1889(b)(1)

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA

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, Executive Director, BCBSA

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Refer to: 08-0881GC

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Wisconsin Physician Services
Byron Lamprecht
P.O. Box 1604
Omaha, NE 68101

RE: Jurisdiction Decision
CHS 2000 DSH SSI Ratio CIRP Group
PRRB Case No.: 08-0881GC

Dear Mr. Hettich and Mr. Lamprecht:

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

Background

Case number 08-0881GC was established on February 11, 2008, when two Providers filed an appeal request with the Board appealing the DSH SSI Percentage. On July 02, 2014, the Board requested the Providers to supply jurisdictional documentation necessary to process this case under the CMS Ruling 1498-R. On August 18, 2014 the Providers supplied the requested documentation to complete the jurisdictional review.

Board's Decision

Gadsden Regional Medical Center, 01-0040, FYE 12/31/2000, Participant 1
Summit Hospital, 19-0202, FYE 09/30/2000, Participant 6
River Region Health System, 25-0031, FYE 06/30/2000, Participant 7
Mary Black Health Systems, 42-0083, FYE 06/30/2000, Participant 9
Carolinas Hospital System, 42-0091, FYE 06/30/2000, Participant 10

The Board does not have jurisdiction over Participants 1, 6, 7, 9 and 10 because these Providers are appealing from revised NPRs that did not specifically adjust or consider the SSI% issue.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. §405.1885 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).

The applicable regulations at 42 C.F.R. § 405.1889 explain that a revised NPR is considered a separate and distinct determination, and, depending on when the revised NPR was issued, the issue on appeal must have been either reviewed[1] or revised[2] as a prerequisite for Board jurisdiction.

In accordance with 42 C.F.R. § 405.1889 (2005), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[3] 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 this 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. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius,* No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). In this case the Court also held that "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

In the Schedule of Providers at tabs 6D, 7D, 9D and 10D the Providers included statements indicating that they self-disallowed the SSI Percentage. Self-disallowance, however, is not applicable to appeals from revised NPRs. In the Schedule of Providers at tab 1D, the Provider included an audit adjustment report that shows a general adjustment to DSH (AA# 1) but did not specifically adjust the SSI%, and no work papers were included that showed that the SSI% was considered during the revised NPR process. This is the same scenario as in the *Emanuel* case. Appeals from revised NPRs are limited to the specific matters revised in the revised determination[4]. Therefore, the Board dismisses Gadsden Regional Medical Center, Summit Hospital, River Region Health System, Mary Black Health System and

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[1] 42 C.F.R. § 405.1885, 1889 (2004); *see also HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding 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).

[2] 42 C.F.R. § 405.1885, 1889 (2008), "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" (emphasis added).

[3] 42 C.F.R. § 405.1889 (2005) stated "[w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened … such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable."

[4] 42 C.F.R. § 405.1889(b)(1)

Carolinas Hospital System.

Flowers Hospital, 01-0055, FYE 06/30/2000, Participant 2

The Board does not have jurisdiction over Participant 2 because the Provider did not include the SSI% issue in its original appeal request nor did the Provider add the issue to their individual appeal before transferring the issue to the group appeal.

Prior to August 21, 2008, and pursuant to 42 C.F.R. § 405.1841(a)(1) (2007), a provider was permitted to add issues to an appeal if, prior to the commencement of the hearing proceedings, the provider identified, in writing, additional aspects of the intermediary's determination with which it was dissatisfied and furnished any documentary evidence in support thereof. The regulation governing a provider's ability to timely add issues to an appeal was amended in 2008. The amended regulation, contained in Federal Register's publication of the May 23, 2008 Final Rule and found at 42 C.F.R. § 405.1835(c)(3) (2008), became effective on August 21, 2008.[5] The amended regulation states that a request to add an issue to an appeal is timely if the Board receives the request no later than 60 days after the expiration of the applicable 180-day period for filing the original hearing request.[6] The following clarification also appeared in the May 23, 2008 Final Rule: "[f]or appeals pending before . . . the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of . . . 60 days after the effective date of this rule."[7] Thus, all providers with properly pending appeals before the Board as of August 21, 2008, had until October 20, 2008, to add issues, in writing, to their appeals.

The Provider requested an individual appeal on 03/12/2003 raising issues of incorrect DSH Medicaid Percentage, HHA settlement issues, and Outpatient Blend issues. The individual appeal did not raise an issue with the SSI %. The Provider requested to transfer the SSI% issue to this group appeal on 05/06/2009. This transfer request is not timely as it occurred after the cutoff date to add issues to existing appeals of 10/20/2008. Therefore, the Board dismisses Flowers Hospital from the group appeal as there was no evidence that the SSI% issue was added timely.

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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

[5] Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008) ("May 23, 2008 Final Rule").
[6] *Id.* at 30249.
[7] *Id.* at 30240.

Enclosures: 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand Letter
Schedule of Providers

cc: Kevin Shanklin, Executive Director, BCBSA

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Wisconsin Physician Services
Byron Lamprecht
P.O. Box 1604
Omaha, NE 68101

RE: Jurisdiction Decision
CHS 2004 DSH SSI Ratio CIRP Group
Provider No.: Various
FYE: Various ending in 2004
PRRB Case No.: 08-1970GC

Dear Mr.Hettich and Mr. Laprecht,

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

Background

The Providers filed an initial request for a CIRP group appeal on May 20, 2008. This is a CIRP group appeal with a single issue, DSH SSI percentage, covered under Ruling 1498-R. On July 2, 2014 the Board requested the Provider to supply the Schedule of Providers (SOP) with associated jurisdictional documentation in order to process the remand under the standard procedure. The Group representative submitted the requested documentation and the Board received it on August 18, 2014.

Board's Decision

Gadsden Regional Medical Center 01-0040, FYE 12/312004
River Region Medical Corporation 25-0031, FYE 06/30/2004

The Board finds that it does not have jurisdiction over Gadsden Regional Medical Center (01-0040, FYE 12/312004), and River Region Medical Corporation (25-0031, FYE 06/30/2004) because the Providers are appealing from a revised NPR which did not specifically adjust or consider the SSI %.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. §405.1885 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).

The version of 42 C.F.R. § 405.1889 in effect prior to the August 2008 rule change explains the effect of a cost report revision:

> 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 42 C.F.R. §§ 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 Schedule of Providers at tab 1D and 23D, the Providers included a statement indicating that it validly self-disallowed the SSI Percentage. Self-disallowance, however, is not applicable to appeals from RNPRs. Appeals from RNPRs are limited to the specific matters revised in the revised determination. Therefore, the Board dismisses Gadsden Regional Medical Center and River Region Medical Corporation from the group appeal as there was no evidence that the SSI Percentage was actually adjusted.

McKenzie Willamette Hospital 38-0020, FYE 12/31/2004

The Board finds that that it does not have jurisdiction over McKenzie Willamette Hospital (38-0020, FYE 12/31/2004) because the Provider did not appeal the SSI% issue in their individual appeal request, nor is there evidence that the Provider separately added the issue to their individual appeal prior to the request to transfer to/from the subject group appeal.

Prior to August 21, 2008, and pursuant to 42 C.F.R. § 405.1841(a)(1) (2007), a provider was permitted to add issues to an appeal if, prior to the commencement of the hearing proceedings, the provider identified, in writing, additional aspects of the intermediary's determination with which it was dissatisfied and furnished any documentary evidence in support thereof. The regulation governing a provider's ability to timely add issues to an appeal was amended in 2008. The amended regulation, contained in Federal Register's publication of the May 23, 2008 Final Rule and found at 42 C.F.R. § 405.1835(c)(3) (2008), became effective on August 21, 2008.[1] The amended regulation states that a request to add an issue to an appeal is timely if the Board receives

1 Provider Reimbursement Determinations and Appeals, 73 Fed. Reg. 30190 (May 23, 2008) ("May 23, 2008 Final Rule").

the request no later than 60 days after the expiration of the applicable 180-day period for filing the original hearing request.[2] The following clarification also appeared in the May 23, 2008 Final Rule: "[f]or appeals pending before . . . the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of . . . 60 days after the effective date of this rule."[3] Thus, all providers with properly pending appeals before the Board as of August 21, 2008, had until October 20, 2008, to add issues, in writing, to their appeals.

The Provider requested an individual appeal for DSH issues on 09/01/2006, raising issues of incorrect Labor and Delivery Days as well as incorrect Medicaid eligible days. The individual appeal did not raise an issue with the SSI %. The Provider requested to transfer the SSI% issue to this group appeal on 07/09/2009. This transfer request is not timely as it occurred after the cutoff date to add issues to existing appeals of 10/20/2008. Therefore, the Board dismisses McKenzie Willamette Hospital from the group appeal as there was no evidence that the SSI% issue was added timely.

Medical Center of South Arkansas 04-0088, FYE 06/30/2004

The Board finds that that it does not have jurisdiction over Medical Center of South Arkansas (04-0088, FYE 06/30/2004) because the Provider did not support the original NPR nor did they add the SSI% issue timely.

The Code of Federal Regulations stipulates the required contents of a request for a Board hearing. 42 C.F.R. §405.1835 provides in relevant part:

> (3) A copy of the contractor or Secretary determination under appeal, and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section

The Provider did not submit support of the original NPR determination. The Provider also did not submit support that the issue was timely added to their individual appeal prior to transferring the SSI% issue to the group appeal via a transfer on 03/13/2009. Per 42 C.F.R. § 405.1835(c)(3) (2008) detailed above, this transfer is not timely. Therefore, the Board dismisses Medical Center of South Arkansas from the group appeal as there was no evidence of the initial contractor's determination, and no evidence that the SSI% issue was added timely.

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
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

2 *Id.* at 30249.
3 *Id.* at 30240.

Enclosures: 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand Letter
Schedule of Providers

cc: Kevin Shanklin, Executive Director, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

09-1674GC

MAR 03 2015

CERTIFIED MAIL

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

Hall, Render, Killian, Heath & Lyman
Elizabeth A. Elias
One American Square, Suite 2000
Box 82064
Indianapolis, IN 46282

RE: Jurisdiction Decision
Community Health Systems 2003-2004 SSI Days Proxy Group
FYE: Various ending in 2003 and 2004
PRRB Case No.: 09-1674GC

Dear Mr. Lamprecht and Ms. Elias,

The Provider Reimbursement Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and noted procedural impediments for one Provider in this group appeal. The Board finds to dismiss De Tar Healthcare System for their 2004 cost report period.

Background

Case number 09-1674GC was established on May 27, 2009, when the Board split several large DSH SSI Percentage cases into smaller cases with similar fiscal year ends. On March 20, 2014 the Board received a request from the Appeal Group to remand this appeal to the Lead Medicare Contractor per the Standard Implementation Process in Section 4a of the CMS Ruling 1498-R.

Board's Decision

The Board finds to dismiss De Tar Healthcare System (45-0147, FYE 09/30/2004), because this Provider is part of a separate SSI% CIRP group appeal.

The Provider Reimbursement Review Board sets their own rules per 42 U.S.C. § 1395oo(e), which states in part "The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section." Provider Reimbursement Review Board rule 4.5 states "A Provider may not appeal an issue from a final determination in more than one appeal." Participant 14 is part of a second SSI Days group appeal, case number 08-1970GC. Therefore, the Board dismisses this Provider from the group appeal as they cannot be part of two different

appeals for the same issue.

