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: 06-1701

APR 01 2015

CERTIFIED MAIL

Westchester Medical Center
Gary F. Brudnicki
CAO & Chief Financial Officer
19 Bradhurst Avenue
Hawthorne, NY 10532

National Government Services, Inc.
Kyle Browning
Appeals Lead
MP INA101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Westchester Medical Center
Provider No. 33-0234
FYE December 31, 2001
PRRB Case No. 06-1701

Dear Mr. Brudnicki and Mr. Browning:

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 over the Organ Transplant Costs – pre-transplant costs. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

Facts/Timeline

November 14, 2005	The Medicare contractor issued the Notice of Program Reimbursement for FYE 12/31/2001.
May 11, 2006	Westchester Medical Center filed an appeal request (timely) regarding FYE 12/31/2001. Issue no. 8[1] is described as Organ Transplant Costs (Pre-transplant costs are listed under Issue no. 8 along with other organ transplant costs).
November 19, 2013	The Medicare contractor challenges the Board's jurisdiction to hear Issue 8.
December 12, 2013	The Provider responds to the Medicare contractor's challenge.

[1] *See* Issue 4e in the Medicare contractor's final position paper at 21.

Medicare contractor's Contentions

The Medicare contractor contends that the Board does not have jurisdiction over the pre-transplant cost issue because the Provider failed to report the services properly on its cost report.[2] The Medicare contractor asserts it made no adjustments related to pre-transplant costs. The Provider included the costs in question as ancillary cost and failed to reclassify them to the organ acquisition line to obtain pass-thru costs. The Medicare contractor argues that the Provider is unhappy with its reimbursement due to its own error of failing to include costs properly on the cost report.

Provider's Contentions

The Provider filed a response to the Medicare contractor's jurisdictional challenge. The Provider states that it "would like to purse [sic] this issue in which the Medicare contractor's audit adjustment did not include all pre-transplant cost for Recipient and Donor patients in accordance with PRM 15-2, Section 3625.3."

Board Decision

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835 – 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 Medicare contractor, 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 Notice of Program Reimbursement (NPR).

42 U.S.C. §1395óo(d) further provides that the Board shall have the power to affirm, modify, or reverse a final determination of the fiscal Medicare contractor with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the Medicare contractor in making such final determination.

In Bethesda Hosp. Assoc. V. Bowen, 485 U.S. 399 (1988), the provider failed to claim a cost because a regulation dictated that it was disallowed. The Supreme Court found section 1395oo(a) permitted jurisdiction over this "self-disallowed" claim.

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*

Id. At 1258 (emphasis added). The Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

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[2] *See* Medicare contractor jurisdictional challenge dated November 19, 2013 at 2.

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the Medicare contractor reimbursement for all costs to which they are entitled under applicable rules*. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal Medicare contractor, those circumstances are not presented here. (emphasis added).

In a September 2013 published decision, the Board ruled that it did not have jurisdiction over a reimbursement appeal filed by St. Vincent Hospital and Health Center.[3] In *St. Vincent*, the provider argued that it was not required to protest appeal items prior to December 31, 2008. The Provider contended that, in order to preserve appeal rights under the 2008 revisions, a provider must either claim an item on its cost report where it is seeking reimbursement that it believes to be in accordance with Medicare policy, or self-disallow the item where it is seeking reimbursement that it believes may not be in accordance with Medicare policy by adding the item as a "protest amount" on its cost report.[4] The Provider suggested that, by adopting this policy, DHHS recognized that the language in *Bethesda* created a discrepancy. However, the Provider argued that this change in policy was not even proposed until the spring of 2008 and is only effective for cost reports ending on or after December 31, 2008.[5] Because there was no clear policy as to the treatment of self-disallowed costs prior to 2008, the Provider believed that *Bethesda* should control, which permits providers to claim dissatisfaction within the meaning of the statute, without necessarily incorporating their challenge in the cost reports filed with their Medicare contractor. The Provider concluded, that once a provider has met the jurisdictional requirements in § 1395oo(a) and been granted the right to be heard, the Board's authority to decide the matter and scope of review is governed under § 1395oo(d).

Here, the Provider states that "[t]he Medicare contractor's audit adjustment did not properly include all pre transplant costs for Recipient and Donor patients in accordance with PRM 15-2, Section 3625.3."[6] The Provider received reimbursement for the costs the way they claimed them on their cost report. Only now are they asking to have them revised by the MAC. There is no evidence that the MAC was requested to and reviewed them during the audit. The NPR did not include any adjustments for pre-transplant costs.

The Board finds that it has jurisdiction over the appeal pursuant to 42 U.S.C. § 1395oo(a) for any issues that were reviewed and disallowed in the NPR. However, the Provider does not have a right to a hearing for pre-transplant costs as they cannot claim dissatisfaction, as they received reimbursement for how they were claimed on the cost report. Based on the circumstances of this case, the Board declines to exercise its discretionary authority under 42 U.S.C. § 1395oo(d).

Therefore, the Board dismisses the pre-transplant cost issue from the subject appeal. Since this is the last remaining issue, the Board closes case no. 06-1701.

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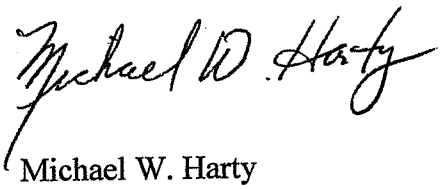
[3] *St. Vincent Hospital and Health Ctr. v. BlueCross BlueShield Ass'n/Nat'l Govt. Serv. Inc.* PRRB Decision No. 2013-D39 (September 13, 2013).
[4] *See* 73 Fed. Reg. at 30194-30205. *See also* 42 C.F.R. §§ 405.1811(a)(1) and 405.1835(a)(1)(ii).
[5] *See* 42 C.F.R. § 405.1811(a). *See also* 73 Fed. Reg. at 30194-30205.
[6] *See* Provider final position paper at 14.

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, C.P.A.

For the Board:



Michael W. Harty
Chairman

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

cc: Arthur E. Peabody, Esq., BCBSA
Kevin Shanklin, BCBSA

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Refer to:

CERTIFIED MAIL

APR 01 2015

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

RE: Duke University 2007 DSH Dual Eligible CIRP Group
FYE: 6/30/2007
PRRB Case No. 09-2094GC

Dear Mr. McKay:

The Provider Reimbursement Review Board (the Board) has reviewed your request to bifurcate the Part C Days issue from the Duke University 2007 DSH Dual Eligible Common Issue Related Party (CIRP) group appeal dated June 20, 2014.[1] The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

This CIRP group appeal was filed on August 6, 2009. The first participant used to form the group was Duke Health Raleigh Hospital (34-0073) for FYE 06/30/2007. The issue description included with the appeal request relates to the treatment of patient days for individuals considered eligible for both Medicare Part A and Medicaid for purposes of computing the Medicare Disproportionate Share (DSH) adjustment (Dual Eligible Days). The statement covers four categories of days

- Exhausted Benefit Days
- Medicare Secondary Payer Days
- Medically Unnecessary or Custodial Care Days and
- Medicare Part C Days

On July 30, 2010 an additional provider, Durham Regional Hospital (34-0155) requested to join the group by filing a Model Form E (Request to Join an Existing Group Appeal: Direct Appeal From Final Determination) for its FYE ending 06/30/2007.

In a letter dated June 20, 2014, you advised the Board that the group is not yet complete pending receipt of a final determination for Duke University Hospital. You also advised that this group contained both dual eligible Part A days and dual eligible Medicare Advantage (HMO or Part C) days and indicated that the group needed to be bifurcated to

[1] Your request for bifurcation also referenced case nos. 09-1668GC, 09-2094GC, 09-2268GC, 09-2279GC and 10-0984GC. Your request for bifurcation will be addressed on a case by case basis, once the Board has had the opportunity to review the available documentation.

separate the Part C days from the dual eligible Part A days issue.

Board Determination:

In accordance with your request, the Board has bifurcated the Part C Days issue from this group and has formed the "Duke University 2007 Part C Days CIRP" to which it has assigned case number 15-1845GC. The new group includes the two participants listed in this letter. Enclosed, please find a Group Acknowledgement (Common Issue Related Party (CIRP/Mandatory Group) letter.

With regard to case no. 09-2094GC, the dual eligible Part A days issue is not subject to remand pursuant to CMS Ruling 1498-R as patient discharges on or after October 1, 2004 are not covered by the Ruling. Please advise the Board once the group is complete.

Should you have any questions regarding this matter, please contact the Board at the above address or by telephoning (410) 786-2671.

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

For the Board:

Michael Harty
Chairman

Enclosure: Group Acknowledgement (Common Issue Related Party (CIRP/Mandatory Group)

cc: Kevin D. Shanklin, Executive Director, Blue Cross Blue Shield Association (w/enclosure)
Cecile Huggins, Palmetto GBA (w/enclosure)

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CERTIFIED MAIL

APR 01 2015

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

RE: North Shore LIJ 2004 Dual Eligible Days CIRP Group, FYE 12/31/2004,
PRRB Case No. 09-1668GC

Dear Mr. McKay:

The Provider Reimbursement Review Board (the Board) has reviewed your request to bifurcate the Part C Days issue from the North Shore LIJ 2004 Dual Eligible Days Common Issue Related Party (CIRP) group appeal dated June 20, 2014.[1] The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

This CIRP group appeal was filed on May 13, 2009. The first participant used to form the group was Northshore Long Island Jewish – Forest Hills Hospital (33-0353) for FYE 12/31/2004. The issue description included with the appeal request relates to the treatment of patient days for individuals considered eligible for both Medicare Part A and Medicaid for purposes of computing the Medicare Disproportionate Share (DSH) adjustment (Dual Eligible Days). The statement covers four categories of days

- Exhausted Benefit Days
- Medicare Secondary Payer Days
- Medically Unnecessary or Custodial Care Days and
- Medicare Part C Days

Subsequently, two additional providers, Long Island Jewish Medical Center (33-0195) and Southside Hospital (33-0043) requested to join the group by filing Model Form E's (Request to Join an Existing Group Appeal: Direct Appeal From Final Determination). Both Providers have FYEs ending 12/31/2004.

