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

Refer to: 10-1033

CERTIFIED MAIL

JUN 03 2015

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1875 Century Park East
Los Angeles, CA 90067-2799

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

RE: Jurisdiction Decision – Pomona Valley Hospital Medical Center
Provider No.: 05-0231
FYE: 12/31/2004
PRRB Case No.: 10-1033

Dear Mr. Getzoff and Ms. Kalafut,

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

BACKGROUND

The Provider filed its initial appeal on May 11, 2010, for its cost reporting period ending December 31, 2004, from a notice of program reimbursement ("NPR") dated November 24, 2009. The Provider initially sought to appeal the following:

1. DSH Adjustment-Unmet Share of Cost
2. DSH Adjustment-Dual Eligible Days (Medicare Part B, Secondary Payor, Unpaid/Denied Part A Days)
3. DSH Adjustment-Out of State Medicaid days
4. DSH-Title XIX aid codes no longer reported as Title XIX
5. DSH Adjustment-Labor Room Days
6. DSH Adjustment-SSI Percentage
7. DSH Adjustment-Medical Assistance Days
8. Unbilled Medicare Crossover Bad Debts
9. Outpatient Physical Therapy Fee Scheduled Bad Debts
10. Medicare and HMO Crossover Bad Debts
11. Interns and Residents-Unavailable Beds
12. Wage Index-Rural Floor

On July 18, 2014, the Provider submitted a response to Alert 10.

On November 25, 2014, the Board remanded the following issues:

2. DSH-Dual Eligible – Unpaid/Denied Part A Days & MSP

5. DSH-Labor Room Days
6. DSH-SSI Percentage

On March 23, 2015, the Parties entered into a Partial Administrative Resolution ("AR") agreement.[1] The Partial AR resolved the following issues:

1. DSH Adjustment-Unmet Share of Cost
2B. DSH Adjustment-Part B Only
3. DSH-Out of State Medicaid Days
11. Interns and Residents-Unavailable Beds

The following issues were withdrawn in the Partial AR:

4. DSH Title XIX Aid Codes No Longer Reported
7. DSH Adjustment-General Medical Assistance Days
8. Unbilled Crossover Bad Debts
9. Physical Therapy Fee Schedule Bad Debts
10. Medicare/HMO Crossover Bad Debts
12. Wage Index-Rural Floor

Issue 2 – DSH Medicaid Eligible Days (Part C Dual Eligible Days)[2]

On page 4 of the Partial AR there is a statement under the heading of Unresolved Issues – "The MAC is questioning jurisdiction over this issue. The Provider requests that the issue be resolved in the event the PRRB determines that jurisdiction exists. The Provider proposes that it ask the PRRB to find jurisdiction, and that the MAC agree to include verifiable Part C dual eligible days in the DSH adjustment calculation if and only if the PRRB finds jurisdiction over this issue in Case No. 10-1033."

Board Decision:

Pursuant to 42 U.S.C. 1395oo(a) and 42 C.F.R. 405.1835-1840, a provider has a right to hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is filed within 180 days of the date of the NPR. Pursuant to 42 U.S.C. 1395oo(d), once the Board has jurisdiction over a disputed cost report under 1395oo(a), the Board may affirm, modify, or reverse a final decision of the fiscal Medicare contractor with respect to that cost report, and make any other revisions on "matters covered by such cost report" (that is, a cost or expense that was incurred within the period for which the cost report was filed) even if such matters were not considered by the Medicare contractor in making a final determination.

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[1] *See* attached Partial AR.
[2] *See* attached Partial AR at 4.

The Provider, in its initial appeal request, described issue 2 DSH Adjustment – Dual Eligible Days (Medicare Part B, Secondary Payor, Unpaid/Denied Part A Days) as:

> "Under the Medicare statute, the numerator of the Medicaid proxy includes all patients who were eligible for medical assistance under a Medicaid plan, but who are not entitled to Medicare Part A benefits. In accordance with 42 C.F.R. § 412.106(b)(4) and HCFAR 97-2, the Provider contends that the Intermediary incorrectly excluded 255 days from the Medicaid percentage based on the erroneous determination that the patients associated with these days were entitled to Medicare Part A benefits. ... 74 days were associated with patients who were Medicaid-eligible but had exhausted their Medicare Part A benefits. ...7 days erroneously excluded ... Part B services ... days for which another part was the primary payor ... 82 days that fall into this category. ... patients eligible for both Medicare and Medicaid, days for which Medicare Part A coverage was denied or unpaid days from the Medicaid proxy. ..."