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand Letter
Schedule of Providers
Schedule of Providers for case no. 08-1970GC

cc: Kevin Shanklin, Executive Director, BCBSA

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Refer to: 13-1906GC

CERTIFIED MAIL

MAR 03 2015

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Wyatt, Tarrant & Combs, LLP
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Louisville, KY 40202

Judith E. Cummings
CGS Administrators
Two Vantage Way
Nashville, TN 37228

RE: Appalachian Regional Healthcare ("ARH") 2007 DSH Medicaid Ratio Part C Days
Provider Nos.: 18-0069, 18-0050, 51-0062 and 18-0029
FYEs: 06/30/2007
PRRB Case No.: 13-1906GC

Dear Mr. Price and Ms. Cummings:

This case involves a group appeal of the providers' Medicare reimbursement for the fiscal year ending ("FYE") on June 30, 2007. The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and dismisses ARH's request for hearing ("RFH") for lack of jurisdiction over the issue being appealed.

Pertinent Facts

On May 1, 2013, the Board received ARH's RFH and group appeal request. In its RFH, ARH seeks Board review of the revised notices of program reimbursement ("RNPRs"), issued on November 1, 2012, for FYE June 30, 2007, for the following four providers:

- Beckley ARH, Provider No. 51-0062
- Harlan ARH, Provider No. 18-0050
- Hazard ARH, Provider No. 18-0029
- Williamson ARH, Provider No. 18-0069

Specifically, the providers dispute "the calculation of the Medicare Disproportionate Share ("DSH") Adjustment [because] the Fiscal Intermediary improperly excluded Medicare Advantage (Part C) days from the numerator of the Medicaid fraction and improperly included Medicare Advantage (Part C) days in the Medicare fraction ("SSI[1] Fraction") used to calculate DSH payment."

The Board bifurcated the group appeal in order to cover the distinct legal questions regarding the DSH Part C Days issue that ARH described in its RFH. One group appeal covered the appeal of the DSH Part C Days in the SSI fraction (PRRB Case Number 13-1903GC), and the other group appeal, the one at issue in the present case, covered the appeal of the DSH Part C Days in the Medicaid fraction.

[1] The abbreviation "SSI" stands for Supplemental Security Income. The terms "Medicare fraction/ratio" and "SSI fraction/ratio" are synonymous.

The Board received two separate jurisdictional challenges in this case: the first was filed by the Medicare contractor and was received by the Board on August 22, 2014; the second was filed by BlueCross BlueShield ("BCBS") on behalf of the Medicare contractor and was received by the Board on October 16, 2014.

ARH filed a response to each of these jurisdictional challenges: the Board received the first on September 17, 2014, and the second on November 13, 2014.

Jurisdictional Challenge

Both of the challenges make the same jurisdictional argument, namely, that the Medicare contractor did not adjust Medicaid Days in the providers' RNPRs. Therefore, the Medicare contractor argues, pursuant to the regulations that govern a Board hearing for an appeal of an RNPR, the Board lacks jurisdiction over the providers' Medicaid Days issue. The Medicare contractor also argues that the present appeal does not meet the amount in controversy requirement necessary to establish Board jurisdiction.

ARH's Response

In its Responses to the Medicare contractor's jurisdictional challenges, ARH argues that the Board has jurisdiction over this appeal for the following four reasons: (1) the providers were not aware of what adjustments the Medicare contractor made to the SSI ratios until they received their respective RNPRS; (2) even if the Medicare contractor did not adjust the providers' Medicare days, the Board still has jurisdiction to hear the appeal because the entire SSI percentage was recalculated; (3) the Medicare contractor's adjustment of the SSI percentage includes the Part C days; and (4) the amount in controversy is only at issue because the Board bifurcated the initial appeal request.

Board's Analysis and Decision

Under 42 C.F.R. § 405.1835(a) (2012), 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 ($50,000 for a group) and the request for hearing is filed within 180 days of the receipt of the final determination.

However, if a provider seeks to appeal a revised determination, such as an RNPR, the scope of an appeal before the Board is narrowed. Under 42 C.F.R. § 405.1889(a)-(b)(1) (2012), if, after a determination is reopened, a revision is made to an intermediary's determination, the revision is considered a separate and distinct determination. Only those matters that are specifically revised in a revised determination are within the scope of any appeal of such a determination.

In the present case, the providers are appealing from their respective RNPRs for FYE June 30, 2007. As such, the more narrow jurisdictional requirements quoted above are applicable in this case.

The issue disputed by the providers in this appeal is whether the Medicare contractor improperly excluded Part C Days from the numerator of the Medicaid fraction of the disproportionate patient percentage calculation. However, when the Medicare contractor reopened the providers' cost reports for FYE June 30, 2007, the Medicare contractor stated that the purpose of the reopening was "[t]o correct the SSI ratio."[2] The Medicare contractor's Audit Adjustment Reports that were attached to ARH's RFH confirm that the Medicare contractor "adjust[ed] SSI% . . . to agree to updated [Centers for Medicare & Medicaid Services' ("CMS")] amounts and to update DSH allowable % accordingly."[3] In BCBS's jurisdictional challenge, BCBS states that each provider's cost report for FYE June 30, 2007, was reopened in order "to update the SSI percentages published by CMS in March 2012 to the revised percentages including Medicare Advantage (Part C) days.

Therefore, while the Medicare contractor reopened providers' cost reports to update the SSI percentages that included Part C days, the contractor did not specifically revise the Part C days in providers' Medicaid fractions. As such, Board review of providers' Part C days in their respective Medicaid fractions is precluded by the regulations pertaining to review of an RNPR.

Summary

The Board hereby dismisses providers' DSH Medicaid Ratio Part C Days issue from this appeal. As there are no remaining issues left in this appeal, case number 13-1906GC 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
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

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, Executive Director, Blue Cross and Blue Shield Association

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[2] See ARH's November 13, 2014 Response to BCBS's jurisdictional challenge, Tab 2.
[3] See ARH's May 1, 2013 RFH.

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CERTIFIED MAIL

MAR 04 2015

Joanne B. Erde, P.A.
Duane Morris
200 South Biscayne Boulevard
Suite 3400
Miami, FL 33131

RE: Provider 28, Metroplex Hospital, Provider No. 45-0152, FYE 09/30/99, and Provider 32, Tennessee Christian Medical Center, Provider No. 44-0135, FYE 06/30/99, as participants in "Southeast Region 98-01 SSI% II DSH" PRRB Case No.: 04-0475G

Dear Ms. Erde:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 04-0475G. The Board finds that it lacks jurisdiction over Provider 28, Metroplex Hospital, provider number 45-0152, fiscal year end (FYE) September 30, 1999, and Provider 32, Tennessee Christian Medical Center, provider number 44-0135, FYE June 30, 1999, as the Providers appealed from revised NPRs and failed to provide evidence that the supplemental security income (SSI) percentage issue was specifically revised in the reopening.

Background

Provider 28, Metroplex Hospital, Provider No. 45-0152

On July 13, 2004, the Medicare contractor issued a revised Notice of Program Reimbursement (NPR) to Metroplex Hospital, Provider No. 45-0152, for the cost reporting period ending September 30, 1999. On December 17, 2004, Metroplex Hospital, requested to join the current group appeal, case number 04-0475G, from a direct appeal of the revised NPR.

Provider 32, Tennessee Christian Medical Center, Provider No. 44-0135

On October 26, 2004, the Medicare contractor issued a revised NPR to Tennessee Christian Medical Center, Provider No. 44-0135, for the cost reporting period ending June 30, 1999. On December 17, 2004, Tennessee Christian Medical Center, requested to join the current group appeal, case number 04-0475G, from a direct appeal of the revised NPR.

Decision of the Board

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 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 ($50,000 for a group) and the request for a hearing is received by the Board within 180 days of the date the notice of the Medicare contractor's determination was mailed to the provider.

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 determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary . . . either on motion of such intermediary . . . or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889 (2004) states:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened . . . 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.

In *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the court held that when a fiscal intermediary reopens its original determination regarding the amount 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 and does not extend further to all determinations underlying the original NPR. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524, at *8 (D.D.C. Apr. 17, 2014), the court held that the Secretary's "issue-specific" interpretation of her NPR reopening regulations is reasonable and entitled to substantial deference.

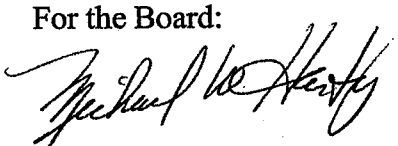
In this case, Provider 28, Metroplex Hospital and Provider 32, Tennessee Christian Medical Center, are appealing from revised NPRs. The Providers provided no supporting documentation to establish the full scope of the issues reviewed within the revised NPR

process. The Providers contend on the Schedule of Providers that, pursuant to *Bethesda,*[1] no audit adjustment report is required for jurisdiction in appeals contesting the SSI ratio. While the Providers correctly argue that *Bethesda* does not require providers to claim dissatisfaction from specific adjustments on a cost report when appealing from original NPRs, it is not the controlling opinion when providers appeal from revised NPRs. Providers cannot self-disallow from a revised NPR. As the Providers failed to provide evidence that the SSI percentage issue was specifically revised in the reopening, the Board finds that it lacks jurisdiction over Provider 28, Metroplex Hospital, provider number 45-0152, FYE September 30, 1999, and Provider 32, Tennessee Christian Medical Center, provider number 44-0135, FYE June 30, 1999 and dismisses the Providers from the 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
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:



Michael W. Harty
Chairman

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

cc: Geoff Pike
First Coast Service Options, Inc.-FL
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32231

Kevin D. Shanklin
Executive Director
Senior Government Initiatives
BC & BS Association
225 North Michigan Avenue
Chicago, IL 60601-7680

[1] *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL

MAR 09 2015

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

RE: SSM Saint Mary's Health Center
Provider No. 26-0011
FYE 12/31/2011
PRRB Case No. 15-1447

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal which was filed without supporting documentation as required by the regulations. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

Blumberg Ribner, Inc. filed an individual appeal for SSM Saint Mary's Health Center on February 13, 2015. The appeal request did not include a copy of the Notice of Program Reimbursement (NPR). Behind exhibit P-1, the Representative indicated that "the item will be sent under separate cover."

The Board established case number 15-1447 and issued an acknowledgement letter on February 18, 2015.

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).

42 C.F.R § 405.1835(b) specifically requires the Provider to include the final determination it is appealing with the timely request, and authorizes the Board to dismiss with prejudice any appeal that does not include a copy of the determination under appeal with its filing. In the referenced case, Blumberg is filing an appeal that does not meet the regulatory requirements.

Board Rule 9 also addresses the acknowledgement of an appeal and issuance of critical due dates:

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

Because the appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, the Board hereby dismisses the individual 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 case on the merits.

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

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, Wisconsin Physicians Service
Kevin D. Shanklin, Executive Director, BC BS Association

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Refer to: 06-0912GC

MAR 10 2015

Certified Mail

HCA Inc.
H. Anne Bown
Sr. Appeals Analyst, Reimbursement Dept.
One Park Plaza, Building 2, 5 East
Nashville, TN 37203

Wisconsin Physician Services
Byron Lamprecht
P.O. Box 1604
Omaha, NE 68101

RE: Jurisdiction Decision
HCA 2004 DSH – Labor/Delivery Room Days Disallowance
PRRB Case No.: 06-0912GC

Dear Ms. Browne and Mr. Lamprecht:

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

Background

On March 6, 2006, the Providers filed a request for a mandatory Common Issue Related Party ("CIRP") group disputing the Labor and Delivery Room Days ("LDR") calculation on their reports. Over the next six years, 90 providers were added to the appeal. On May 14, 2012, this group was remanded to the Medicare contractor via the alternate method pursuant to CMS Ruling CMS-1498-R. On March 27, 2014, the Participants requested reinstatement for the three providers listed below from original and revised notices of program reimbursement ("NPR"), as the Medicare contractor did not adjust these providers' LDR issue upon remand.