In a letter dated June 20, 2014, you advised the Board that the group is not yet complete pending receipt of a final determination for Staten Island Hospital. You also advised that this group contained both dual eligible Part A days and dual eligible Medicare Advantage

[1] Your request for bifurcation also referenced case nos. 09-1668GC, 09-2094GC, 09-2268GC, 09-2279GC and 10-0984GC. Your request for bifurcation will be addressed on a case by case basis, once the Board has had the opportunity to review the available documentation.

(HMO or Part C) days and indicated that the group needed to be bifurcated to separate the Part C days from the dual eligible Part A days issue.

Board Determination:

In accordance with your request, the Board has bifurcated the Part C Days issue from this group and has formed the "North Shore LIJ 2004 Part C Days CIRP" to which it has assigned case number 15- 1843GC. The new group includes the three participants listed in this letter. Enclosed, please find a Group Acknowledgement (Common Issue Related Party (CIRP/Mandatory Group) letter.

With regard to case no. 09-1668GC, the dual eligible Part A days issue is subject to remand pursuant to CMS Ruling 1498-R for patient discharges before October 1, 2004. Discharges on or after October 1, 2004 are not covered by the Ruling. Therefore, the Board requests that you file a Schedule of Providers with the associated jurisdictional documentation within 30 days of the date of this letter covering the period from 1/1/2004 through 9/30/2004 for the participants in the group. The Board is aware that Staten Island Hospital had not yet received its final determination and that the group may not be complete. However, Board Alert 7 allows for 1498-R remands to be processed even when a CIRP group is incomplete.

The three Providers' remaining periods from 10/1/2004 through 12/31/2004, are being transferred to the North Shore LIJ 2005 DSH Dual Eligible Days CIRP, case number 10-0984GC. The Parties will receive correspondence regarding the bifurcation of the Part C Days issue from that group under separate cover.

Should you have any questions regarding this matter, please contact the Board at the above address or by telephoning (410) 786-2671.

For the Board:

Michael Harty
Chairman

cc: Kevin D. Shanklin, Executive Director, Blue Cross Blue Shield Association
Kyle Browning, Appeals Lead, National Government Services

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CERTIFIED MAIL

APR 01 2015

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

RE: North Shore LIJ 10/1/2004 -2005 Dual Eligible Days CIRP Group[1]
FYEs: 10/1/2004-12/31/2004 and 12/31/2005
PRRB Case No. 10-0984GC

Dear Mr. McKay:

The Provider Reimbursement Review Board (the Board) has reviewed your request to bifurcate the Part C Days issue from the North Shore LIJ 2005 Dual Eligible Days Common Issue Related Party (CIRP) group appeal dated June 20, 2014.[2] The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

This CIRP group appeal was filed on April 30, 2010. The first participant used to form the group was North Shore Long Island Jewish – Forest Hills Hospital (33-0353) for FYE 12/31/2005. The issue description included with the appeal request relates to the treatment of patient days for individuals considered eligible for both Medicare Part A and Medicaid for purposes of computing the Medicare Disproportionate Share (DSH) adjustment (Dual Eligible Days). The statement covers four categories of days

- Exhausted Benefit Days
- Medicare Secondary Payer Days
- Medically Unnecessary or Custodial Care Days and
- Medicare Part C Days

On July 30, 2010 an additional provider, Franklin Hospital & Medical Center (33-0372) requested to join the group by filing a Model Form E (Request to Join an Existing Group Appeal: Direct Appeal From Final Determination) for its FYE ending 12/31/2005.

In a letter dated June 20, 2014, you advised the Board that the group is not yet complete

[1] North Shore Long Island Jewish – Forest Hills Hospital (33-0353), Long Island Jewish Medical Center (33-0195) & Southside Hospital (33-0043) were transferred to the subject group from case no. 09-1668GC for the period 10/1/2004 through 12/31/2004 in a concurrent letter.
[2] Your request for bifurcation also referenced case nos. 09-1668GC, 09-2094GC, 09-2268GC, 09-2279GC and 10-0984GC. Your request for bifurcation will be addressed on a case by case basis, once the Board has had the opportunity to review the available documentation.

pending receipt of a final determination for Staten Island Hospital. You also advised that this group contained both dual eligible Part A days and dual eligible Medicare Advantage (HMO or Part C) days and indicated that the group needed to be bifurcated to separate the Part C days from the dual eligible Part A days issue.

After bifurcating the Part C days issue from case number 09-1668GC, (North Shore LIJ 2004 Dual Eligible Days CIRP) the Board transferred the dual eligible days issue for the period from 10/1/2004 through 12/31/2004 for the three participants in that group to the subject appeal as they are not subject to CMS Ruling 1498-R.

Board Determination:

In accordance with your request, the Board has bifurcated the Part C Days issue from this group and has formed the "North Shore LIJ 2005 Part C Days CIRP" to which it has assigned case number 15-1844GC. The new group includes the two participants listed in this letter. Enclosed, please find a Group Acknowledgement (Common Issue Related Party (CIRP/Mandatory Group) letter.

With regard to case no. 10-0984GC, the dual eligible Part A days issue is not subject to remand pursuant to CMS Ruling 1498-R as patient discharges on or after October 1, 2004 are not covered by the Ruling. Please advise the Board once the group is complete.

Should you have any questions regarding this matter, please contact the Board at the above address or by telephoning (410) 786-2671.

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

For the Board:

Michael Harty
Chairman

cc: Kevin D. Shanklin, Executive Director, Blue Cross Blue Shield Association
Kyle Browning, Appeals Lead, National Government Services

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Refer to: 14-2828

APR 02 2015

CERTIFIED MAIL

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

James R. Ward
Appeals Resolution Manager
JF Provider Audit Appeals
Noridian Healthcare Solutions, LLC
P.O. Box 6722
Fargo, ND 58108-6722

RE: Jurisdictional Decision
Scottsdale Healthcare – Osborn Medical Center
Provider No.: 03-0038
PRRB Case No.: 14-2828
FYE: 9/30/2009

Dear Mr. Ravindran and Mr. Ward:

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

On August 30, 2013, the Medicare Contractor issued Scottsdale Healthcare – Osborn Medical Center's Notice of Program Reimbursement ("NPR") for the fiscal year end September 30, 2009. On September 10, 2013, the Medicare Contractor issued the Provider a revised NPR ("RNPR") to properly report bad debts.[1] On March 5, 2014, the Board received the Provider's appeal request in which it appealed both the NPR and RNPR. The Provider initially raised nine issues and identified all the issues as self-disallowed. On September 22, 2014, the Provider requested to transfer six issues to group appeals and to withdraw one issue from the appeal as follows:

Issue	*Disposition*
DSH/SSI (Provider Specific)	
DSH/SSI (Systemic Errors)	Transfer to 14-4372GC
DSH – Medicaid Eligible Days	
DSH – SSI Fraction/Medicare Managed Care Part C Days	Transfer to 14-4385GC
DSH – Medicaid Fraction/Medicare Managed Care Part C Days	Transfer to 14-4386GC
DSH – Medicaid Eligible Labor Room Days	Withdrawn
DSH – SSI Fraction/Dual Eligible Days	Transfer to 14-4388GC
DSH – Medicaid Fraction/Dual Eligible Days	Transfer to 14-4389GC
Outlier Payments – Fixed Loss Threshold	Transfer to 14-4387GC

[1] *See* RNPR adjustment report in Provider's appeal request at Tab 4.

On January 7, 2015, the Medicare Contractor submitted a jurisdictional challenge, and on February 4, 2015, the Provider submitted its jurisdictional response.

Medicare Contractor's Position

The Medicare Contractor challenges the Board's jurisdiction over this appeal and argues that it should be dismissed because the appeal request from the NPR was untimely filed 182 days after the presumed date of receipt of the NPR. Also, the RNPR, while timely filed, did not address the issues that were raised in the appeal.

Provider's Position

The Provider contends that its appeal was filed timely because the NPR and RNPR were intended to be merged into one final determination. Therefore, the date of issuance of the RNPR represents the issuance date of the NPR and the appeal should be deemed timely filed.

Board's Decision

Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, a hearing request must be filed with the Board no later than 180 days after the Provider has received its final determination. PRRB Rule 6.2 states, in pertinent part:

> For individual appeals, an appeal may be for only one cost reporting period. If multiple final determinations were issued on different dates for the cost reporting period being appealed (e.g., NPR, revised NPRs ...), separate appeal requests must be timely filed for each subsequent final determination.

The Provider is effectively requesting that the Board consolidate two separate Medicare contractor determinations into a single determination for purposes of establishing timeliness. However, each request for hearing must stand on its own and independently meet the timeliness requirements.

Per 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of a final determination is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier.

Here, the Provider's NPR was issued on August 30, 2013. Because the Provider has not provided any evidence to establish that the date of receipt of the NPR was actually later than five days from issuance by the Medicare Contractor, the presumed date of receipt was September 4, 2013. The appeal request was delivered via United Parcel Service and received by the Board on March 5, 2014. Thus, the date of filing was 182 days after the presumed receipt of the NPR. As the Provider did not timely file its appeal request from the NPR, the Board does not have jurisdiction over this portion of the appeal.

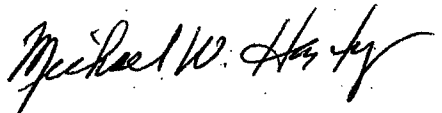
The Provider's RNPR was issued September 10, 2013, and since the Board received the appeal request on March 5, 2014, 171 days after the presumed day of receipt, the appeal from the RNPR was filed timely. However, the Provider's RNPR adjusted only bad debts. 42 C.F.R § 405.1889(b)(1) (2012) explains that, "[o]nly matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision." The Provider raised nine issues in its appeal, but none of those issues were actually adjusted in the RNPR. Therefore, the Board does not have jurisdiction over the appeal from the RNPR.

Since the Provider did not timely file its appeal request from its NPR and the issues raised were not adjusted in the RNPR, the Board has no jurisdiction over either determination raised in the appeal. The Board hereby dismisses Case No. 14-2828 in full. Consequently, the Board also denies the transfer requests to Case Nos. 14-4372GC, 14-4385GC, 14-4386GC, 14-4388GC, 14-4389GC and 14-4387GC.