The appeal request did not make any reference of an appeal of Medicare Part C or HMO days. As the Medicare Part C days issue was not raised in the appeal request, or timely added, the Board finds that the Medicare Part C days issue is not properly pending in this appeal.

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

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

The Provider's NPR was issued on November 24, 2009, which makes the deadline for adding issues to its appeal July 22, 2010. The Provider raises the Medicare Part C issue for the first time when it submitted its response to Alert 10 on July 18, 2014[3] which is well after the deadline for adding issues had passed. Therefore, the Board finds that the issue was not timely added, and it lacks jurisdiction over the Medicare Part C Days issue. All issues have been remanded, resolved or withdrawn from the subject appeal. The Board hereby closes Case No. 10-1033.

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

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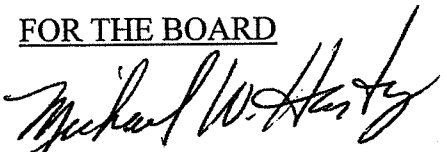
[3] *See* Response to Alert 10 at 2.

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

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Refer to: 14-4194

JUN 03 2015

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Geoff Pike
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32231-0014

RE: Jurisdictional Decision – Wuesthoff Memorial Hospital
Provider No.: 10-0092
FYE: 9/30/2012
PRRB Case No.: 14-4194

Dear Mr. Carlton and Mr. Pike,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The Board finds that Wuesthoff Memorial Hospital's appeal was not timely filed. The decision of the Board is set forth below.

Background

On February 27, 2013, the Medicare Administrative Contractor ("MAC") received Wuesthoff Memorial Hospital's cost report. On August 27, 2014, Wuesthoff Memorial Hospital filed an individual appeal request with the Board.

Board's Decision

The Board finds that it does not have jurisdiction over this appeal because it was not timely filed from the non-issuance of the Provider's Notice of Program Reimbursement ("NPR").

42 C.F.R. 405.1835(a)(3)(ii) (2014) governs when the MAC fails to issue an NPR, as is the case here. It states:

> If the contractor determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the contractor 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 contractor determination.* (Emphasis added).

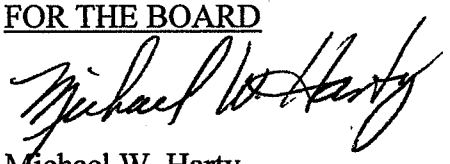
In the instant case, the MAC received the Provider's cost report on February 27, 2013 and had one year (until February 27, 2014) to issue its NPR but never did so. Therefore, the Provider had within 180 days of February 27, 2014 to file its appeal request with the Board (until August 26, 2014).

The Board received the Provider's appeal 181 days later, on August 27, 2014, which is outside the 180 day timeframe. Because Wuesthoff Memorial Hospital did not timely file its appeal request, the Board finds that it does not have jurisdiction and dismisses this Provider's individual 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.

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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Refer to: 14-2769

JUN 03 2015

CERTIFIED MAIL

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

RE: Iberia Medical Center
Provider No. 19-0054
FYE 9/30/2010
PRRB Case No. 14-2769

Dear Mr. Ravindran and Mr. Tisdale

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 outlier payments issue.[1] The Board finds that it does not have jurisdiction over the outlier payments issue. The decision of the Board is set forth below.

BACKGROUND

The Provider filed its initial appeal on March 4, 2014, for its cost reporting period ending 9/30/2010, from a Notice of Program Reimbursement (NPR) dated September 5, 2013. The Provider initially appealed the outlier payments and Rural Floor Budget Neutrality Adjustment (RFBNA) issues. The Provider withdrew the RFBNA issue, which leaves the outlier payments as the only issue in the appeal.

MEDICARE CONTRACTOR'S JURISDICTIONAL CHALLENGE

The Medicare contractor challenges the Board's jurisdiction over this individual appeal and argues that it should be dismissed because the Provider did not claim the outlier payments issue as a protested item on its cost report and therefore the Medicare Contractor did not adjust the outlier payments issue.

PROVIDER'S RESPONSE TO JURISDICTIONAL CHALLENGE

The Provider contends that it has received fewer and substantially lower outlier case payments than it should have. The Provider states that the erroneously computed outlier payments were not costs which could be claimed on its cost report, and that the Board's jurisdiction is not contingent upon the Provider claiming each disputed item in the cost report. The Provider cites *Bethesda Hospital Ass'n v. Bowen*,

[1] The MAC also challenged the Board's jurisdiction over the Rural Floor Budget Neutrality Adjustment issue, however the Provider requested to withdraw that issue on March 2, 2015, therefore the jurisdiction challenge is moot.