- Coliseum Medical Centers, 11-0164, FYE 06/30/2004, Participants 1a and 1b
- Emory Medical Center, 11-0172, FYE 12/31/2004, Participants 1a and 2b
- Doctors Hospital of Augusta, 11-0177, FYE 03/31/2004, Participants 3a and 3b

On April 25, 2014, the Board reinstated the appeal for the three referenced providers, and requested a Schedule of Providers with supporting jurisdictional documentation for these participants. On May 13, 2014, the Providers supplied the requested documentation to complete the jurisdictional review.

Board's Decision

The Board finds that it does have jurisdiction over Participants 1a and 2a because there is no specific adjustment or protest required for these providers appealing LDR from an original NPR. However the Board does not have jurisdiction over Participants 1b, 2b, 3a and 3b because these providers are appealing from a revised NPR that did not specifically adjust or consider the LDR issue.

The applicable regulations at 42 C.F.R. § 405.1889 explain that a revised NPR is considered a separate and distinct determination, and, depending on when the revised NPR was issued, the issue on appeal must have been either reviewed[1] or revised[2] as a prerequisite for Board jurisdiction.

While Participant 1a and 2a did not specifically claim the excluded LDR days on their cost reports and did not receive audit adjustments by the Medicare contractor on the issue, providers may "self-disallow" the LDR days pursuant to *Bethesda*. *Bethesda* held that providers could meet the dissatisfaction requirement without incorporating their challenges in their cost reports if the item was barred from being claimed or reported because of a specific statute, regulation, or ruling.[3] Providers were barred from reporting the DSH LDR days issue prior to the 2009 DSH policy change.[4] Therefore the "self-disallowed" LDR days may be pursued without a specific claim or protested item[5] on the Provider's cost report for appeals filed from an original NPR (Participants 1a and 2a). A remand pursuant to CMS Ruling 1498-R is enclosed.

However the Board lacks jurisdiction over the appeals from revised NPRs for Participant 1b, 2b, 3a and 3b[6] because the Medicare contractor did not specifically consider or adjust the LDR days in the revised NPR. Per adjustment 4 on the audit adjustment report for each Participant, the Medicare contractor adjusted the DSH calculation "per the provider's new information." The Participant did not provide further documentation as to what this new

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[1] 42 C.F.R. § 405.1885, 1889 (2004); *see also HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding 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).

[2] 42 C.F.R. § 405.1885, 1889 (2008), "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" (emphasis added).

[3] *See Bethesda v. Bowen*, 485 U.S. 399.

[4] *See* 74 Fed. Reg. 43899 (Aug. 27, 2009) (to be codified at 42 C.F.R. § 412.106) ("Under existing regulations at § 412.106(a)(1)(ii)(B), patient days associated with beds used for ancillary labor and delivery are excluded from the Medicare DSH calculation."). The final policy change allowed inpatient labor and delivery days to be included in the DSH calculation. *Id.* at 43900.

[5] Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 et seq. into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." These provisions only apply to a cost reporting period "ending on or after December 31, 2008." Here, the Provider's cost report was for fiscal year 2004; therefore, self-disallowed items are not required to be protested according to rules instituted for fiscal year end "on or after December 31, 2008."

[6] Participant 3 did not appeal from an original NPR, but rather from two separate revised NPRs.

information was, and thusly, the Board cannot determine whether the Medicare contractor adjusted the LDR days. As it is Participant's burden to provide all jurisdictional documentation, the Board hereby dismisses Participants 1b, 2b, 3a and 3b from this CIRP 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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand Letter
Schedule of Providers

cc: Kevin Shanklin, Executive Director, BCBS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL

MAR 10 2015

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

RE: Roxborough Memorial Hospital
Provider No. 39-0304,
FYE 2/22/2012 – 12/31/2012
PRRB Case No. 15-0871

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has reviewed the appeal request you submitted on behalf of Roxborough Memorial Hospital (Roxborough) for FYE 2/22/2012 through 12/31/2012 which was filed based on the Medicare Administrative Contractor's (MAC's) failure to issue a timely determination. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

Healthcare Reimbursement Services, Inc. (HRS) filed an individual appeal for Roxborough on December 1, 2014. The appeal is based on the MAC's failure to issue a timely final determination. Instead of documentation evidencing receipt and acceptance of the as filed cost report, HRS included a copy of an email request it sent to the MAC, requesting copies of the STAR screens for various Providers. The subject Provider is not included on the list of Providers for which it was requesting copies of the STAR screens.

The Board established case number 15-0871 and issued an Acknowledgement and Critical Due Dates letter on January 8, 2015. On the same date the Board issued a Request for Additional Information, requesting copies of the documentation required to support filing from the MAC's failure to issue a timely final determination (i.e. evidence of the date the MAC received the filed cost report, the date of the MAC's acceptance of the same cost report). The Request for Information allowed 30 days for the information to be submitted or advised that the appeal may be dismissed.

On January 21, 2015, HRS submitted a copy of a letter from the MAC, Novitas, accepting the cost report for FYE 2/21/2012. This is not the period under appeal in the subject case (2/22/2012 – 12/31/2012). Further, it does not evidence the MAC's receipt date of the cost report.

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 final determination.
42 C.F.R. § 405.1835(a)(3) states:

> Unless the provider qualifies for a good cause extension under § 405.1836 of this subpart, the date of receipt by the Board of the provider's hearing request is—
>
> ***
>
> (ii) If the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination. The date of receipt by the intermediary of the provider's perfected cost report or amended cost report is presumed to be the date the intermediary stamped "Received" unless it is shown by a preponderance of the evidence that the intermediary received the cost report on an earlier date.

42 C.F.R § 405.1835(b) specifically requires the Provider to include documentary evidence to demonstrate that the Provider satisfies the hearing request requirements as specified in paragraph (a). The regulation authorizes the Board to dismiss with prejudice any appeal that does not comply.

Board Rule 7.4 provides a list of required items to support an appeal from the lack of a Medicare contract or final determination:

- the certification page of the perfected or amended cost report,
- the certified mail receipt evidencing the Intermediary's receipt of the as-filed and any amended cost reports,
- the Intermediary's letter/e-mail acknowledging receipt of the as-filed and any amended cost reports,
- evidence of the Intermediary's acceptance or rejection of the as-filed and any amended cost reports, and
- the documentation described in Rule 7.2, as relevant, if the issue(s) being appealed involves one or more self-disallowed items *[March 2013]*

Board Rule 9 also addresses the acknowledgement of an appeal and issuance of critical due dates:

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

Because the information submitted does not apply to the subject FYE under appeal in this case, the Board finds that the appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules. Therefore, the Board hereby dismisses the individual 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 case on the merits.

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

For the Board:
Michael W. Harty
Chairman

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

cc: Bruce Snyder, Novitas Solutions, Inc.
Kevin D. Shanklin, Executive Director, BC BS Association

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Refer to:

CERTIFIED MAIL

MAR 10 2015

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

RE: Anaheim General Hospital
Provider No. 05-0768
FYE 08/31/2012
PRRB Case No. 14-3599

Requests for 5 new groups to be formed by transferring the following issues from Case No. 14-3599:

- DSH SSI Percentage
- SSI Fraction Medicare Managed Care Part C Days
- Medicaid Fraction Medicare Managed Care Part C Days
- SSI Fraction Dual Eligible Days
- Medicaid Fraction Dual Eligible Days

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) is in receipt of the above-referenced Common Issue Related Party (CIRP) group appeal requests filed on February 2, 2015. Upon review, the Board notes a jurisdictional impediment with the Provider's individual appeal from which the issues are being transferred to form the groups. The pertinent facts of the individual case and the Board's determination are set forth below.

PERTINENT FACTS:

Quality Reimbursement Services, Inc. (QRS) filed an individual appeal for Anaheim General Hospital on June 9, 2014. The appeal request did not include a copy of the Notice of Program Reimbursement (NPR). (The Representative submitted a copy of a Freedom of Information (FOI) Request to Noridian Healthcare Solutions (Noridian) requesting a copy of the final determination dated May 29, 2014.)

The Board established case number 14-3599 and issued an acknowledgement letter on June 10, 2014. Because the Representative included the FOI request, the Board did not issue a Request for Additional Information, requesting a copy of the final determination.

To date, there is no record that a copy of the final determination was ever submitted.

On February 2, 2015, QRS filed 5 new CIRP group requests to be formed by transferring the DSH SSI Percentage, the SSI Fraction Medicare Managed Care Part C Days, the Medicaid Fraction Medicare Managed Care Part C Days, the SSI Fraction Dual Eligible Days and the Medicaid Fraction Dual Eligible Days from the Provider's individual appeal. QRS did not supply a copy of the Provider's NPR as an exhibit in any of the group appeal requests.

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).

42 C.F.R § 405.1835(b) specifically requires the Provider to include the final determination it is appealing with the timely request, and authorizes the Board to dismiss with prejudice any appeal that does not include a copy of the determination under appeal with its filing. In the referenced individual and group cases, QRS is filing appeals that do not meet the regulatory requirements.

Board Rule 9 also addresses the acknowledgement of an appeal and issuance of critical due dates:

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

Because the appeal requests were not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, the Board hereby dismisses the individual appeal. Further, because the required documentation has not been submitted for the first participant being used to form the 5 new CIRP groups, the Board also denies QRS' requests for transfer of the DSH SSI Percentage, the SSI Fraction Medicare Managed Care Part C Days, the Medicaid Fraction Medicare Managed Care Part C Days, the SSI Fraction Dual Eligible Days and the Medicaid Fraction Dual Eligible Days issues from case number 14-3599 and the formation of the 5 new CIRP groups.

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 on the merits.

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

For the Board:
Michael W. Harty
Chairman

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

cc: Donna Kalafut, Noridian Healthcare Solutions
Kevin D. Shanklin, Executive Director, BC BS Association

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MAR 11 2015

CERTIFIED MAIL

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

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

RE: Jurisdiction Determinations
Group Name: Blumberg Ribner 1997-2004 SSI Percentage Group
Provider No.: Various
FYE: Various
PRRB Case No.: 95-2120G

Dear Mr. Ribner and Ms. Kalafut:

The above-referenced appeal was originally filed by two Participants on June 12, 1995. Over the years, 375 additional Participants were added into this group.[1] The Provider Reimbursement Review Board ("PRRB" or "Board") notes that this group contains both optional and Common Issue Related Party ("CIRP") providers, but as the appeal is subject to remand under CMS Ruling 1498-R, the Board will process all of the providers in the same appeal.

The Board finds that this appeal satisfies the applicable jurisdictional and procedural requirements of 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-1840. However, certain Participants identified below must be dismissed from this appeal for the reasons specified below. Participants are referenced by Participant number as identified on the Schedule of Providers.

PROVIDERS TRANSFERRED OUT OF CASE NUMBER 95-2120G

The Board hereby dismisses the following Participants from case number 95-2120G because they were transferred to another PRRB Case:

Participant #115 was transferred to PRRB case number 11-0725GC by letter dated June 20, 2013.

Participants #276 and #277 were transferred to case number 09-2320GC by letter dated May 27, 2011.

Participants #293 through #309 were transferred to case number 09-1707GC by letter dated May 19, 2014.

[1] *See* enclosed Schedule of Providers.

Participants #267 through 272 were transferred to case number 09-1361GC by letter received on January 21, 2011.

Participants #318 through 320 were transferred to case number 09-1366GC by letter dated October 1, 2009.