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, BCBSA
Executive Director
Senior Government Initiatives
Blue Cross and Blue Shield Association
225 N. Michigan Ave.
Chicago, IL 60601-7680

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Refer to: 14-2829

CERTIFIED MAIL

APR 02 2015

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

James R. Ward
Appeals Resolution Manager
JF Provider Audit Appeals
Noridian Healthcare Solutions, LLC
P.O. Box 6722
Fargo, ND 58108-6722

RE: Jurisdictional Decision
Scottsdale Healthcare – Shea Medical Center
Provider No.: 03-0087
FYE: 09/30/2009
PRRB Case No.: 14-2829

Dear Mr. Ravindran and Mr. Ward:

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

On August 30, 2013, the Medicare Contractor issued Scottsdale Healthcare – Shea Medical Center's Notice of Program Reimbursement ("NPR") for the fiscal year end September 30, 2009. On September 10, 2013, the Medicare Contractor issued the Provider a revised NPR ("RNPR") to properly report bad debts.[1] On March 5, 2014, the Board received the Provider's appeal request in which it appealed both the NPR and RNPR. The Provider initially raised nine issues and identified all the issues as self-disallowed. On October 22, 2014, the Provider requested to transfer six issues to group appeals and to withdraw one issue from the appeal as follows:

Issue	*Disposition*
DSH/SSI (Provider Specific)	
DSH/SSI (Systemic errors)	Transfer to 14-4372GC
DSH – Medicaid Eligible Days	
DSH – SSI Fraction/Medicare Managed Care Part C Days	Transfer to 14-4385GC
DSH – Medicaid Fraction/Medicare Managed Care Part C Days	Transfer to 14-4386GC
DSH – Medicaid Eligible Labor Room Days	Withdrawn
DSH – SSI Fraction/Dual Eligible Days	Transfer to 14-4388GC
DSH – Medicaid Fraction/Dual Eligible Days	Transfer to 14-4389GC
Outlier Payments – Fixed Loss Threshold	Transfer to 14-4387GC

[1] *See* RNPR adjustment report in Provider's appeal request at Tab 4.

On January 8, 2015, the Medicare Contractor submitted a jurisdictional challenge, and on February 4, 2015, the Provider submitted its jurisdictional response.

Medicare Contractor's Position

The Medicare Contractor challenges the Board's jurisdiction over this appeal and argues that it should be dismissed because the appeal request from the NPR was untimely filed 182 days after the presumed date of receipt of the NPR. Also, the RNPR, while timely filed, did not address the issues that were raised in the appeal.

Provider's Position

The Provider contends that its appeal was filed timely because the NPR and RNPR were intended to be merged into one final determination. Therefore, the date of issuance of the RNPR represents the issuance date of the NPR and the appeal should be deemed timely filed.

Board's Decision

Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, a hearing request must be filed with the Board no later than 180 days after the Provider has received its final determination. PRRB Rule 6.2 states, in pertinent part:

> For individual appeals, an appeal may be for only one cost reporting period. If multiple final determinations were issued on different dates for the cost reporting period being appealed (e.g., NPR, revised NPRs ...), separate appeal requests must be timely filed for each subsequent final determination.

The Provider is effectively requesting that the Board consolidate two separate Medicare contractor determinations into a single determination for purposes of establishing timeliness. However, each request for hearing must stand on its own and independently meet the timeliness requirements.

Per 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of a final determination is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier.

Here, the Provider's NPR was issued on August 30, 2013. Because the Provider has not provided any evidence to establish that the date of receipt of the NPR was actually later than five days from issuance by the Medicare Contractor, the presumed date of receipt was September 4, 2013. The appeal request was delivered via United Parcel Service and received by the Board on March 5, 2014. Thus, the date of filing was 182 days after the presumed receipt of the NPR. As the Provider did not timely file its appeal request from the NPR, the Board does not have jurisdiction over this portion of the appeal.

The Provider's RNPR was issued September 10, 2013, and since the Board received the appeal request on March 5, 2014, 171 days after the presumed day of receipt, the appeal from the RNPR was filed timely. However, the Provider's RNPR adjusted only bad debts. 42 C.F.R § 405.1889(b)(1) (2012) explains that, "[o]nly matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision." The Provider raised nine issues in its appeal, but none of those issues were actually adjusted in the RNPR. Therefore, the Board does not have jurisdiction over the appeal from the RNPR.

Since the Provider did not timely file its appeal request from its NPR and the issues raised were not adjusted in the RNPR, the Board has no jurisdiction over either determination raised in the appeal. The Board hereby dismisses Case No. 14-2829 in full. Consequently, the Board also denies the transfer requests to Case Nos. 14-4372GC, 14-4385GC, 14-4386GC, 14-4388GC, 14-4389GC and 14-4387GC.

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
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Clayton J. Nix, Esq.
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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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RE: Jurisdictional Decision – Saint Bernadine Medical Center, *as a participant in* CHW 2001 DSH SSI Ratio CIRP Group
Provider No.: Various
FYE: 12/31/2001
PRRB Case No.: 06-0076GC

Dear Mr. Knight and Ms. Kalafut:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. The Board has found that it does not have jurisdiction over Saint Bernardine Medical Center because there was not a specific adjustment to the SSI percentage in Saint Bernardine Medical Center's revised Notice of Program Reimbursement ("NPR") appeal. The jurisdictional decision of the Board is set forth below.

Background

Saint Bernardine Medical Center was issued a revised NPR for FYE 12/31/2001 on February 26, 2009. The Provider filed an individual appeal request with the Board which included the SSI percentage issue. On September 21, 2009, the Provider requested to transfer the SSI percentage issue to this CHW 2001 DSH SSI Ratio CIRP Group appeal, case number 06-0076GC.

Board's Decision

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

Although the Medicare contractor did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over Saint Bernardine Medical Center (FYE 12/31/2001) because the

Provider appealed from a revised NPR in which there was not a specific adjustment to the SSI percentage. 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, in *Emanuel Med. Ctr. v. Sebelius*, 37 F. Supp. 3d 348, 357 (2014), the United States District Court for the District of Columbia held that the Department of Health and Human Services' interpretation of 42 C.F.R. § 405.1889 (2008) – that only matters actually revised in a revised NPR are subject to appeal – was reasonable and entitled to substantial deference.

In *Emanuel*, the Court held that the "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.

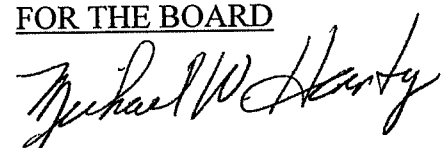
In the current appeal before the Board, the group representative did not submit any Medicare contractor work papers to document if a change in the SSI percentage for Saint Bernadine Medical Center was made in the revised NPR. This is the same scenario as in the *Emanuel* case. Because appeals from revised NPRs are limited to the specific matters revised in the revised determination the Board finds that it does not have jurisdiction over Saint Bernadine Medical Center since there was no evidence that SSI percentage was actually adjusted. As such, the Board dismisses Saint Bernadine Medical Center as a

participant in case number 06-0076GC. The case will remain open as there are other providers pending in the appeal.

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 this 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

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13-0508

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RE: Jurisdictional Decision
Chesterfield General Hospital
Provider No.: 42-0062
PRRB Case No.: 13-0508
FYE: 02/29/2008

Dear Mr. Hettich and Mr. Lamprecht:

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

On July 18, 2012, the Medicare contractor issued Chesterfield General Hospital's Notice of Program Reimbursement ("NPR") for the fiscal year end February 29, 2008. On January 14, 2013, the Board received the Provider's appeal from the NPR – the sole issue the Provider appealed was bad debts. On July 30, 2013, the Board received the Medicare Contractor's Jurisdictional Challenge. On August 27, 2013, the Board received the Provider's response to the Jurisdictional Challenge.

Medicare Contractor's Contentions

The Medicare contractor challenged the Board's jurisdiction over this individual appeal and argued that it should be dismissed because the Provider did not claim the bad debts it now seeks on its cost report.

Provider's Contentions

The Provider contends that, although it did not include the bad debts on its cost report, the Provider has a right to a Board hearing because, pursuant to *Bethesda*, providers can claim dissatisfaction without incorporating their challenge in the cost report filed with their Medicare contractors.

Board's Decision

42 U.S.C. §1395oo(a) establishes the Board's jurisdiction. It provides in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report . . .

After jurisdiction is established under 42 U.S.C. §1395oo(a) the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. §1395oo(d) which states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Provider did not claim bad debts it now seeks on its as filed cost report, nor did it claim bad debts as a protested item. As the cost was not claimed, there was no adjustment made to the cost by the Medicare contractor. In addition, the appeal request states that the Provider only found out after the fiscal year end that it should have claimed the bad debts now under appeal.

The Board finds that the Provider does not have a right to hearing on the bad debts issue under 42 U.S.C. § 1395oo(a). In Bethesda Hosp. Association v. Bowen, supra, the Provider failed to

claim a cost because a regulation dictated that it would have been disallowed. In that situation, the Supreme Court found section 1395oo(a) permitted jurisdiction over the "self disallowed" claim.

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.* (Emphasis added).

Id. at 1258, 1259.

The Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here. (Emphasis added).

Id. at 1259.

The Provider here stands "on different ground" than the Provider did in Bethesda, as in the instant case the Provider was not barred from claiming the bad debt. While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost unclaimed through inadvertence rather than futility, other appellate courts have done so.

The Ninth Circuit stated it was joining the First Circuit's view as expressed in MaineGeneral and St Luke's Hospital v. Secretary, 810 F.2d 325 (1st Cir. 1987). Id. MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The mistakes were not discovered until after the NPRs had been issued. Providers appealed several items adjusted by the NPRs but also included claims for the bad debts. The Board dismissed the bad debt claim for lack of jurisdiction because they had not been disclosed on the cost reports despite there being no legal impediment to doing so. The MaineGeneral court relied on its prior decision in St Luke's in which costs were self-disallowed, not inadvertently omitted. However, it found that the St. Luke's decision had nevertheless addressed the question of whether the Board has the power to

decide an issue that was not first raised before the intermediary and held that it does, but that the power is discretionary. The St. Luke's Court expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospitals had a strong equitable argument favoring review under the particular circumstances. St. Luke's at 332. "The statute [1395oo(d)] does not say that the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so." (Emphasis in original). St. Luke's at 327-328. The First Circuit in MaineGeneral advised that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The court further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued." MaineGeneral at 501. Similarly, St. Luke's opined that even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly. St. Luke's at 327.