PROVIDERS WITHDRAWN FROM CASE NUMBER 95-2120G

The Board hereby dismisses the following Participant from case number 95-2120G because it was withdrawn from case number 95-2120G:

Participant #160 was withdrawn by letter dated September 4, 2008.

PROVIDERS APPEALING FROM REVISED NPRS

A number of Participants appealed from revised Notices of Program Reimbursement ("NPR"). The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 provides, in relevant part:

> A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary . . . either on motion of such intermediary . . . or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective for revised NPRs issued prior to August 21, 2008, stated:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened . . . such revision shall be considered a separate and distinct determination or decision . . .

The United States District Court for the District of Columbia recently issued a decision upholding what it characterized as the Secretary of the Department of Health and Human Services' "issue-specific interpretation" of the above-quoted reopening regulations.[2] Based on the decision in *Emanuel*, in order for the Board to have jurisdiction over a Provider appealing from a revised NPR in this appeal, that Provider's revised NPR must have specifically adjusted the SSI percentage.

The Board hereby dismisses the Participants whose revised NPRs did not specifically adjust the SSI percentage as required by 42 C.F.R. § 405.1889(b):

Participant #13
Participant #15
Participant #21
Participant #24
Participant #25

[2] *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014).

Participant #30
Participant #60[3]
Participant #61
Participant #69
Participant #135
Participant #187
Participant #193
Participant #201
Participant #212
Participant #215
Participant #231
Participant #245
Participant #300 – The Board also hereby denies the Provider's May 19, 2014 request to transfer the SSI percentage issue to case number 09-1707GC.
Participant #321[4]
Participant #322
Participant #344
Participant #349
Participant #371[5]
Participant #223 – The Board hereby dismisses this Provider's appeal from a revised NPR. However, Participant #223 has also appealed from an original NPR, over which the Board does have jurisdiction.

PROVIDERS THAT DID NOT SUBMIT ALL NECESSARY DOCUMENTS TO ESTABLISH JURISDICTION

The Board hereby dismisses Participant #35 from case number 95-2120G because the Board cannot determine from which final determination the Provider is appealing. The Provider submitted a revised NPR dated July 24, 2001, however it did not include an appeal request or audit adjustment pages related to this revised NPR. The Provider did include a request dated June 30, 2000 (prior to the issuance of the submitted revised NPR) requesting to add the SSI ratio issue to case number 96-1238, however the Provider did not include the final determination it appealed to establish this appeal and did not include the original appeal request for this appeal.

The Board hereby dismisses Participant #39 because it did not establish that the SSI percentage issue was properly transferred into case number 95-2120G. The Provider submitted a request to transfer the SSI percentage issue from case number 95-1407G to case number 95-2120G. However, the Provider did not submit a letter indicating that the SSI percentage issue was ever transferred from its individual appeal, case number 96-1631, to case number 95-1407G.

The Board hereby dismisses Participant #141 because it did not establish that the SSI percentage issue was properly transferred into case number 95-2120G. The Provider indicated on its Schedule of Providers that it was participated in two individual appeals, case numbers 04-0284 and 07-0069, prior to being transferred to this group appeal. The Provider only submitted a letter requesting to transfer

[3] The Board notes that it also lacks jurisdiction over this Provider because its appeal was not timely filed.
[4] The Board notes that it also lacks jurisdiction over this Provider because its appeal was not timely filed.
[5] The Board notes that it also lacks jurisdiction over this Provider because its appeal was not timely filed.

the SSI percentage issue from case number 07-0069 to case number 95-2120G. However, the Provider did not include the final determination or appeal request for case number 07-0069; it submitted the final determination and appeal request for case number 04-0284. The Provider did not establish that the SSI percentage issue was ever transferred into case number 07-0069 or to this group appeal, case number 95-2120G.

The Board hereby dismisses Participant #285 from case number 95-2120G because it did not establish that the SSI percentage issue was transferred to case number 95-2120G. The letter the Provider included behind Tab 285G referenced a different Provider, therefore the issue was not properly transferred to this group appeal.

PROVIDERS THAT TRANSFERRED THE ISSUE FROM A CLOSED APPEAL

The Board hereby dismisses the following Participants from case number 95-2120G because these Participants requested to transfer the SSI percentage issue to this group appeal from a closed individual appeal:

Participant #	Individual Appeal Number	Date Individual Appeal Closed	Transfer Request Date
20	94-1765	March 3, 1997	May 16, 1997
66	97-2809	May 25, 2000	June 30, 2000
147	03-0897	September 14, 2006	September 22, 2006
156	01-3397	July 29, 2005	September 12, 2005
252	00-1278	July 25, 2001	September 12, 2001
295	96-1068	March 10, 2004	August 24, 2004
340	92-2340	September 23, 1996	April 21, 1997
348	95-0759	October 22, 1998	November 10, 1998
352	95-0886	August 17, 1998	September 28, 1998
365	98-1117	November 20, 2001	January 22, 2002

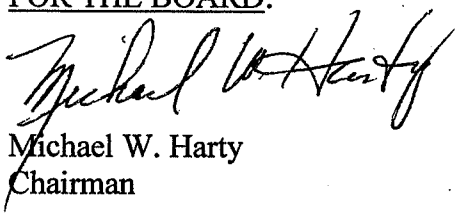
Participant #295 requested to be transferred to case number 09-1707GC by letter dated May 19, 2014. The Board hereby denies this transfer request because the Board has found that it does not have jurisdiction over the Provider's appeal.

The Participants in case number 95-2120G challenged the data matching process used in calculating the Supplemental Security Income ("SSI") fraction. This issue will be remanded to the Medicare Administrative Contractor ("MAC") under the terms of the Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1498-R for recalculation of the disproportionate share hospital ("DSH") payment adjustment under separate cover.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 1877 upon final disposition of the appeal.

Board Members:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD:



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 15-1440GC, 15-1443,
15-1448GC, 15-1450GC

MAR 17 2015

Certified Mail

Sheree R. Kanner, Esq.
Hogan Lovells US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004

RE: Banner Health FFY 2015 0.2 Percent Reduction Group, Provider Nos. Various, FFY 2015, PRRB Case No. 15-1440GC
The Mount Sinai Hospital, Provider No. 33-0024, FFY 2015, PRRB Case No 15-1443
Wake Forest University Baptist Medical Center, FFY 2015 0.2 Percent Reduction Group, Provider Nos. Various, FFY 2015, PRRB Case No. 15-1448GC
Albert Einstein Health Care Network FFY 2015 0.2 Percent Reduction Group, Provider Nos. Various, FFY 2015, PRRB Case No. 15-1450GC

Dear Ms. Kanner:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 13, 2015 requests for expedited judicial review (EJR) (received February 18, 2015) in the above-referenced appeals. The decision of the Board granting the Providers' requests for EJR is set forth below.

Issue in Dispute

The Providers challenge the validity of the Secretary of Health & Human Services' determination of the standardized amount,[1] hospital-specific rate, and capital federal rate that are used to calculate the amounts paid under the inpatient prospective payment system (IPPS) for

[1] 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 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) *available at* http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf).

Federal fiscal year (FFY) 2015.[2] The Providers maintain that these FFY 2015 payment rates are invalid and arbitrary and capricious because they reflect an unlawful and invalid 0.2 percent reduction that the Centers for Medicare & Medicaid Services (CMS) applied to the standardized amount, hospital-specific rate, and capital federal rate in FFY 2014. The Providers assert that because the FFY 2015 standardized amount, hospital-specific rate, and capital federal rate are calculated based on the understated FFY 2014 amounts, CMS' errors are also built in to the FFY 2015 amounts and they are, therefore, invalid. The Providers are seeking a revision of the standardized amount, the hospital specific rate, and capital Federal rate for FFY 2015 and additional reimbursement under Medicare Part A for the discharges of Medicare patients occurring on or after October 1, 2014.

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) 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). 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

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[2] *See* 78 Fed. Reg. 50,496, 50,508 and 50,746 (Aug 19, 2013). The standardized amount hospital specific and capital Federal rate initial reduced in 2014. Because recalculations of the rates for 2015 were based on the 2014 reduced rates, the reductions impacted the later rates.
[3] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[4] 78 Fed. Reg. at 50,907.
[5] *Id.*

reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one 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 necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physicians responsible for patient care who decides if the patient should be admitted.[8]

In the 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 decisions 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).

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[6] *Id.*
[7] Chapter 6, § 20.6 and Chapter 1, § 10.
[8] 78 Fed. Reg. at 50,907-08.
[9] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[10] 78 Fed. Reg. 50,908.

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 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 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

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[11] *Id.*
[12] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[13] 78 Fed. Reg. at 50,909.
[14] *Id.* at 50,927.
[15] *Id.* at 50,944.

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 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 amount was reduced by 0.2 percent.[18] 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.[19]

Providers' Request for EJR

The Providers in these cases are reimbursed under IPPS for care furnished to Medicare beneficiaries. Specifically, the Providers are paid a predetermined amount for each discharged based on the Medicare Severity Diagnosis-Rated Group (MS-DRG) that corresponds to the beneficiary's clinical condition and treatment provided. The MS-DRG payment amount is based on two national payment rates, one providing for operating expenses, known as the "standardized amount," and one for capital expenses, known as the "federal capital rate." The operating portion of the per-discharge amount for SCHs is calculated using either the national base payment amount or the hospital's "hospital specific rate," which ever uses the greater aggregate payment for the fiscal year.[20]

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[16] *Id.*
[17] *Id.* at 50,945.
[18] *Id.* at 50,952-53.
[19] *Id.* at 50,990.
[20] 42 C.F.R. §§ 412.90, 412.92(d).

To calculate the standardized amount for operating expenses for a given fiscal year, such as FFY 2015, the Secretary starts with a base rate from the prior fiscal year, in this case FFY 2014. Several adjustments or offsets applied to FFY 2014 standardized amount are removed from the prior year's calculation, and then the FFY 2014 rate is multiplied by an update factor and several other factors in order to calculate the standardized amount for 2015. A similar process was used to update the hospital specific rate that is used to reimburse hospital for sole community hospitals (SCHs), a category of hospitals that are also participating in case number 14-1440GC. SCHs are also impacted by the 0.2 percent reduction.[21] The standard federal capital rate is established after the Secretary determines an "update" factor and combines the update factor with several other adjustment factors and multiplies them by the previous year's capital federal rate to determine the new federal capital rate.[22] This rate was also affected by a 0.2 percent reduction in 2014 which was used to establish the FFY 2015 capital rate.

The Providers explain that in the FFY 2014 final IPPS rule the Secretary adopted policies intended "to reduce the uncertainty regarding requirements for payments to hospitals and [critical access hospitals] under Medicare Part A related to when a Medicare beneficiary should be admitted as an inpatient."[23] This included:

- instruct physician that they "should order admission if [they] expect[] that the beneficiary's length of stay will exceed a 2-midnight threshold or if the beneficiary requires a procedure specified as inpatient-only under 42 C.F.R. [§] 419.22;"

- establish a time-based presumption to be applied during medical review of inpatient claims that "inpatient admissions spanning 2 midnights in the hospital would generally qualify as appropriate for payment under Medicare Part A;"[24]

- establish as a rule that hospitals cannot obtain payments under Part A unless the patient's record contains a physician's order admitting the patient as an inpatient;[25]

- uses its "exceptions and adjustments authority under section 1886(d)(5)(I)(i) of the [Social Security] Act to offset the additional IPPS expenditures under this policy change by reducing the standardized amount, the hospital-specific amount, and the PuertoRico-specific standardized amount by 0.2 percent"[26] and

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[21] Providers' February 13, 2015 EJR request in case number 15-1440GC at 5.
[22] 79 Fed. Reg. 50,388-9.
[23] 78 Fed. Reg. 50,496, 50,506 (Aug. 19, 2013).
[24] *Id.* at 50,907.
[25] *Id.*
[26] *Id.* at 50,506.