In UMDNJ v. Leavitt, 539 F. Supp. 2d. 70 (D.D.C. 2008) (UMDNJ), the D.C. District Court reached the same conclusion as the First and Ninth Circuits. As in MaineGeneral and Loma Linda, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied but it also included costs for its clinical medical education programs which were omitted entirely from the cost report. The D.C. Court found guidance in the D.C. Circuit's decision in HCA Health Services of Oklahoma. Inc. v. Shalala, 27 F.3d 614 (D.C. Cir. 1994) that involved an appeal of a reopened intermediary decision. The D. C. District Court also refused the Provider's request for it to order the Board to hear a claim inadvertently omitted, saying "the Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis." UMDNJ at 79.

The Board takes from these cases the principle that a provider does not have a right to an appeal of an expense inadvertently omitted from the cost report or mistakenly reported. As the Ninth Circuit stated in Loma Linda, "There is no dispute that 1395oo(a) is the gateway provision for Board jurisdiction." Id at 1070. Nor does the case law stand for the proposition that §1395oo(d) is a grant of "alternate" jurisdiction. That view ignores the very essence of the Courts' holdings. These decisions make it clear the Board's power under §1395oo(d) is discretionary. The Board may hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is not required to hear those claims. Based on the circumstances of this case, the Board declines to exercise its discretionary authority. As bad debts was the sole issue in this appeal, the appeal is hereby dismissed.

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

Board Members Participating
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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, Blue Cross and Blue Shield Association

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APR 07 2015

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Re: Provider Name: Bismarck MedCenter One
Provider No.: 35-0015
FYE: 12/31/2007
PRRB Case No.: 13-2753

Dear Mr. Ravindran and Mr. Ward,

The Medicare Administrative Contractor, Noridian Healthcare Solutions (hereinafter "Noridian"), reopened the Provider, Bismarck MedCenter One's (hereinafter "Bismarck") fiscal year end 2007 cost report. Bismarck's cost report was reopened to " . . . revise the Medicaid days – based upon additional days identified as Medicaid eligible."[1] Noridian issued Bismarck's revised Notice of Program Reimbursement ("RNPR") on February 21, 2013. Bismarck timely appealed its RNPR to the Provider Reimbursement Review Board (hereinafter "Board"). Bismarck appealed the following three issues:

(1) DSH/SSI% (Provider Specific): whether the Contractor used the correct SSI% in Bismarck's DSH calculation;
(2) DSH/SSI% (Systemic Errors): whether the Secretary properly calculated the Provider's DSH SSI%; and,
(3) DSH – Medicaid eligible days: whether the Contractor properly excluded Medicaid

[1] Noridian's July Notice of Reopening at 1, Jul. 23, 2012 *attached to* Bismarck's Individual Appeal Request Tab 1, Jul. 29, 2009. Noridian also issued a separate Notice of Reopening on March 26, 2012 to revise the SSI fraction, which was later rescinded because the "newly released SSI% from [CMS] shows no change in the SSI ratio." *See* Noridian's March Notice of Reopening, Mar. 26, 2012 *attached to* Noridian's Jurisdictional Challenge Ex I-3; Noridian's Notice of Rescindment of Reopening of Cost Report, Jun. 26, 2012 *attached to* Noridian's Jurisdictional Challenge Ex I-4.

eligible days from the DSH calculation.[2]

Bismarck referenced audit adjustment numbers 4 and 5 in its appeal request.[3] Adjustment number 4 adjusted "Medicaid days per provider request and audit" and, adjustment number 5 adjusted "the SSI ratio and resulting DSH percentage per CMS and audit."[4]

The Board received several submissions of Model Form D – Requests to Transfer Issue to a Group Appeal.[5] Bismarck requested the following transfers:

(1) DSH/SSI (Adj. 5) to Case No. 13-2676G (QRS 2007 DSH Medicare Managed Care Part C Days);
(2) DSH/SSI (Adj. 5) to Case No. 14-1173G (QRS 2007 DSH SSI Fraction/Medicare Managed Care Part C Days);
(3) DSH/SSI (Adj. 5) to Case No. 14-1174G (QRS 2007 DSH SSI Fraction/Dual Eligible Days); and,
(4) DSH/SSI (Adj. 5) to Case No. 13-2679G (QRS 2007 DSH SSI Percentage).[6]

Noridian filed a Jurisdictional Challenge with the Board, claiming that no final determination or adjustment was made to Bismarck's DSH/SSI%.[7] Noridian cites to 42 C.F.R. § 405.1889, which states that a provider may only appeal those items specifically revised in a RNPR.[8] Noridian states that the only revision in Bismarck's RNPR was the inclusion of 163 additional Medicaid eligible days in the numerator of the DSH Medicaid fraction.[9] Further, Noridian states that by transferring one DSH/SSI% issue to several different group appeals, Bismarck improperly bifurcated the issue into several issues, namely: (1) SSI fraction *Baystate*; (2) SSI fraction Part C days; (3) SSI fraction dual eligible days; (4) Medicaid fraction Part C days; and, (5) Medicaid fraction dual eligible days.[10] Noridian requests that the Board dismiss the DSH/SSI% (Provider Specific) issue for lack of jurisdiction.[11]

Additionally, Noridian argues that Bismarck improperly appealed an additional 549

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[2] Bismarck's Individual Appeal Request Tab 3, Aug. 14, 2013.
[3] *Id.*
[4] *Id.*
[5] Bismarck's Transfer Requests, Mar. 6, 2014.
[6] *Id.*
[7] *See* Noridian's Jurisdictional Challenge, Jul. 24, 2014.
[8] *Id.* at 3-5 (citing 42 C.F.R. § 405.1889).
[9] *Id.* at 5 (Noridian calls Medicaid eligible days by a different term, Title XIX days).
[10] *Id.* at 3.
[11] *Id.* at 7.

Medicaid eligible days in its preliminary position paper, filed on March 14, 2014.[12] Noridian argues that this is a new set of days that were never previously presented to Noridian. Therefore, no final determination was made regarding those 549 days. Noridian requests that the Board determine that it lacks jurisdiction over the 549 Medicaid eligible days referenced in Bismarck's preliminary position paper.[13]

Bismarck filed a Jurisdictional Response, arguing that the Board does have jurisdiction because Noridian " . . . adjust[ed] the Provider's DSH calculation and the Provider is dissatisfied with the amount of DSH payments . . . ."[14] Bismarck states that it is entitled to appeal an item that it is dissatisfied with.[15] Bismarck does not address the specific regulations that apply to RNPR appeal rights.

Board's Determination

The Board determines that it lacks jurisdiction in this case.

The regulations provide an opportunity for a provider to obtain a RNPR through a reopening of its cost report. 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).
>
> . . . .
>
> (5) If a matter is reopened and a revised determination or decision is made, a revised determination or decision is appealable to the extent provided in § 405.1889 of this subpart.[16]

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[12] *Id.* at 6 (Noridian argues that Bismarck cannot prove dissatisfaction because it did not seek inclusion of these days through the reopening and, Noridian did not make a determination related to these days); Bismarck's Proof of Filing its Preliminary Position Paper, Mar. 14, 2014.
[13] Noridian's Jurisdictional Challenge at 6.
[14] Bismarck's Jurisdictional Response at 3, Aug. 5, 2014.
[15] *Id.*
[16] 42 C.F.R. § 405.1885(a)(1), (5) (2012).

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 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. [17]

These regulations provide that the Board only has jurisdiction over issues "specifically revised" in Bismarck's RNPR. Bismarck's cost report was reopened in order to "revise the Medicaid days – based upon additional days identified as Medicaid eligible."[18] Therefore, since "[o]nly those matters that are specifically revised"[19] are appealable, Bismarck may only appeal Medicaid eligible days. The Board finds that Bismarck improperly appealed DSH/SSI% because it was not specifically revised in the reopening.[20] Noridian states that:

> A review of the adjustment report [Ex. I-2 of Noridian's Jurisdictional Challenge] shows reopening adjustment number 4 was proposed to include 163 additional [Medicaid eligible] days on worksheet S-3 line 1 column 5. In addition, adjustment number 5 was proposed to amend the allowable DSH percentage reported on [worksheet] E part A line 4.03 from 6.66% to 7.04% to account for the inclusion of 163 additional [Medicaid eligible] days in the numerator of the Medicaid fraction. No other revisions were made

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[17] 42 C.F.R. § 405.1889; *see also* 42 C.F.R. § 405.1887(d), which states, "[a] reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening, but is not revised, is not within the proper scope of an appeal of a revised determination or decision . . . ;" *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).

[18] Noridian's July Notice of Reopening, Jul. 29, 2009 *attached to* Bismarck's Individual Appeal Request at Tab 1.

[19] 42 C.F.R. § 405.1889(b)(1).

[20] Noridian's Jurisdictional Challenge at 5 ("Based on the reopening work papers and the reopening adjustment report[,] it is clear the SSI ratio was not revised on February 21, 2013."). It should be noted that Bismarck appealed "DSH/SSI% Provider Specific" and "DSH/SSI% Systemic Errors" as two separate issues; however, the Board considers these to be the same issue since they are based on SSI data. The issue is really whether the Provider's SSI ratio was calculated properly; the Contractor is bound to use the SSI ratio provided by CMS. As previously stated, the SSI% reopening was rescinded; no revisions were made to DSH/SSI%. *Supra* n. 1.

to the cost report through the February 21, 2013 [RNPR].[21]

Although audit adjustment 5 refers to the SSI ratio in the memo line, the actual adjustment was solely to update Bismarck's DSH calculation as a result of the adjustment to the Medicaid fraction on Line 4.03.[22] The SSI% is reported on Line 4.00 of the cost report, and clearly was not revised in the adjustment report. The Board, therefore, hereby dismisses the DSH/SSI% issues for lack of jurisdiction. Consequently, the Board also denies Bismarck's transfer requests (all four related to the SSI%) for the same reason.

Bismarck also appealed Medicaid eligible days. The Board finds that Bismarck cannot meet the dissatisfaction requirement necessary for an appeal. Pursuant to 42 C.F.R. § 405.1835(a), 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 contractor; 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.[23] Bismarck claimed 163 Medicaid eligible days in its reopening request, and all 163 days were allowed by Noridian. Therefore, since Bismarck received all of the days it requested, the Board determines that Bismarck failed to demonstrate that it was "dissatisfied" with Noridian's determination.

Although 163 Medicaid eligible days were specifically revised in its RNPR, Bismarck stated, in its preliminary position paper, that it was appealing 549 additional Medicaid eligible days. The 549 Medicaid eligible days were never presented or considered by Noridian in the reopening.[24] Appeals of RNPRs are limited in scope to the matter at issue.[25] Applying this limitation, the Board finds that the matter at issue was 163 Medicaid eligible days allowed and revised by Noridian. Because none of the 549 new days were part of the original 163 days, the Board finds that it does not have jurisdiction over the Medicaid eligible days issue.[26] Further, Bismarck cannot appeal a new universe of days in its preliminary position paper.[27] Therefore, the Board finds that Bismarck is unable to meet the jurisdictional requirements under 42 C.F.R. §§ 405.1889 and 405.1835. The Board hereby dismisses the Medicaid eligible days issue from the appeal.

For the reasons stated above, the Board is precluded from taking jurisdiction in this case.

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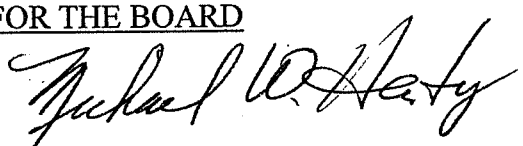
[21] Noridian's Jurisdictional Challenge at 5.
[22] *Id.*; *supra* n. 4.
[23] *See* 42 C.F.R. § 405.1835(a).
[24] *See* Noridian's Jurisdictional Challenge at 6.
[25] *See* 42 C.F.R. § 405.1889.
[26] *See Illinois-Masonic Medical Center v. Sebelius*, 859 F. Supp. 2d 137, 144-148 (2012) (holding that the Secretary reasonably determined that the additional days sought by the hospital were outside the scope of review of a RNPR). In *Illinois-Masonic*, the Provider appealed 2,244 Medicaid eligible days that were never reviewed by the Contractor. *Id.*
[27] Notwithstanding the limitation that the RNPR appeal is limited to the issue(s) revised in the reopening, Bismarck's appeal of 549 Medicaid eligible days was not properly added pursuant to 42 C.F.R. § 405.1835(c).

The Board hereby dismisses the appeal as all issues under appeal have been dismissed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 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 (without enclosures)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Internet: www.cms.gov/PRRBReview
Phone: 410-786-2671

Refer to: 15-0888

APR 08 2015

CERTIFIED MAIL

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

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

RE: Lovelace Westside Hospital
Provider No.: 32-0074
FYE: 01/31/2013
PRRB Case No.: 15-0888

Dear Mr. Ravindran and Mr. Tisdale,

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

Lovelace Westside Hospital was issued an original Notice of Program Reimbursement (NPR) for the fiscal year ending January 31, 2013 on July 2, 2014. On January 6, 2015, the Provider filed an appeal request with the Board appealing the following eight issues:

1. Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") (Provider Specific)
2. DSH/SSI (Systemic Errors)
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
4. DSH Payment - SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
8. Outlier Payments – Fixed Loss Threshold

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) (2014) and 42 C.F.R. §§ 405.1835-405.1840 (2014), a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is

dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the receipt of the final determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not challenge jurisdiction over the issues appealed, the Board nonetheless finds that it does not have jurisdiction over this appeal because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3) (2014) and PRRB rules, an appeal must be filed with the Board no later than 180 days after the provider has received its final determination. 42 C.F.R. § 405.1835(a)(3) (2014) states,

> (3) Unless the provider qualifies for a good cause extension, the date of the receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) (2014) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) (2014) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

In the instant case, Lovelace Westside Hospital was issued its NPR on July 2, 2014 and presumed to have received it on July 7, 2014. The Provider did not present evidence that the NPR was received later than the five day presumption. An appeal request from this original NPR was delivered by UPS and received by the Board on Tuesday, January 6, 2015. Thus, the date of filing was 183 days after the presumed date of receipt of the determination from the Medicare contractor.

Because the appeal request was not received by the Board within 180 days as required by 42 C.F.R. § 405.1835 (2014), the Board finds that it was not timely filed. The Board hereby dismisses the appeal and case number 15-0888 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.

FOR THE BOARD

Michael W. Harty

Charlotte F. Benson, CPA

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: 05-1509

CERTIFIED MAIL

APR 15 2015

Morgan, Lewis & Bockius LLP
Albert W. Shay
Partner
1111 Pennsylvania Avenue, NW
Washington, D.C. 2004

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

RE: Jurisdiction Challenge – University of Colorado
Provider No.: 06-0024
FYE: 06/30/2001
PRRB Case No.: 05-1509

Dear Mr. Shay and Mr. Tisdale,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in this appeal. The decision of the Board with regard to jurisdiction of the above mentioned Provider is set forth below.

Background

The Provider submitted a request for hearing on May 4, 2005, based on a Notice of Program Reimbursement (NPR) dated November 11, 2004. On August 23, 2011, the Medicare Administrative Contractor (MAC) challenged the Board's jurisdiction over the Disproportionate Share Hospital (DSH) – Medicaid eligible days issue. On August 29, 2011, the Provider submitted a responsive brief.

The Board finds that it has jurisdiction over University of Colorado (PN 06-0024, FYE 6/30/2001) because the Provider was able to establish they faced a practical impediment in gaining Medicaid eligibility data from the State of Colorado. The practical impediment prevented the Provider from reporting the correct number of DSH Medicaid eligible days on the as-filed cost report.

Intermediary's Position

The MAC asserts that the Board does not have jurisdiction over the DSH – Medicaid eligible days issue because there was no final determination for this issue. The MAC argues that it made no adjustment to the DSH payment on the cost report, and that the Provider was not precluded from claiming the additional payment for which it is now claiming in the appeal.

Provider's Postion

The Provider contends that the Board should accept jurisdiction consistent with *Bethesda Hospital et al. v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*"), in which the Supreme Court dealt with the Board's authority to hear appeals on matters that were not included on the cost report and were not he subject of an adverse intermediary determination. The Provider also references several prior PRRB jurisdictional decisions in which the Board majority found that within the preamble to the final rule implementing the DSH regulation, the Secretary stated that hospitals need not make a formal claim for the DSH adjustment.

Alternatively, the Provider argues that the MAC is being inconsistent in its assertions regarding jurisdiction for the DSH issue. The Provider indicates that it requested a reopening of the cost report in 2005, but the MAC denied the request stating the resolution of the issue was within the jurisdiction of the Board. It is fundamentally unfair for the MAC to reject the Provider's reopening request because the issue was included in an appeal that was within the jurisdiction of the PRRB, and then later argues that the Board has no jurisdiction to hear the issue.

Board's Decision

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§ 405.1835 – 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 ($50,000 for a group), and the request for a hearing is filed within 180 days after the date of receipt by the provider of the intermediary determination. 42 U.S.C. §1395oo(a) provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report.

The Board finds that pursuant to the rationale in *Barberton Citizens Hosp. vs. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015)("*Barberton*"), the Provider was able to establish a practical impediment in regards to their Medicaid eligible days.

In *Barberton* the Board states "pursuant to the concept of futility in *Bethesda*, the Board has jurisdiction of a hospital's appeal of additional Medicaid eligible days for the DSH adjustment calculation if that hospital can establish a "practical impediment" as to why it could not claim

these days at the time that it filed its cost report."[1]

The Provider detailed several unsuccessful attempts to gain access to the Medicaid eligible days from the State of Colorado prior to submitting their as-filed cost report. The Board determined that these attempts constituted the establishment of a practical impediment and therefore finds they have jurisdiction over the Medicaid eligible days issue in this case.

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
Charlotte Benson, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD,

Michael W. Harty
Chairman

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

cc: Robin Sanders, Esq., BCBSA

1 *Barberton* at 4.

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Refer to: 13-1904

APR 15 2015

CERTIFIED MAIL

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

RE: Union General Hospital
Provider No: 11-0051
FYE: 04/30/2007
PRRB Case No: 13-1904

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (PRRB) has reviewed the record in the above referenced case, including the appeal request, the authorization of representation letter, all transfer requests, etc, and has found the following:

Quality Reimbursement Services, Inc. (QRS), on behalf of the Provider, Union General Hospital (hereinafter "Union General"), filed an individual appeal request on May 7, 2013 from a revised Notice of Program Reimbursement (NPR) dated November 5, 2012. The appeal did not include a copy of the revised NPR, nor did it include the audit adjustment pages. Instead, the QRS supplied a copy of the HCRIS –DSH Report.

The appeal included the following issues:
--SSI Systemic Errors
--DSH SSI Percentage (Provider Specific) -realignment
--DSH Medicare Managed Care Part C Days (Medicaid & SSI Fraction)
--DSH Dual Eligible Days (Medicaid & SSI Fraction)
--Rural Floor Budget Neutrality Adjustment (RFBNA)
*Note: none of the issues reference audit adjustment numbers.

Included with the appeal was an authorization letter, dated July 6, 2012, appointing QRS as the designated representative for only the RFBNA in the context of both individual and any related group.

The Board acknowledged the appeal and assigned case number 13-1904 in an email to QRS dated May 7, 2013. On the same date, the Board sent a Request for Additional Information, requesting the Revised NPR information (the preceding Revised NPR, the Revised NPR, the Reopening request, etc.)

QRS responded to the Board's request for additional information, supplying the preceding NPRs and worksheets, but did not supply a copy of the revised NPR in dispute. (The Medicare Administrative Contractor (MAC) did submit the revised NPR, adjustment report and workpaper as exhibits to its jurisdictional challenge over the RFBNA issue).

On December 13, 2013, QRS requested the transfer of various issues from the individual appeal to group appeals as follows:
--DSH SSI Fraction Medicare Managed Care Part C Days to group case 14-1173G
--DSH SSI Fraction Dual Eligible Days to group case 14-1174G
--DSH SSI Percentage to group case 13-2679G
--DSH Dual Eligible Days to group case13-2678G
--DSH Medicare Managed Care Part C Days to group case 13-2676G
--Rural Floor Budget Neutrality issue to group case 13-3125G

The RFBNA group, case no. 13-3125G, was subsequently withdrawn and closed on March 24, 2015 in accordance with the CMS settlement of the RFBNA issue.