- applied "that 0.2 percent reduction to the capital Federal rates using [its] authority under section 1886(g) of the Act."[27]

As a result of these changes in hospital admissions policies, the Secretary's actuaries estimated that expenditures under IPPS would increase by approximately $220 million due to an expected increase in hospital inpatient encounters.[28] Specifically, 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, resulting in a net shift of 40,000 encounters.[29] The Providers note two limitation on the actuarial analysis: (1) claims not containing observation or major procedures were excluded;[30] and (2) in estimating the number of claims that would shift from inpatient to outpatient, the actuaries examined only claims containing surgical MS-DRGs. Claims including medical MS-DRGs were excluded.[31]

As the result of the impact of the 2-midnight policy on IPPS the Secretary reduced the standardized amount, the hospital-specific rate for operating expenses and the capital federal rate by 0.2 percent in FFY 2014. This reduction was not reversed prior to calculating the FFY 2015 rates which are based on the FFY 2014 rates. The Providers assert that the FFY 2015 amounts are lower than they would have been without the 0.2 percent reduction.

The Providers believe that EJR is appropriate because, although the Board has jurisdiction over the appeals, it lacks the authority to grant the relief sought: reversing the 0.2 percent reduction to the 2014 rates and then recalculating the FFY 2015 reimbursement rates. The Providers believe the reduction is unlawful and the 2014 rate was defective.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The Providers have filed timely appeals of the August 22, 2014 Federal Register notice containing the final IPPS rules. The group appeals exceed the $50,000 threshold for Board jurisdiction and the individual appeal exceeds the $10,000 threshold for jurisdiction. The Administrator has determined that the Federal Register is a final determination that can be appealed to the Board in *District of Columbia Hospital Association Wage Index Group Appeal*.[32] The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount.

The Board finds that:

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[27] *Id.* at 50,508.
[28] *Id.* at 50,952.
[29] *Id.*
[30] *Id.* at 50,953.
[31] *Id.*
[32] HCFA Adm'r Dec., Medicare and Medicaid Guide (CCH) ¶ 41025 (Jan. 15, 1993).

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, the hospital specific rate and the Federal capital rate, 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, the hospital specific rate and the Federal capital rate, 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' requests 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 cases.

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

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: Bryon Lamprecht, WPS (Certified Mail w/Schedule of Providers)
Cecile Huggins, Palmetto GBA (Certified Mail w/Schedule of Providers)
Bruce Snyder, Novitas (Certified Mail w/Schedule of Providers)
Kyle Browning, NGS (Certified Mail w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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Refer to: 13-0968

MAR 18 2015

CERTIFIED MAIL

Loria Associates, LLC
Lance S. Loria, CPA
9300 Old River Court West
Montgomery, TX 77356-3915

Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Oakbend Medical Center
Provider No. 45-0330
FYE December 31, 2007
PRRB Case No. 13-0968

Dear Mr. Loria and Mr. LeJeune:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare contractor's challenge to the Board's jurisdiction. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

BACKGROUND:

The Provider filed its initial appeal on March 6, 2013, for its cost reporting period ending December 31, 2007, from an original notice of program reimbursement ("NPR") dated September 7, 2012.[1] The Provider's appeal request stated the issue as "failure to issue a timely determination" and "Other (Specify): - Reopening adjustments without prior Notice and beyond 3 years for reopening." The statement of the issue was "[w]hether the intermediary's adjustments (Nos. 26-30) for PS&R data, almost five years after the end of the cost reporting period, was proper."

The Medicare contractor filed a jurisdictional challenge on January 13, 2014 disputing that the amount in controversy did not meet the $10,000 threshold. The Provider submitted its responsive brief on March 19, 2014.

MEDICARE CONTRACTOR'S CONTENTIONS:

The Medicare contractor contends that the adjustments that the Provider is appealing pertain to updated settlement data. The Medicare contractor claims that the Provider incorrectly computed the increase in

[1] It should be noted that the Provider refers to a reopening. However, the NPR issued on September 12, 2012 was the initial NPR due to CMS' mandate to hold NPRs for the publication of updated SSI percentages. *See* Medicare contractor preliminary position paper at 4.

the DRG payment as having a negative impact on the cost report instead of a positive, resulting in an incorrect calculation of reimbursement impact. The Medicare contractor initially calculated the reimbursement effect to be $6,706[2] based on the information in the appeal request.[3] However, the Medicare contractor reran the cost report with and without the adjustments in dispute and determined that there actually is zero reimbursement impact on the cost report under appeal.[4] The Medicare contractor asserts that the Provider has failed to meet the amount in controversy threshold as required in 42 C.F.R. § 405.1835(a).

Provider's Contentions:

The Provider argues that the Medicare contractor's reimbursement calculations are incorrect because they improperly limit the reimbursement effect to the audit adjustments in dispute and fails to recognize the effect on other payment areas (e.g., Bad Debts, DSH, Capital, and other areas).

Board's Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1840, a provider has a right to 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 ($50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the NPR.

The Board finds that it does not have jurisdiction over the subject appeal because it does not meet the $10,000 amount in controversy threshold. Pursuant to Board Rule 6, an individual appeal request must have a total amount in controversy of at least $10,000 and the Provider must supply a calculation or support demonstrating the amount in controversy for each issue. In this case, the Provider did supply a manual calculation arriving at its amount in controversy of $75,056, while the Medicare contractor manually calculated the net reimbursement impact of the $6,706. However, when the adjustments in dispute were reversed in full and reprocessed through the cost report, the reimbursement impact was determined to be zero and the Provider was unable to provide a different cost report calculation demonstrating a different impact. The Provider's argument is negated by the mechanics of the cost report flow.

Therefore, the Board dismisses the subject appeal as the Provider has not shown that it meets the amount in controversy jurisdictional threshold of $10,000 for a PRRB appeal per 42 C.F.R. § 405.1835(a). The Provider also does not qualify for an Medicare contractor appeal since the amount in controversy is less than $1,000. The Board hereby closes the subject 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.

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[2] *See* Medicare contractor jurisdictional challenge at Exhibit I-3 and preliminary position paper at Exhibit I-3.
[3] *Id.*
[4] *See* Medicare contractor preliminary position paper at 5 and Exhibit I-4.

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

For the Board:

Michael W. Harty
Chairman

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

cc: Kevin Shanklin, BCBSA

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Refer to 14-4257

Certified Mail

MAR 18 2015

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

Re: MidState Medical Center, Provider No. 07-0017, FYE 09/30/12, Case No. 14-4257

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") recently reviewed MidState Medical Center's ("MidState") appeal. The background of the case and the Board's decision are set forth below.

Background

On September 9, 2014, the Board received MidState's appeal based on the Medicare Administrative Contractor's (MAC) failure to issue a timely determination. On November 5, 2014, the Board requested evidence of the date the MAC received the filed/amended cost report and the date of acceptance of the same cost report in accordance with 42 C.F.R. § 405.1835(a)(3)(ii).

On December 2, 2014, the Representative responded and stated:

> The Connex submission upload date PDF lists the FY 2012 MidState re-filing near the bottom of the page with a submission date of 2/17/2014 (please also see the attached e-mail chain between NGS and the provider regarding the upload). Please note that the certification page shows a net amount due before applying the initial settlement as noted in the attached cover letter. Furthermore, the cover letter for the re-filing agrees to the revised tentative settlement attached.

Decision of the Board

The Board hereby denies jurisdiction over MidState's appeal based on the MAC's failure to issue a timely determination as it was prematurely filed. In accordance with 42 C.F.R. § 405.1835(a)(3)(ii), the MAC has within 12 months of the date of receipt of the Provider's perfected or amended cost report to issue a determination, and the Provider has no later than 180 days after the expiration of the 12 month period to appeal.

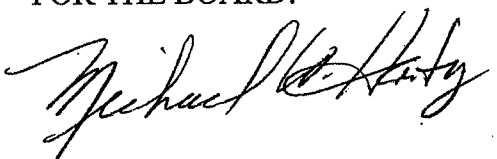
The "Re-Filed Medicare Cost Report" cover letter shows a February 14, 2014 date and an upload date of February 17, 2014. The MAC had 12 months from the receipt date to issue a final

determination, and the Provider would have had 180 days thereafter to file its appeal. The Provider's appeal was received September 9, 2014, which was prior to the 12-month deadline for the MAC to issue the cost report. If the Provider did not receive an NPR by the one-year deadline (February 17, 2015), they may file a new appeal within the 180 day time frame.

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 this case.

Board Members:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.

FOR THE BOARD:



Michael W. Harty
Chairman

cc: Kyle Browning, National Government Services
Kevin Shanklin, Blue Cross Blue Shield Association

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CERTIFIED MAIL

MAR 20 2015

CHE Trinity Health
Cynthia F. Wisner
Associate Counsel
20555 Victor Parkway
Livonia, MI 48152

CGS Administrators, LLC
Judith E. Cummings
Accounting Manager
CGS Audit & Reimbursement
Two Vantage Way
Nashville, TN 37228

RE: St. Ann's Hospital
Provider No.: 36-0012
FYE: 5/31/99
PRRB Case No.: 02-1329

Dear Ms. Wisner and Ms. Cummings,

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

Background

The Provider filed a timely appeal request on March 19, 2002 containing three issues, including (1) home office costs, (2) observation days and charges and (3) telemetry charges. On January 28, 2005, the Provider added the Medicaid percentage issue to the appeal. On July 9, 2007, the Provider added the prior year interns and residents count issue to the appeal. On December 17, 2007, the Provider added the federal standardized amount applicable to the federal fiscal year issue to the appeal and requested to transfer the issue to a group appeal, PRRB Case No. 07-2154G – Trinity Health 2004/2005 Rural Floor Budget Neutrality Group.

On December 7, 2012, the Provider requested to withdraw its appeal because it reached a full administrative resolution ("A/R") with the MAC. On December 10, 2012, the Board granted the Provider's request for withdrawal and closed the case.

On September 27, 2013, the Provider submitted correspondence requesting that the Board reinstate its original appeal in case number 02-1329 because the revised NPR dated April 4, 2013 failed to make an adjustment for appeal issue #5 in the administrative resolution. Additionally, the Provider filed an appeal of the revised NPR disputing that the MAC failed to implement appeal issue #5 from the fully executed administrative resolution by not making an adjustment to the prior year resident-to-bed ratio in the revised NPR. The Board assigned case number 13-3947 to the appeal of the revised NPR.

On May 29, 2014, the Board reinstated original appeal case number 02-1329 and consolidated the appeal of the revised NPR, case number 13-3947 with case number 02-1329, and closed case number 13-3947.

On June 10, 2014, the Provider requested to transfer the SSI percentage issue to PRRB Case No. 12-0241GC – Trinity Health Pre-2000 DSH/SSI CIRP Group.

On September 29, 2014, the MAC filed a jurisdictional challenge on the prior year resident-to-bed ratio in the revised NPR dated April 4, 2013, the MAC's alleged failure to apply the prior year FTE count to the prior year resident-to-bed ratio in implementing the full A/R for case number 02-1329, and the addition of the SSI percentage dispute. On October 10, 2014, the Provider responded to the MAC's jurisdictional challenge.

MAC's Contentions

The Medicare contractor contends that it made no adjustment to the prior year resident-to-bed-ratio on the revised NPR dated April 4, 2013, thus the issue is not within the scope of the appeal.[1]

The Medicare contractor notes that in accordance with 42 C.F.R. § 405.1835:

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

In addition 42 C.F.R. § 405.1889 (b) also states that:

> "(1) (o)nly those matters that are specifically revised in the 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."

The MAC explains that on the Provider's reinstatement request dated September 26, 2013, the Provider contends that the "MAC failed to make the adjustment to which the MAC agreed in Appeal issue 5 of the A/R". Specifically, the Provider disputes the MAC's failure to adjust the prior year resident-to bed ratio. The MAC asserts that the Provider only appealed the prior year resident FTE count (W/S E, Part A, line 3.15) and the Provider never appealed the prior year resident-to-bed ratio (W/S E, Part A, line 3.19). The MAC notes that when the Provider added the prior year interns and residents count issue to the appeal on July 9, 2007, the Provider never mentioned the prior year resident-to-bed ratio. The Provider specifically appealed the prior year interns and residents count which is a separate and distinct issue from the prior year resident-to-bed ratio.[2]

With respect to the A/R, the MAC asserts that it performed the necessary review and adjusted the prior year FTEs (W/S E, Part A, line 3.15) to the proper amount. The adjustment was clearly stated on the AR agreed to by the Parties, and included in the Revised Notice of Program Reimbursement ("RNPR") issued on April 4, 2013.[3]

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[1] MAC's Jurisdictional Brief at 5.
[2] *Id.* at 5-6.
[3] *Id.* at 6.

The MAC contends that the Provider's appeal of prior year resident-to-bed ratio does not meet the general requirements specified in 42 C.F.R. § 405.1841(a) which sets forth the time, place, form and content of request for Board hearing:

> (a) "*General requirements.* (1) ....Such request for Board hearing **must** identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. Prior to the commencement of the hearing proceedings, the provider may identify in writing any additional aspects of the intermediary's determination with which it is dissatisfied and furnish any documentary evidence in support thereof (emphasis added)."[4]

The MAC explains that the Provider's July 9, 2007 add issue request did not express any dissatisfaction with the prior year resident-to-bed ratio reported on W/S E, Part A, line 3.19. If the Provider wanted to appeal the prior year resident-to-bed ratio it should have added the issue to the appeal in writing.[5]

The MAC asserts that any additional issues should have been added within 60 days after the expiration of the applicable 180-day period prescribed in 42 C.F.R. § 405.1835(a)(3) according to the provisions of 42 C.F.R. § 405.1835(c), or within 60 days from the implementation of the Federal Register, Vol. 73, No. 101, page 30249. 42 C.F.R. § 405.1835(c) states:

> "**(c) Adding issues to the hearing request.** – After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may *add specific Medicare payment issues* to the original hearing request by submitting a written request to the Board, only if the following requirements are met (emphasis added):
>
> **(1)** The request to add issues complies with the requirements of paragraphs (a)(1) and (b) of this section as to each new issue.
>
> **(2)** The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) of this section.
>
> **(3)** The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section."[6]

The MAC notes that to coincide with the CMS Final Rule at 73 Fed. Reg. 30190, the PPRB issued new PRRB Rules on August 8, 2008. The new PRRB rules apply to all appeals pending as of, or filed on or after, August 21, 2008. As this case was pending as of August 21, 2008, the Board Rules effective on August 21, 2008 apply to this case.[7]

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[4] *Id.* at 6-7.
[5] *Id.* at 7.
[6] *Id.*
[7] *Id.* at 7-8.

The MAC notes that the Federal Register, Vol 73, No. 101, page 30240 states: "...For appeals pending before an intermediary hearing officer(s) or the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of the later of the following periods:

> ++ Sixty days after the expiration of the applicable 180-day period prescribed in § 405.1811(a)(3) (for intermediary hearing officer hearings).
>
> ++ Section 405.1835 (a)(3) (for Board hearings); or (ii) 60 days after the effective date of this rule. For appeals filed on or after the effective date of this rule, the provisions of § 405.1811(c) and §405.1835(c) apply....".[8]

The MAC states that it has no record that the Provider added the prior year resident-to-bed ratio issue to the appeal within a time frame established by 42 C.F.R. § 405.1835(c) and the Federal Register, Vol 73, No. 101, page 30240.[9]

The MAC contends that the SSI Percentage issue was not included in the original appeal or added to the appeal in a timely manner. Additionally, the issue is not relevant to the revised NPR as the Provider did not appeal the issue on the revised NPR.[10]

The MAC explains that the Provider, in its request letter dated January 28, 2005, specifically added a dispute of its Medicaid percentage as reflected on Worksheet E, Part A, line 4.01 to its appeal, but never mentioned the SSI percentage reported on Worksheet E, Part A, line 4.[11]

The MAC contends that in their preliminary position paper dated March 27, 2012, the Provider added to appeal issue #4, their dispute of the Medicaid percentage, an additional dispute of the SSI percentage as not properly calculated. With the Provider adding the SSI percentage component to their existing dispute of the Medicaid percentage, the Provider improperly disputed multiple Disproportionate Share Hospital (DSH) components under a single appeal issue. This is in violation of PRRB Rule 8 – Framing Issues for Adjustments Involving Multiple Components, which specifically addresses DSH cases in an example. In addition to the Provider improperly briefing multiple DSH components in a single issue, the Provider has not added the dispute of the SSI percentage in a timely manner. The March 27, 2012 date is well after the PRRB issued rules effective August 21, 2008 that required the addition of issues to an appeal case be submitted within 60 days after the expiration of the 180 day appeal request window. This is in violation of PRRB Rule 11 – Adding a New Issue to an Individual Case. Since the SSI percentage issue is not a properly appealed issue, the Board should not permit a transfer to a CIRP group case.[12]

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[8] *Id.* at 8.
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.* at 8-9.

Provider's Contentions

The Provider contends that it entered into an A/R with the MAC in which, among other adjustments, the MAC agreed to carry forward to FYE 5/31/1999 the full time equivalent ("FTE") intern and resident count from the Provider's FYE 5/31/1998 FTE, which had been adjusted. As stated in the A/R, the Medicare impact of this agreed upon adjustment was $66,753. This identical impact was stated by the Provider when it added this issue to its appeal. The Provider's computation of the impact was based on: (1) adjusting the FYE 5/31/1999 FTE count to reflect the 5/31/1998 FTE count; and (2) applying the prior year FTE count to the intern and resident to bed ratio (the "IRB Ratio") in the computation of the Indirect Medical Education ("IME") adjustment. This agreement was entirely consistent with Provider Reimbursement Review Manual ("PRM") Part 2, §3630.1, which required the MAC to apply the prior year FTE count to the IRB ratio in the computation of the IME adjustment. The MAC, however, failed to take that action. As a result, although the MAC agreed in the A/R to make an adjustment in the amount of $66,753, the MAC paid the Provider nothing regarding this item.[13]

The Provider contends that by letter dated January 28, 2005, it timely added to its appeal the issue of the proper computation of the DSH Adjustment based on the DSH SSI percentage issue. As evidenced by Issue #4 in the A/R, the MAC also agreed to resolve the DSH adjustment, including correction of the SSI percentage consistent with CMS 1498-R. With notice to the MAC and BCBSA, the Provider transferred the DSH percentage issue to the Trinity Health Pre-2000 DSH/SSI CIRP Group, Case No. 12-0241GC, filed a complaint commencing an action in the United States District Court for the District of Columbia entitled *Mercy Medical Center –Sioux City v Burwell* and notified the Board, the lead MAC and BCBSA. Thus, the DSH SSI percentage issue is no longer before the Board and the MAC's jurisdictional challenge regarding this issue is moot.[14]

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 date of receipt of the final determination. The regulations require that:

> Such request for Board hearing must identify the aspects of the determination with which the provider is dissatisfied, explain why the provider believes the determination is incorrect in such particulars, and be accompanied by any documenting evidence the provider considers necessary to support its position. [15]

PRRB Rules elaborate this regulatory requirement as follows:

> You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree; and you must specify the basis for contending that the findings and conclusions are incorrect. You must clearly and specifically identify your

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[13] Provider's Jurisdictional Brief at 7.
[14] *Id.* at 7-8.
[15] 42 C.F.R. § 405.1841 (2007).

> position in regard to the issues in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not define the issue as "DSH". You must precisely identify the component of the DSH issue that is in dispute.[16]

The effect of a revised NPR on a provider's right to a Board hearing is addressed at 42 C.F.R. § 405.1889 (2006), which provides that:

> 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 a 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.

The limit on issues that can be appealed from revised NPR's was discussed in *HCA Health Serv. of Okla. v. Shalala,* 27F.3d 614 (D.C. Cir. 1994). In that case, the Court concluded that when an intermediary reopens a determination regarding an amount of reimbursement that a Medicare provider is to receive, an appeal of the reopened cost report is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original reimbursement determination for the fiscal year in question.

The regulation at 42 C.F.R. § 405.1889 was amended in 2008 to state:

> (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.

Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. 42 C.F.R. § 1835 (2008) provides in relevant part:

> (c) Adding issues to the hearing request. After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:
>
> ***
>
> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section.

---

[16] Provider Reimbursement Review Board Rules (2002), Part I § B.II.a., http://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.

For appeals already pending when this regulation was promulgated, Providers were given 60 days from the date that the new regulations took effect, August 21, 2008, to add issues to their appeals.[17] In practice this means that new issues had to be added to pending appeals by October 20, 2008.

The Board finds that the Provider never specifically appealed the prior year resident-to-bed ratio in its original appeal and failed to add the issue in a timely manner as per 42 C.F.R. § 1835. Additionally, the MAC made no adjustment to the prior year resident-to-bed ratio in the revised NPR dated April 4, 2013, thus the issue is not within the scope of the appeal of the revised NPR per the regulation at 42 CFR § 405.1889(b).

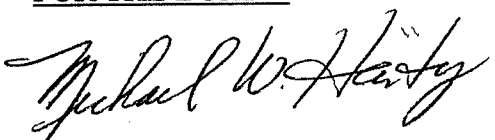
With respect to the SSI percentage issue, the Board finds that although the issue was not included in the original appeal nor was it added to the appeal in a timely manner, the SSI% was adjusted on the RNPR dated April 4, 2013. This was due to the fact that the revision to Medicaid days, which was properly under appeal, resulted in the Provider qualifying for the DSH payment for the first time (they previously did not meet the threshold and did not qualify on the as-filed cost report or in the original NPR). The A/R at page 4 of 6 clearly shows a proposed adjustment to include 4.37 as the SSI% on the RNPR. However, neither upon the Provider's request to reinstate 02-1329 for failure to properly implement the A/R, nor upon appeal of the revised NPR, both dated September 27, 2013, was the issue related to the inaccuracy of the SSI% raised. It was only upon the subsequent transfer request of the SSI accuracy issue dated June 10, 2014, that the issue of the SSI% was raised as an issue related to the implementation of the A/R and RNPR dated April 4, 2013. From the record, it is clear that this issue was not appealed from the revised NPR, nor was it raised in the reinstatement request of 02-1329. Additionally from the record it is clear that the MAC implemented the adjustment for the SSI% exactly the way it had agreed to in the A/R.

The Board therefore denies the Provider's request to transfer the issue to PRRB Case No. 12-0241GC as it was implemented as agreed upon from the A/R in 02-1329 and was not appealed from the appeal of the RNPR. As there are no remaining issues in this appeal, the Board hereby closes the appeal and removes it 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.

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

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, Executive Director, Blue Cross Blue Shield Association

[17] *See* 73 FR 30,236 (May 23, 2008).