With regard to the SSI realignment issue, the Provider indicates that it is seeking data from CMS in order to reconcile its records and has not yet decided whether to request realignment (based upon the Provider's cost reporting period.) Because there is no final determination and the Provider has not yet requested realignment, the issue is prematurely appealed. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data.

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.

The Board finds that the appeal establishment of case no. 13-1904, was based upon a QRS appeal request for which they only had proper authorization to appeal the RFBNA issue. As noted above, the representation letter submitted with the appeal request solely identified RFBNA as the issue for which QRS could act on behalf of the Provider. The RFBNA issue was transferred to group case no. 13-3125G and was subsequently withdrawn on March 24, 2015 in accordance with the CMS settlement of the RFBNA issue.

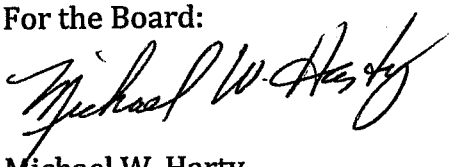
Therefore, the Board dismisses the following issues and denies the respective transfer requests as follows:

--DSH SSI Percentage (Provider Specific)[1]
--DSH SSI Fraction Medicare Managed Care Part C Days to group case 14-1173G
--DSH SSI Fraction Dual Eligible Days to group case 14-1174G
--DSH SSI Percentage to group case 13-2679G
--DSH Dual Eligible Days to group case13-2678G
--DSH Medicare Managed Care Part C Days to group case 13-2676G

Since there are no remaining issues, the Board hereby closes case no. 13-1904. 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: Renee Rhone, Cahaba Government Benefit Administrators, LLC
Kevin D. Shanklin, Blue Cross Blue Shield Association

[1] The Representative did not request the transfer of the Provider Specific SSI Percentage issue to a group.

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CERTIFIED MAIL

APR 16 2015

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

RE: Provider 6, University Medical Center, Provider No. 45-0686, FYE 12/31/1999, as a participant in "QRS 1999 Medicare DSH Labor Room Day Group II," PRRB Case No. 08-2604G

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents incident to the Board's own motion review of the group appeal which is subject to remand pursuant to CMS Ruling 1498-R. The Board's jurisdiction with respect to University Medical Center, provider number 45-0686, for the fiscal year ending (FYE) December 31, 1999, is set forth below.

Background

On May 14, 2010, a revised Notice of Program Reimbursement (NPR) was issued to University Medical Center for the cost reporting period ending December 31, 1999. On November 4, 2010, University Medical Center requested to join a group appeal, case number 08-2604G, from a direct appeal of the revised NPR.[1]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) (2009) and 42 C.F.R. § 405.1835-405.1841 (2009), 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 filed within 180 days of the NPR.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2009) provides in relevant part:

[1] The Provider listed May 7, 2010 as the date of the revised NPR on their Request to Join an Existing Group Appeal form. However, the Provider included a May 7, 2010 Notice of Reopening of Cost Report in the jurisdictional documents. The Provider did not supply the revised NPR. A review of the STAR database shows that there have been three revised NPRs issued for this Provider. The first revised NPR was issued on December 15, 2013; the second revised NPR was issued on April 29, 2009; and the third revised NPR which is the subject of this appeal was issued on May 14, 2010, not May 7, 2010.

> (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).

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889(a) (2009) states:

> [i]f 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 are applicable.
>
> § 405.1889(b)(1) explains the effect of a cost report revision: [o]nly 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.

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 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*, 37 F.Supp. 3d 348, 357 (D.D.C. 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 6, University Medical Center, Provider no. 45-0686, FYE December 31, 1999, appealed from an audit adjustment report (adjustment 5) that did not specifically adjust labor and delivery room days. The adjustment report shows an adjustment to the total disproportionate share percentage as reported on Worksheet E, Part A, Line 4.03, "[t]o adjust the DSH payment percentage in accordance with the administrative resolution for PRRB case 03-1353" but there is no proof that labor and delivery room days was specifically adjusted. The Board sent University Medical Center a letter on January 17, 2014, requesting that University Medical Center provide the Board with a copy of the May 14, 2010 revised NPR, the reopening work papers, and a copy of Worksheet E Part A for the May 14, 2010 revised NPR. The Provider's representative responded to the Board's letter on February 18, 2014, advising the

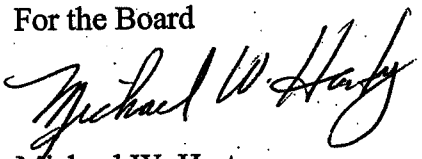
Board that they could not locate the May 14, 2010 revised NPR nor the work papers for the revised NPR. The Provider's representative stated that she believes that the May 14, 2010 revised NPR work papers are the same as the May 7, 2010 work papers provided to the Board, except that some days were disallowed for not being inpatient days. However, the labor room days stayed the same.

Per a review of the STAR database there have been three revised NPRs issued for University Medical Center. The first revised NPR was issued on December 15, 2003; the second revised NPR was issued on April 29, 2009; and the third revised NPR was issued on May 14, 2010. The original NPR was issued on January 14, 2003. The work papers provided in the jurisdictional documents for University Medical Center were provided for the January 14, 2003 original NPR and for the second revised NPR dated April 29, 2009, not the third revised NPR dated May 14, 2010, which is the subject of the appeal. As University Medical Center did not supply supporting documentation for the May 14, 2010 revised NPR to determine the full scope of the issues reviewed within the revised NPR process, the Board finds that it lacks jurisdiction over Provider 6, University Medical Center, Provider no. 45-0686, FYE 12/31/1999, and dismisses the Provider 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.

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: Bill Tisdale
Novitas Solutions, Inc.
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

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

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Refer to:

14-1243; 14-1164; 14-4347GC

APR 16 2015

CERTIFIED MAIL

Durham Regional Hospital
Galen Ezzell, Director
Reimbursement & Revenue Accounting
615 Douglas Street, Suite 700
Durham, NC 27705

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

Akin Gump Strauss Hauer & Feld
Stephanie Webster
1333 New Hampshire Avenue, NW
Suite 400
Washington D.C., 20036

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

RE: Durham Regional Hospital
Provider No: 34-0155
FYE: 06/30/09
PRRB Case Nos.: 14-1243; 14-1164; 14-4347GC

Dear Mr. Ezzell, Mr. Ravindran, Ms. Webster and Ms. Huggins:

The Provider Reimbursement Review Board (PRRB) has reviewed the records in the above identified cases, including all appeal requests, representation letters, transfer requests, etc, and has found the following:

McKay Consulting, on behalf of the Provider, Durham Regional Hospital (hereinafter "Durham Regional"), filed an individual appeal request on December 3, 2013. This appeal for fiscal year end 06/30/2009 was assigned case no. 14-1146.

Subsequently, on December 4, 2013, QRS filed a duplicate appeal for Durham Regional for the same fiscal year end, with an insufficient representation letter (QRS was not deemed the representative based on their representation letter and the Providers Reimbursement Director Galen Ezzell was made the representative). The duplicate case was assigned case no. 14-1243. In January, 2014, the Board found identified there were duplicate cases for this provider/FYE and consolidated 14-1243 with case no. 14-1146. Galen Ezzell of Durham Regional was informed in writing that case no. 14-1243 was closed and consolidated with 14-1146. Durham Regional was asked to reference only case no. 14-1146 in future correspondence with the Provider Reimbursement Review Board ("Board"), and was informed that the Board would correspond solely with McKay Consulting regarding the appeal.

The preliminary position paper in case 14-1164 was filed on August 19, 2014, and it briefed one issue, the issue of Medicaid eligible days in the disproportionate share hospital payment calculation.[1] The Board then received two Requests from QRS to transfer issues (outlier and Rural Floor Budget Neutrality (RFBNA)) from closed case no. 14-1243 on August 28, 2014. [2]

The Board finds that the appeal establishment of 14-1243, was based upon a QRS appeal request for which they did not have proper authorization to appeal the outlier issue. The representation letter submitted with the appeal request solely identified RFBNA as the issue for which QRS could act on behalf of the Provider. The Board notified the provider when the appeal was established that the representation letter provided did not cover the entire appeal, and an updated letter covering all issues must be submitted. The Provider failed to do so. Therefore, as the party who filed the appeal of the outlier issue had no authority to do so, and the representative failed to cure, the outlier issue is dismissed from 14-1164 (the appeal to which 14-1243 was consolidated) and the transfer of the outlier issue to PRRB appeal 14-4347GC is also denied. As Durham Regional for 6/30/09 was the sole provider in 14-4347GC, that appeal is hereby dismissed.

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

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

[1] The Preliminary Position Paper was filed by Akin Gump Strauss Hauer & Feld, LLP, as they were authorized as the representative for 14-1164 by the Provider on June 23, 2014.
[2] The RFBNA transfer was to group appeal 14-4112GC, which was subsequently withdrawn on March 4, 2015. Therefore the RFBNA issue and transfer is moot.

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, Blue Cross Blue Shield Association

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Refer to:

CERTIFIED MAIL

APR 20 2015

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

RE: Crouse Hospital, Provider No. 33-0203, FYE 12/31/2012, PRRB Case No. 15-0478

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

Blumberg Ribner, Inc. filed an individual appeal for Crouse Hospital on November 21, 2014. The Board established case number 15-0478 and issued an acknowledgement letter on December 3, 2014. The appeal is based on the MAC's failure to issue a timely determination. The appeal request did not include evidence of the date the Intermediary received the filed/amended cost report nor the date of the Intermediary's acceptance of the same cost report. 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. The Request for Additional Information allowed 30 days for the information to be submitted or advised that the appeal may be dismissed.

On December 26, 2014, Blumberg Ribner submitted a certification page via e-mail which does not provide evidence of the MAC's receipt date of the cost report or the MAC's acceptance of that 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(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. The referenced case does not meet the regulatory requirements.

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.

Board Rule 7.4 provides a list of required items to support an appeal from the lack of an Intermediary documentation:

- 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, ...

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.

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

For the Board:

Michael W. Harty
Chairman

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

cc: National Government Services
Kyle Browning
Appeals Lead
MP: INA102 – AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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CERTIFIED MAIL

APR 20 2015

Baptist Health System
Shaw Seely, CPA
Director of Reimbursement
800 Prudential Drive
Jacksonville, FL 32207

RE: **Baptist Health 2005 SSI CIRP Group**, PRRB Case No. 15-2125GC
Specifically:
Baptist Medical Center - Nassau, Provider No. 10-0140, FYE 9/30/2006, PRRB Case No. 08-2693; and
Baptist Medical Center, Provider No. 10-0088, FYE 9/30/2006, PRRB Case No. 10-0805

Dear Mr. Seely:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced CIRP group appeal. The Board's review and determination is outlined below.

Pertinent Facts:

The initial request for the CIRP Group Case No. 15-2125GC was filed with the Board on April 7, 2015. The CIRP group was established by transferring the SSI% issue from individual Case Nos. 10-0140 and 10-0088 to form the new CIRP group appeal. You also indicate that CIRP Group Case No. 15-2125GC is complete.

Board's Determination:

Upon review of the individual appeals referenced above, it was noted that the Board previously remanded the SSI% issue in both appeals in 2014. Therefore, your request to transfer the issue from the individual appeals to form the new CIRP group appeal is invalid.

Board Rule 12.5.B states:

> Providers that are commonly owned or controlled must bring a group appeal for any issue common to the related Providers and for which the amount in controversy for cost reporting period ended in the same calendar year is, in the aggregate, at least $50,000. *While one Provider may initiate a CIRP group; at least two different Providers must be in the group upon full formation.... (Emphasis added.)*

Since the SSI issue was remanded to the Intermediary in both individual appeals, the issues cannot be transferred to form a new CIRP Group Appeal. The Board therefore denies the transfer requests to form the new CIRP Group Appeal Case No. 15-2125GC. Since there are no remaining Providers, the Board closes Case No. 15-2125GC.

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: First Coast Service Options, Inc. - FL
Geoff Pike
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32231-0014

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

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Refer to:

CERTIFIED MAIL

APR 20 2015

Eastpoint Healthcare
Al Gancman
1800 Century Park East
6th Floor
Century City, CA 90067

RE: Pampa Regional Medical Center, Provider No. 45-0099

FYE 5/31/2012	PRRB Case No. 15-2033
FYE 12/31/2011	PRRB Case No. 15-2035
FYE 12/31/2010	PRRB Case No. 15-2034

Dear Mr. Gancman:

The Provider Reimbursement Review Board (the Board) is in receipt of the above-referenced appeal requests and notes a jurisdictional impediment in each case. The pertinent facts of these individual cases and the Board's determination are set forth below.

PERTINENT FACTS:

Eastpoint Healthcare filed individual appeals for Pampa Regional Medical Center on March 30, 2015. The appeal requests did not include copies of the final determination in dispute, the Notices of Program Reimbursement (NPRs).[1] The Representative included a "Provider NPR History Report" prepared by QRS. The Board established the above-referenced case numbers and issued acknowledgement letters on April 8, 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 final determination.

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

[1] On each appeal request, the Representative lined through part of the certification which attests that there are no other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on any of the same issues for a cost reporting period that ends in the same calendar year.

that does not comply. In the referenced individual cases, Eastpoint Healthcare 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 case numbers 15-2033, 15-2034 and 15-2035.

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

For the Board:
Michael W. Harty
Chairman

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

cc: Bill Tisdale, Novitas Solutions, Inc.
Kevin D. Shanklin, Executive Director, BC BS Association

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Refer to:

CERTIFIED MAIL APR 20 2015

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

Re: Southampton Hospital, Provider No: 33-0340, FYE 12/31/2012, PRRB Case No. 15-0466

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

Blumberg Ribner, Inc. filed an individual appeal for Southampton Hospital on November 21, 2014. The Board established case number 15-0466 and issued an acknowledgement letter on December 1, 2014. The appeal is based on the MAC's failure to issue a timely determination. The appeal request did not include evidence of the date the Intermediary received the filed/amended cost report nor the date of the Intermediary's acceptance of the same cost report. 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. The Request for Additional Information allowed 30 days for the information to be submitted or advised that the appeal may be dismissed.

On December 30, 2014, the Board received e-mailed information from New York State Department of Health, which does not provide evidence of the MAC's receipt date of the cost report or the MAC's acceptance of that 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(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. The referenced case does not meet the regulatory requirements.

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.

Board Rule 7.4 provides a list of required items to support an appeal from the lack of an Intermediary documentation:

- 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, ...

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.

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

For the Board:
Michael W. Harty
Chairman

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

cc: National Government Services
Kyle Browning
Appeals Lead
MP: INA102 – AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

BC BS Association
Kevin D. Shanklin
Executive Director
Senior Government Initiatives
225 North Michigan Avenue
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Refer to:

CERTIFIED MAIL

APR 24 2015

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

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

RE: Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R
Group Name: QRS HMA 2006 DSH SSI Percentage CIRP Group
Participant Nos. 9, 10, 11, 28, and 30
FYE: 12/31/2006
PRRB Case No.: 13-0309GC

Dear Byron Lamprecht and James C. Ravindran:

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

The issue in this group appeal is whether the Providers' Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) percentage was properly calculated. Five of the thirty-two providers have not supplied copies of the final determinations from which they are appealing under Tab A in the Schedule of Providers. They are:

1) Heart of Florida Regional Medical Center (Provider No. 10-0137), Participant No. 9, Notice of Program Reimbursement (NPR) dated September 18, 2007,

2) Pasco Regional Medical Center (Provider No. 10-0211), Participant No. 10, NPR dated August 1, 2008,

3) Seven Rivers Regional Medical Center (Provider No. 10-0249), Participant No. 10, NPR dated September 18, 2007,

4) Harton Regional Medical Center (Provider No. 44-0144), Participant No. 28, NPR dated September 17, 2007, and

5) Medical Center of Mesquite (Provider No. 45-0031), Participant No. 30, NPR dated February 29, 2008.

Board Determination:

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 from the date of receipt of the final determination.

Regarding Participant Nos. 9, 10, 11, 28 and 30, the Board is not able to make a determination that these Providers have filed a jurisdictionally valid appeal because they did not submit their NPRs to the Board with the Schedule of Providers. PRRB Rule 20 indicates that the Providers in a group appeal must submit a Schedule of Providers to the Board, and PRRB Rule 21 outlines what should be included on the Schedule as well as the supporting documentation that should be submitted. Because of the missing documentation, the Board hereby dismisses Heart of Florida Regional Medical Center, Pasco Regional Medical Center, Seven Rivers Regional Medical Center, Harton Regional Medical Center, and Medical Center of Mesquite from this group appeal. The remaining participants in the appeal are subject to remand pursuant to CMS-1498-R. Enclosed please find the Board's remand under the standard procedure.

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: Standard Remand of SSI Fraction for case no. 13-0309GC
Schedule of Providers
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BCBSA (w/ Enclosures)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 09-0419

APR 24 2015

CERTIFIED MAIL

Blumberg Ribner, Inc.
Isaac Blumberg
Chief Operating Office
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: Jurisdictional Decision
Provider No.: 05-0235
FYE: 12/31/2005
PRRB Case No.: 09-0419

Dear Mr. Blumberg and Ms. Kalafut:

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

Background

Providence St. Joseph's Medical Center was issued a Notice of Program Reimbursement ("NPR") for FYE 12/31/2005 on June 16, 2008. On November 19, 2008, the Provider filed an appeal request with the Board in which it appealed the following issues:

- SSI Realignment
- Medicare/Medicaid Dual Eligible Patient Days
- Labor & Delivery Room (LDR) Days

On February 6, 2009, the Provider requested to add the SSI Percentage issue to its appeal and also established the Providence Health & Services 2005 SSI Percentage Group Appeal, to which the Provider transferred the SSI Percentage issue (case number 09-0831GC). On July 27, 2009, the Provider filed a request to transfer the dual eligible days issue to a group appeal (case number 09-0937GC). The only two issues that remain in the appeal are the SSI Realignment and the LDR Days issues.

Decision of the Board

SSI Realignment

The Board finds that it does not have jurisdiction over the SSI Percentage Provider Specific issue and dismisses the issue from case number 09-0419. The Provider appealed this issue using the

following language:

> The Disproportionate Share Adjustment is calculated according to a formula that includes the determination of a hospital's "disproportionate share percentage" 42 U.S.C. §1395 ww(d) (5) (F)(vi). This percentage is defined as the sum of the Medicaid fraction, and the Medicare fraction. The Provider contends that its Medicare fraction has not been calculated in accordance with Medicare regulations and Manual provisions as described in 42 CFR Section 412.106.
>
> Specifically, the Provider contends that the Federal Fiscal Year SSI percentage used by the Fiscal Intermediary to settle the cost report is understated. Finally, the Provider is requesting the MEDPAR data underlying its SSI Percentage and after reviewing this data will decide whether to request a realignment of its SSI Percentage.

The Board finds that, to the extent the Provider is arguing that the SSI Percentage is understated and that it needs the underlying data to determine what records were not included, the issue is the same as the SSI Percentage issue that was transferred to case number 09-0831GC. The basis of each issue is that the Provider does not have the underlying data and cannot determine if the Percentage is understated.

To the extent the Provider is preserving its right to request realignment if it so chooses once the data is made available, the Board finds that it does not have jurisdiction over the issue as it is premature. The SSI realignment issue is premature because the Medicare contractor has not yet issued a final determination as there is no indication that the Provider has requested realignment.[1] The Board hereby dismisses the SSI Realignment issue from case number 09-0419.

Labor & Delivery Room Days

The Labor & Delivery Room Days issue is subject to remand pursuant to CMS Ruling 1498-R and will be addressed under separate cover.

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.

---

[1] *See* 42 C.F.R. § 405.1835, which 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."