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Refer to:

CERTIFIED MAIL

MAR 23 2015

McKay Consulting, Inc.
Michael K. McKay, President
8590 Business Park Drive
Shreveport, LA 71105

RE: McKay 2004-2006 DSH Labor and Delivery Room Days Group, PRRB Case No.09-1052G
Specifically: Albermarle Hospital (34-0109), FYE 9/30/2005 – participant #3 and
Kalispell Regional Medical Center (27-0051), FYE 3/31/2004 - participant #9

Dear Mr. McKay:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the subject group appeal, and on its own motion noted jurisdictional impediments to the above-referenced participants that filed from revised Notices of Program Reimbursement (NPRs) in the group. The pertinent facts and the jurisdictional decision of the Board are set forth below

Pertinent Facts:

The McKay 1996-2006 DSH Labor Delivery II Group (Case No. 07-2805G) was filed on September 5, 2007 and included various FYEs. In accordance with a request from the Representative, the Board restructured the case to account for changes in the regulations that became effective in October 2003. The subject case, Case No. 09-1052G, was created to handle twenty one Providers with FYEs after 2003 and includes FYEs 2004 through 2006. On February 14, 2013, the Representative requested a standard remand of Case No. 09-1052G.

Five of the twenty one Participants in the group appealed from revised NPRs. As noted, two of these Participants have jurisdictional impediments.

42 C.F.R. § 405.1889(b)(1) explains that, "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."

Participant 3 (Albermarle Hospital - 34-0109) requested a reopening of the cost report prior to the issuance of the original NPR. Although the Representative provided supplemental documentation behind tab 3H, including a copy of the administrative resolution filed in the Provider's individual appeal (case no. 07-2194), there is not enough information to support an adjustment to Labor Room Days on the revised NPR. In fact, on

the worksheets provided, there is no change in the DSH percentage between the original and the reopening. Further, the Provider did not include the Labor Room Days issue in its appeal of the original NPR. When Albermarle Hospital filed its appeal from the revised NPR, it was incorporated into the existing original NPR case, however, it was not filed until October 29, 2008. If the revised NPR appeal had been filed prior to October 21, 2008, it could have been considered a request to add an issue to the original NPR appeal and the provisions of Bethesda would apply.[1]

Participant 9 (Kalispell Regional Medical Center - 27-0051) filed from a revised NPR that resulted from an administrative resolution of case no. 06-1125 (the appeal of the original NPR). The administrative resolution does not say there was any adjustment being made to Labor Room Days. In fact, the signed resolution states "The Intermediary reviewed and tested the provider's revised listing of total Medicaid days and is proposing an adjustment to reduce total patient days by 116 **(net of Labor & Delivery days).**" (Emphasis added)

Because the revised NPR appealed by Kalispell Regional Medical Center was issued to implement a full administrative resolution for case no. 06-1125, the signed resolution shows the Provider's agreement that the dissatisfaction had been resolved for the issues in its case. Therefore, the Board finds that Kalispell Regional Medical Center resolved/withdrew its dissatisfaction with the issues appealed in the original case when it withdrew before the Board. Had the Provider been only "partially" satisfied with the resolution, it had an open appeal and an opportunity to bring remaining issues before the Board for hearing.

Board's Decision

The Board finds that it does not have jurisdiction over Albermarle Hospital (34-0109) and Kalispell Regional Medical Center (27-0051) because these Providers are appealing from revised NPRs which did not specifically adjust the Labor Delivery Room Days issue.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 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 stated the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been

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1 42 C.F.R. 405.1835(c) and Board Rules issued August 21, 2008.

reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 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.

As the Board lacks jurisdiction over Albermarle Hospital (34-0109) and Kalispell Regional Medical Center (27-0051), they are dismissed from this group appeal. Enclosed, please find a Standard Remand of Labor/Delivery Room Inpatient Days Uncer CMS Ruling CMS 1498-R for the remaining participants in the group.

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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

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

Standard Remand of Labor/Delivery Room Inpatient Days Under CMS Ruling CMS1498-R

cc: Kevin D. Shanklin, Executive Director, BC BS Association (w/enclosures)
Kyle Browning, National Government Services (w/enclosures)

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Refer to: 06-1063G

MAR 24 2015

CERTIFIED MAIL

Christopher L. Keough
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Timothy LeJeune
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JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburg, PA 15219

RE: Jurisdictional Decision
Catholic Health Initiatives (CHI) 2004 DSH SSI Group
Provider No.: Various
FYE: Various 2004
PRRB Case No.: 06-1063G

Dear Mr. Keough and Mr. LeJeune,

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. John's Regional Medical Center, provider no. 26-0001, FYE 6/30/2004

St. John's Regional Medical Center, listed as participant 35 on the Schedule of Providers, was issued a revised Notice of Program Reimbursement (NPR) for FYE 6/30/2004 on January 26, 2009. The Provider requested to be directly added to this group appeal on July 16, 2009.

St. Elizabeth Regional Medical Center, provider no. 28-0020, FYE 6/30/2004

St. Elizabeth Regional Medical Center, listed as participant 36 on the Schedule of Providers, was issued a revised NPR for FYE 6/30/2004 on November 20, 2008. The Provider requested to be directly added to this group appeal on May 15, 2009.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), 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 final determination. However, before the Board can make a

determination over all matters covered by the cost report, it must first determine that a Provider has filed a jurisdictionally valid appeal.

Although the Medicare Contractor did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over St. John's Regional Medical Center and St. Elizabeth Regional Medical Center's revised NPR appeals for FYE 6/30/2004 because the Providers appealed from revised NPRs in which the issue on appeal, the SSI percentage, was not specifically revised. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (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 (2008), 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.

Furthermore, numerous courts have repeatedly held that when dealing with revised NPRs, the PRRB's jurisdiction is limited to reviewing only those specific issues that were adjusted by the revised NPRs. *See Hennepin Cnty. Med. Ctr. v. Shalala*, 81 F.3d 743, 749 (8th Cir. 1996); *French Hosp. Med. Ctr. v. Shalala*, 89 F.3d 1411, 1420 (9th Cir. 1996). The District Court for the District of Columbia recently continued this trend by granting deference to the Secretary of the Department of Health and Human Services' (DHHS) decision to deny PRRB jurisdiction over Medicare providers' appeals from revised NPRs that raised Medicare reimbursement issues which were not the subject of reopening. *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014).

In the instant case, St. John's Regional Medical Center shows in adjustment number 4 that there was an adjustment to DSH, but from the other documents submitted, the SSI percentage was not adjusted. Similarly, St. Elizabeth Regional Medical Center also demonstrates in adjustment number 4 that there was an adjustment to DSH, but from the other documents submitted, the SSI percentage was not adjusted. Therefore, since the Providers did not establish that the SSI percentage was specifically revised as required by the regulations in their respective revised NPRs, the Board dismisses both Providers from case number 06-1063G.

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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

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

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Refer to: 10-1066, 10-1067, & 10-1068

MAR 24 2015

CERTIFIED MAIL

David L. Cohan
Quality Reimbursement Services
150 North Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

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

RE: Jurisdictional Decision – Valley Presbyterian Hospital
Provider No.: 05-0126
FYE: 10/31/2004, 10/31/2005, & 10/31/2006
PRRB Case No.: 10-1066, 10-1067, & 10-1068

Dear Mr. Cohan and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeals. The Board finds that it does not have jurisdiction over the SSI Percentage Provider Specific issue for all three fiscal years referenced above as the issue is premature. The Board's decision is set forth below.

BACKGROUND

Valley Presbyterian Hospital filed three timely appeals from three original Notices of Program Reimbursement for FYEs 2004, 2005, and 2006. Valley Presbyterian Hospital appealed the following five issues in each of the three appeals:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)
3. DSH/Medicare Managed Care (Part C) Days
4. DSH/Medicaid Eligible Labor Room Days
5. DSH/Exhausted Dual Eligible Days

Valley Presbyterian Hospital later requested to transfer issues 2 through 5 into group appeals as follows:

	10-1066 (2004)	10-1067 (2005)	10-1068 (2006)
Issue #2: SSI Percentage (Systemic Errors)	Transferred to case number 08-2929G	Transferred to case number 08-2269G	Transferred to case number 09-1003G
Issue #3: Managed Care	Transferred to case number 07-2388G	Transferred to case number 07-2389G	Transferred to case number 09-0996G

(Part C) Days			
Issue #4: Exhausted Medicare Benefits Dual Eligible Days	Transferred to case number 09-0377G	Transferred to case number 09-1002G	Transferred to case number 09-1002G
Issue #5: Labor Room Days	Transferred to case number 07-2324G	Transferred to case number 07-2899G	Transferred to case number 09-2333G

The last remaining issue in case numbers 10-1066, 10-1067, & 10-1068 is the SSI Percentage Provider Specific.

BOARD'S DECISION

The Board has reviewed jurisdiction over these three appeals on its own motion and finds that it does not have jurisdiction over the SSI Percentage Provider Specific in any of the three appeals because the Medicare contractor has not issued a final determination from which the provider can appeal. 42 C.F.R. § 405.1835 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."

Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare contractor.

There is no indication that the Provider has submitted a written request to the Medicare contractor to use the cost reporting period instead of the federal fiscal year for any of the three fiscal year ends covered by case numbers 10-1066, 10-1067, and 10-1068. Without this request it is not possible for the Medicare contractor to have made a final determination. In addition, the Board finds that the corresponding SSI issues pertaining to the accuracy of the data were transferred to group appeals and have been remanded pursuant to CMS Ruling 1498-R. Therefore, each of these Providers will receive revised NPRs with updated SSI percentages. Accordingly, the Board finds that it lacks jurisdiction over the SSI Percentage Provider Specific issue in case numbers 10-1066, 10-1067, and 10-1068. Since the SSI Percentage Provider Specific issue is the sole remaining issue in these cases, case 10-1066, 10-1067, and 10-1068 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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

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: 07-1801GC

MAR 24 2015

CERTIFIED MAIL

Stephanie A. Webster
Akin, Gump, Strauss, Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Suite 400
Washington, DC 20036-1532

Steven Holubowicz
Novitas Solutions, Inc.
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Request for Reconsideration
St. Joseph Hospital East *as a participant in*
CHI 2005 DSH Labor and Delivery Room Days Group
Provider No.: 18-0143
FYE: 6/30/2005
PRRB Case No.: 07-1801GC

Dear Ms. Webster and Mr. Holubowicz,

The Provider Reimbursement Review Board ("Board") has reviewed the documents related to the Request for Reconsideration. The Board hereby grants the Request for Reconsideration.

BACKGROUND

St. Joseph Hospital East ("St. Joseph") was issued a revised NPR for FYE 6/30/2005 and filed a direct add request with the Board in case number 07-1801GC. On May 23, 2014, the Board issued a jurisdictional decision in which it dismissed St. Joseph from case number 07-1801GC based on the rationale that the Provider's revised Notice of Program Reimbursement ("NPR") did not specifically adjust labor and delivery room days. The Board then remanded all of the Providers with jurisdictionally valid appeals to the Medicare contractor pursuant to CMS Ruling 1498-R. On July 9, 2014, the Providers' representative submitted a request that the Board reconsider its decision to dismiss St. Joseph from the group appeal.