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
Executive Director
Senior Government Initiatives
Blue Cross and Blue Shield Association
225 N. Michigan Ave.
Chicago, IL 60601-7680

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Refer to:

CERTIFIED MAIL

APR 24 2015

Sutter Health
Wade H. Jaeger
Reimbursement Manager, Appeals/Litigation
P.O. Box 619092
Roseville, CA 95747

RE: Sutter Health 2004 DSH - Dual Eligible Days CIRP Group, PRRB Case No. 10-0421GC
Sutter Health 2005 DSH - Dual Eligible Days CIRP Group, PRRB Case No. 10-0419GC

Dear Mr. Jaeger:

The Provider Reimbursement Review Board (Board) has begun a review of the above-captioned group appeals which challenge the exclusion of Medicare dual eligible days (where the patient was eligible for Medicaid but whose Part A benefits were exhausted or were in a Medicare HMO or had no Part A paid claim) from the calculation of the disproportionate share (DSH) percentage. This issue, for patient discharges before October 1, 2004, is subject to the Centers for Medicare & Medicaid Services (CMS) Ruling CMS 1498-R. Discharges on or after October 1, 2004 are not covered by the Ruling. Upon review, the Board notes that case no. 10-0421GC is made up of Providers that have partial periods that are not covered by the Ruling. The Board's determination is set forth below.

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 Intermediary's final determination.

CMS Ruling 1498-R – Patient Discharges Prior to October 1, 2004:

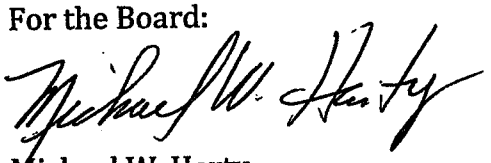
As noted above, the Dual Eligible Days issue, for patient discharges before October 1, 2004, is subject to the Centers for Medicare & Medicaid Services (CMS) Ruling CMS 1498-R. Discharges on or after October 1, 2004 are not covered by the Ruling. Because the Ruling affects a portion of the FYEs under appeal in case no. 10-0421GC, the Board is bifurcating the period from 10/1/2004 through 12/31/2004 for all participants in this group and is transferring the post-Ruling period to case number 10-0419GC, The Sutter Health 2005 DSH –Dual Eligible Days CIRP.

The group name for case no. 10-0421GC is being modified to reflect the periods remaining under appeal and is now called the Sutter Health Pre-10/1/2004 DSH - Dual Eligible Days CIRP. The Parties will receive correspondence regarding the applicability of CMS Ruling 1498-R to the participants in case number 10-0421GC under separate cover.

The group name for case no. 10-0419GC is being modified to reflect the inclusion of the period from 10/1/2004 through 12/31/2004. Please be sure the Schedule of Providers and jurisdictional documentation you file for case no. 10-0419GC is reflective of the additional participants for this period.

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

For the Board:



Michael W. Harty
Chairman

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL APR 29 2015

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

RE: Moses Taylor Hospital, Provider No. 39-0119, FYE 12/31/2011, Case No. 15-2196

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (the Board) is in receipt of the above-referenced appeal request and notes a jurisdictional impediment. The pertinent facts of the individual case and the Board's determination are set forth below.

PERTINENT FACTS:

Blumberg Ribner filed an individual appeal for Moses Taylor Hospital on April 10, 2015. The appeal request did not include a copy of the NPR.[1] The Board established case number 15-2196 and issued an acknowledgement letter on April 16, 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 final determination.

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 Ribner 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:

---

[1] In the cover letter to the appeal, the Representative stated "Please note the missing documents will be sent under separate cover."

> 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.

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

For the Board:
Michael W. Harty
Chairman

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

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

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: 14-0004

APR 29 2015

CERTIFIED MAIL

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Noridian Healthcare Solutions, LLC
James R. Ward
Appeals Resolution Manager
JF Provider Audit Appeals
P.O. Box 6722
Fargo, ND 58108-6722

RE: Jurisdictional Decision
Provider No.: 46-0009
FYE: 06/30/2009
PRRB Case No.: 14-0004

Dear Ms. Viskochil and Mr. Ward:

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

Background

University of Utah Hospital was issued a Notice of Program Reimbursement (NPR) for FYE 06/30/2009 on April 12, 2013. On October 9, 2013, the Provider filed an appeal request with the Board in which it appealed the following issues:

- Disproportionate Share Hospital (DSH)/SSI Percentage (Provider Specific),
- DSH/SSI Percentage (Systemic Errors),
- Rural Floor Budget Neutrality Adjustment (RFBNA),
- DSH Medicare Managed Care Part C Days, and
- Outlier Payments – Fixed Loss Threshold.

On June 17, 2014, the Provider filed a request to transfer various issues in the appeal to group appeals, including:

- DSH/SSI Fraction/Medicare Managed Care Part C Days issue to case number 13-3928G,
- DSH SSI Percentage Group issue to case number 13-3931G,
- DSH Medicaid Fraction Medicare/Managed Care Part C Days issue to case number 13-3941G,
- DSH Medicaid Fraction/Dual Eligible Days issue to case number 13-3942G,
- DSH SSI Fraction Dual Eligible Days issue to case number 13-3944G, and
- Outlier Payments – Fixed Loss Threshold to case number 14-0728G.

On February 27, 2015, the Provider requested to withdraw the RFBNA issue from its appeal, leaving the DSH/SSI Percentage (Provider Specific) as the sole remaining issue in the appeal.

Decision of the Board

The Board finds that it does not have jurisdiction over the SSI Percentage Provider Specific issue and dismisses the issue from case number 14-0004. The Provider appealed this issue using the following language:

> The Provider contends that its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation. The Provider contends that the SSI percentage issued by CMS flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.

The Board finds that, to the extent the Provider is arguing that the SSI Percentage is understated and that it needs the underlying data to determine what records were not included, the issue is the same as the Systemic Errors issue that was transferred to case number 13-3931G. The basis of each issue is that the Provider does not have the underlying data and cannot determine if the Percentage is understated.

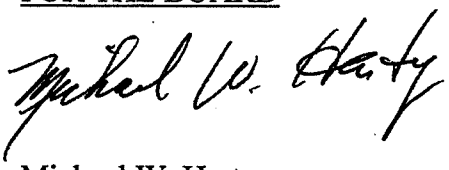
To the extent the Provider is preserving its right to request realignment if it so chooses once the data is made available, the Board finds that it does not have jurisdiction over the issue as it is premature. The SSI realignment issue is premature because the Medicare contractor has not yet issued a final determination as there is no indication that the Provider has requested realignment.[1] The Board hereby dismisses the SSI Provider Specific/Realignment issue from case number 14-0004 and closes the appeal as it was the last remaining issue.

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.

[1] *See* 42 C.F.R. § 405.1835, which 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."

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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APR 29 2015

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RE: Trinity Hospital Holding 2006 Dual Eligible CIRP Group, Case No. 09-2268GC

Trinity Health System, Provider No. 36-0211, FYE 12/31/2006, Case No. 09-0732

Dear Messrs. McKay and Keough:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal in response to correspondence from McKay Consulting, Inc. (McKay) regarding the inclusion of the Medicare Advantage Days sub-issue in the subject Dual Eligible Days group. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Trinity Hospital Holding 2006 Dual Eligible CIRP Group was filed on September 21, 2009 by McKay. The first participant used to form the group was Trinity Hospital Holding Company (36-0211) for FYE 12/31/2006.[1] The issue description included with the appeal request relates to the treatment of patient days for individuals considered eligible for both Medicare Part A and Medicaid for purposes of computing the Medicare Disproportionate Share (DSH) adjustment (Dual Eligible Days). The statement covers four categories of days:

- Exhausted Benefit Days
- Medicare Secondary Payer Days
- Medically Unnecessary or Custodial Care Days and
- Medicare Part C Days

The Board assigned case number 09-2268GC and issued a Group Acknowledgement (Common Issue Related Party(CIRP/Mandatory Group)) letter on September 23, 2009.

In May 2013, McKay requested that the subject group appeal be part of a Case Management Plan. As part of the plan, the Representative was required to submit periodic status reports on those groups that were incomplete. McKay submitted status reports on September 30, 2013, December 30, 2013, March 31, 2014, June 20, 2014, September 10, 2014 and December 12, 2014. In the status reports, McKay advised that the subject group contains

[1] The Provider's name is now Trinity Health System.

only one participant. The only other related hospital in the system (St. Joseph Hospital) appealed the dual eligible days issue in the Swedish 2005 Medi-Medi Group, case number 08-2000G.[2] McKay also advised that the subject group contains both the Dual Eligible Part A and Medicare Advantage (HMO or Part C) Days issue and requested the bifurcation of the Part C Days issue. In the status reports filed after June 2014, McKay advised that the sole participant in the group, Trinity Health System, is no longer contesting the Part A Dual Eligible Days issue. Therefore, McKay is requesting the bifurcation of the Part C Days issue from the group, the transfer of the Part C Days issue for the sole participant to the Provider's pending individual appeal (case number 09-0732) and the withdrawal of the Dual Eligible Days issue from case number 09-2268G. This would result in the closure of the group appeal.[3]

Board Determination:

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

In accordance with McKay's request, the Board is bifurcating the Medicare Advantage (HMO) or Part C Days issue from the Dual Eligible Days CIRP. Since Trinity Health System (36-0211) is the only participant in the chain pursuing the Part C Days, the Board is transferring the Part C Days issue to the pending individual appeal, case number 09-0732.[4] The Representative is advised to file a supplemental position paper on the Part C Days issue with the Board and the Intermediary within 30 days of the date of this letter. The Intermediary's supplemental position paper is due to the Board and the Representative 30 days later. Failure of the Representative to file a timely supplemental position paper will result in dismissal of the Part C Days issue.

As indicated in the pertinent facts section above, McKay has requested the withdrawal of the Dual Eligible Days issue for Trinity Hospital Holding Company. As there are no participants remaining in the Trinity Hospital Holding 2006 Dual Eligible CIRP Group, the Board is closing case number 09-2268GC.

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.

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[2] The group representative for the optional group is Salvatore G. Rotella, Jr. of Reed Smith.
[3] The individual appeal, case number 09-0732, was previously scheduled for hearing so final and supplemental position papers have already been submitted by both Parties.
[4] The group representative for the Provider's individual appeal is Akin, Gump, Strauss, Hauer & Feld, LLP

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: Judith Cummings, CGS Administrators
Kevin D. Shanklin, Executive Director, BC BS Association