REQUEST FOR RECONSIDERATION ARGUMENTS

St. Joseph Hospital East requests that the Board reconsider its jurisdictional determination in case number 07-1801GC and reverse that determination. St. Joseph Hospital East argues that the workpapers show that labor and delivery room days were included in the as-filed cost report, not excluded in the original NPR, and subsequently excluded from the revised NPR. The Provider argues that the Board misinterpreted a workpaper that shows labor and delivery room days were removed from the DSH calculation in the revised NPR. The Provider argues that, in its revised NPR, the MAC excluded 123 labor and delivery room days, including 120 labor and delivery room days that were included in the original NPR and 3 additional days identified by the

Provider in a revised DSH claim. St. Joseph Hospital East states that it submitted a revised DSH claim to the MAC that identified 4,881 Medicaid days for inclusion in the Medicaid fraction, which did not include the 123 labor and delivery days that were excluded in accordance with the rules then in place.

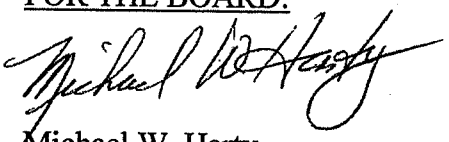
BOARD'S DECISION

The Board grants St. Joseph Hospital East's Request for Reconsideration, reinstates case number 07-1801GC, and grants jurisdiction over the Provider. Based on the additional documents the Provider submitted with its reconsideration request, the Board has determined that there was an adjustment to labor and delivery room days in the revised NPR which satisfies the jurisdictional requirements of 42 C.F.R. §§ 405.1885, 405.1889 (2007). The Board finds that the Medicare contractor paid for labor and delivery room days in the Provider's original NPR. Subsequently, the Medicare contractor reopened the Provider's cost report to include some days and exclude other days, and in that process the Medicare contractor excluded labor and delivery room days. Based on the adjustment to remove labor and delivery room days from the revised NPR, the Board finds that it has jurisdiction over St. Joseph Hospital East.

The Board will address the remand of the labor and delivery room days issue pursuant to CMS Ruling 1498-R for St. Joseph Hospital East under separate cover.

Board Members:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

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:

09-2140GC

MAR 25 2015

Certified Mail

Sutter Health
Wade H. Jaeger
Reimbursement Manager, Appeals/Litigation
P.O. Box 619092
Roseville, CA 95661

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

RE: Jurisdiction Decision
Sutter Health 2006 DSH – L& D Room Days CIRP Group
Provider No.: Various
FYE: 12/31/2006
PRRB Case No.: 09-2140GC

Dear Mr. Jaeger and Ms. Kalafut,

The Provider Reimbursement Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and on its own motion noted jurisdictional impediments for two Providers in this group appeal. The Board finds it lacks jurisdiction over the following Providers for their 12/31/2006 cost report period:

- Sutter Amador Hospital	05-0014	Participant 1
- Marin General Hospital	05-0360	Participant 5
- Memorial Hospital – Modesto	05-0557	Participant 6
- Alta Bates Medical Center	05-0305	Participant 10
- California Pacific Medical Center – Pacific	05-0047	Participant 11
- California Pacific Medical Center – Davies	05-0008	Participant 12
- Sutter Davis Hospital	05-0537	Participant 13
- Summit Medical Center	05-0043	Participant 14
- Sutter Medical Center – Sacramento	05-0108	Participant 15
- Sutter Medical Center – Santa Rosa	05-0291	Participant 16

Background

Case number 09-2140GC was established on August 17, 2009, when the group of providers appealed the removal of their labor and delivery days by their MAC. The initial schedule of providers indicated the group would consist of sixteen Providers, but jurisdictional documentation was only received for nine of the Providers on the schedule.

Board's Decision

The Board finds that it does not have jurisdiction over Participants 1, 5 and 6 because the Participants did not transfer the issue from their individual appeals to the group appeal prior to their individual appeals being closed or dismissed.

The Provider Reimbursement Review Board sets their own rules per 42 U.S.C. § 1395oo(e), which states in part "The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section." Provider Reimbursement Review Board rule 16.1 lists the requirements of a provider to transfer an issue from an individual appeal to a group appeal.[1] Rule 16.1 states in part the following requirements:

2. documentation showing that the issue being transferred is currently part of the individual appeal from which it is to be transferred; and
   a. If the Provider asserts that the issue was included in the initial appeal request, it MUST attach a copy of the initial appeal request showing that the issue was in fact included in the initial appeal request.
   b. If the Provider asserts that the issue was added subsequent to filing the initial appeal request, it MUST attach a copy of the letter and/or a copy of the Model Form C (Request to Add Issue(s) to an Individual Appeal) showing that the issue was in fact added subsequent to filing the initial appeal request.

Participants 1, 5 and 6 all neglected to submit the above documentation, and therefore the Board dismisses these Participants from the group appeal as there is no evidence the issue was transferred from the Participants individual appeals to the group appeal.

The Board finds that it does not have jurisdiction over Participants 10, 11, 12, 13, 14, 15 and 16 because the Participants did not submit any of the required jurisdictional documentation. Provider Reimbursement Review Board rule 21 prescribes the content of the group schedule of providers as well as the required supporting documentation.[2] Participants 10-16 failed to submit any of the required documentation listed in rule 21 and therefore the Board dismisses these Participants 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 upon final disposition of this case.

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1 *See* page 13 of the PRRB Board rules

2 *See* page 16 of the PRRB Board rules

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand Letter
Schedule of Providers

cc: Kevin Shanklin, Executive Director, BCBSA

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Refer to: 01-3199G

MAR 25 2015

CERTIFIED MAIL

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

Renee Rhone
Senior Auditor/Appeals Specialist
Cahaba Government Benefit Administrators
P.O. Box 1448
Birmingham, AL 35201-1448

RE: Group Name: BMHC 95 DSH/SSI Proxy Group
Provider No.: Various
FYE: 09/30/1995
PRRB Case No.: 01-3199G

Dear Amrish Mathur and Renee Rhone:

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

Background

The Board received the request to establish this group appeal on June 28, 2001. The appeal challenges whether the Medicare SSI fraction is correct, as covered by CMS Ruling 1498-R. Specifically, the group contends that CMs has significantly understated the number of qualifying SSI patient days for purposes of calculating the respective providers' DSH payments.

Board's Determination

The Board finds that it has jurisdiction over all of the Providers in the Group except for BMH – North Mississippi, Provider No. 25-0034 (Participant 1), BMH – De Soto, Provider No. 25-0141 (Participant 4), and BMH – Medical Center East, Provider No. 44-0048 (Participant 5).[1] Participants 1, 4, and 5 appealed from revised Notices of Program Reimbursement (RNPRs); however, they did not document that SSI% was adjusted in their RNPRs.

[1] Participants 2, 3, and 6 all appealed from original NPRs. It should be further noted that a jurisdictional challenge was filed by the Contractor regarding Participant 2, and the Board determined that jurisdiction over Participant 2 was proper.

The Code of Federal Regulations provides an opportunity for a provider to obtain a RNPR through a reopening of its cost report. 42 C.F.R. § 405.1885(a) (2003) provides, in relevant part:

> 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.[2]

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

> 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.[3]

More recently, 42 C.F.R. § 405.1889 was addressed in *Emanuel Medical Center, Inc. v. Sebelius,* No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). In that case, the Court held that the "issue-specific" interpretation of the RNPR regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

Here, Participant 1 only documented a revision to Medicaid days; Participant 4 specifically documented no change to the SSI fraction; and, Participant 5's workpapers did not support a revision to the SSI fraction in its RNPR. Therefore, pursuant to 42 C.F.R. § 405.1889, the SSI fraction is beyond the scope of any appeal of the revised determination.[4] The Board finds that it lacks jurisdiction over Participants 1, 4, and 5. Accordingly, BMH – North Mississippi, BMH – De Soto, and BMH – Medical Center East are dismissed from this case.

The Board has found that it has jurisdiction over the remaining Providers and will issue a remand under separate cover. Review of this determination is available under the provisions of

---

[2] 42 C.F.R. § 405.1885(a) (2003). This part of the statute remained the same in 2004 and 2005 (RNPRs were issued for Participant 1 on October 27, 2005; Participant 4 on February 2, 2004; and, Participant 5 on February 24, 2005).
[3] 42 C.F.R. § 405.1889. This statute remained the same throughout 2004 and 2005. *See supra* n. 2.
[4] *See also HCA Health Services of Oklahoma, Inc. v. Shalala,* 27 F.3d 614, 615 (D.C. Cir. 1994) (holding that a provider's appeal of that reopening is limited to the specific issues revisited on reopening).

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

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

cc: Kevin Shanklin, BCBSA

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Refer to:

CERTIFIED MAIL

MAR 25 2015

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

RE: Mercy Hospital Springfield
Provider No. 26-0065
FYE 6/30/2011
PRRB Case No. 15-0460

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal in response to your January 20, 2015 requests to transfer multiple issues from the individual appeal to group appeals. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

This appeal was filed on November 17, 2014, from a Notice of Program Reimbursement (NPR) dated May 23, 2014. The sole issue raised in the appeal was stated as follows:

> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage.

The Statement of the Legal Basis included in the Statement of the Issue behind Tab 3 of the appeal request referred specifically to *Baystate v. Leavitt* and inconsistencies in the data match methodology.[1]

On January 20, 2015, the Representative, Quality Reimbursement Services, Inc. (QRS), requested the transfer of multiple issues to Common Issue Related Party (CIRP) groups as follows:

[1] *Baystate Medical Center v. Leavitt, 587 F. Supp. 2d 37 (D.C. 2008).*

- SSI Percentage (to 14-4168GC)
- Outlier Fixed Loss Threshold (to 14-4173GC)
- SSI Fraction Dual Eligible Days (to 14-4172GC)
- SSI Fraction Medicare Part C Days (to 14-4170GC)
- Medicaid Fraction Dual Eligible Days (to 14-4171GC)
- Medicaid Fraction Medicare Part C Days (to 14-4169GC)

The Outlier Fixed Loss Threshold, SSI Fraction Dual Eligible Days, SSI Fraction Medicare Part C Days, Medicaid Fraction Dual Eligible Days and Medicaid Fraction Medicare Part C Days issues were never properly added to the appeal. Attached to each Transfer Request was a copy of the Provider's Request to Add the issue to the appeal for Mercy Hospital Joplin, case number 15-0459 (not this case 15-0460).

On February 11, 2015, QRS filed copies of the Model Form C (Request to Add Issue) and the previously submitted Transfer Requests for the subject appeal. Using the February 11, 2015 receipt date, the issues were not added within 245 days of the issuance of the NPR.

Board Determination:

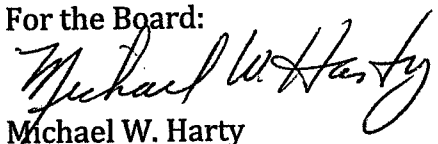
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more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

42 C.F.R. § 405.1835(c) addresses a Provider's request to add an issue to an appeal. The regulation indicates a request to add an issue is timely if the Board receives the request to add no later than 60 days after the expiration of the applicable 180-day appeal period set forth in 42 C.F.R. § 405.1835(a)(3). Because the Provider's request to add the Outlier Fixed Loss Threshold, SSI Fraction Dual Eligible Days, SSI Fraction Medicare Part C Days, Medicaid Fraction Dual Eligible Days and Medicaid Fraction Medicare Part C Days issues was filed 264 days after the issuance of the NPR, the Board denies the addition of these issues. Consequently, the requests to transfer these issues to group cases 14-4173GC, 14-4172GC, 14-4170GC, 14-4171GC and 14-4169GC, respectively, are hereby denied.

Since the only issue properly appealed in this case was the DSH SSI Percentage issue, the Board will grant the transfer of the SSI Percentage issue to case number 14-4168GC. Since there are no remaining issues in the individual appeal, the Board hereby closes case number 15-0460.

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 on the merits.

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

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, Wisconsin Physicians Service
Kevin D. Shanklin, Executive Director, BC BS Association