485 U.S. 399 (1988) and asserts that the 2009 revised regulations in 42 C.F.R. §405.1835(a)(1) are inconsistent with the plain language of the governing statute, and there is no requirement for a provide to submit a claim first to its Contractor in order to preserve an appeal right.

BOARD'S DECISION:

The Board finds that it does not have jurisdiction over the outlier payment issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i) (2009) or 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

The Provider states that adjustments made by the Contractor regarding its outlier payments were covered by Adjustment Nos. 3, 18, 20, 26, 28, 29 and 37;[2] however, upon review of those adjustment numbers form the attached adjustment report, none of these items reference the outlier payments.[3] Even if the Medicare contractor did make a PS&R adjustment to the outliers line, that adjustment would have only been to adjust the paid outliers PS&R and would not have specifically adjusted the contested outlier payments that are under appeal. The Provider admits that it did not "claim" the outlier payments it is now requesting and states that it could not have claimed those disputed payments on the cost report. The Board does not agree with this argument. The Provider indicates that it was under-reimbursed for outlier claims, and could have computed an estimate and included them as a protested amount, but failed to do so. Those payments were not claimed and therefore were not adjusted by the Medicare contractor as required by 42 C.F.R. §405.1835(a)(1)(i) (2009) and 42 C.F.R. §405.1835(a)(1)(ii).

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. §405.1835(a)(1)(ii) (2009) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." Here, the Provider's cost report was for FYE September 30, 2010; therefore, any self-disallowed items are required to be protested. The Provider failed to file the outlier payments issue under protest. Therefore, the Provider failed to preserve its rights and lacks any legal basis to appeal the item to the Board under 42 C.F.R. § 405.1835(a)(1)(ii) for self-disallowed costs. The Provider argues that the 2008 regulation requiring a provider to claim an item on its cost report in order to preserve its appeals rights is inconsistent with the PRRB statute; however, the Board is bound by the regulation and finds that the Provider failed to meet it.

The Board finds that it does not have jurisdiction over the last issue in the appeal, the outlier payments issue. The Board hereby dismisses the issue and closes case number 14-2769.

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

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[2] Provider's Jurisdictional Response, Tab 4.

[3] Adjustment 20 is the adjustment to the PS&R on W/S E Part A, but the provider only included the first page of that audit adjustment and not the portion which would have possibly adjusted the outliers line.

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 .1877

cc: Kevin Shanklin, Managing Director, BCBSA

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JUN 04 2015

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RE: University of Utah Hospitals and Clinics
Provider No: 46-0009
FYE: 6/30/2010
PRRB Case No.: 14-2781

Dear Mr. Ravindran and Mr. Ward:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional briefs of the parties in the above-referenced appeal. The Board finds that it has jurisdiction over University of Utah Hospitals and Clinics' individual appeal because the appeal was timely filed.

Background

On August 29, 2013, a Notice of Program Reimbursement ("NPR") was issued to University of Utah Hospitals and Clinics (Provider No. 46-0009) for the cost reporting period ending June 30, 2010. On March 4, 2014, University of Utah Hospitals and Clinics filed an appeal of the NPR challenging four issues:

1. Disproportionate Share Hospital ("DSH") – Supplemental Security Income ("SSI") Percentage[1];
2. DSH – Medicare Managed Care Part C Days;
3. Rural Floor Budget Neutrality Adjustment ("RFBNA"); and
4. Outlier Payments – Fixed Loss Threshold.

The Board assigned Case No. 14-2781 to the appeal. On October 22, 2014, University of Utah Hospitals and Clinics requested to transfer issues from this individual appeal to the following group appeals:

[1] The statement of the issue for Issue No. 1, SSI Percentage, addressed multiple sub-issues, including fundamental accuracy problems with SSI calculation, the treatment of Medicare exhausted benefit and secondary payer days in both the SSI fraction and the Medicaid fraction of DSH, and the treatment of Medicare managed care Part C days in both the SSI fraction and the Medicaid fraction. The treatment of Medicare managed care days in both fractions of the DSH calculation was also separately raised as Issue No. 2.

Issue No.	Group Name and Case No.
1A.	QRS 2010 DSH SSI Percentage (Baystate) Group, Case No.14-1815G
1B.	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group, Case No. 14-1818G
1C.	QRS 2010 DSH SSI Fraction Medicare Managed Care Part C Days Group, Case No. 14-1820G
1D, 2A.	QRS 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days Group, Case No. 14-1822G
1E, 2B.	QRS 2010 Outlier Payments – Fixed Loss Threshold Group, Case No. 14-3041G

On January 7, 2015, the Medicare Contractor filed a jurisdictional challenge alleging that the appeal request was not timely filed. The Medicare Contractor argues that the Board received the appeal request on March 4, 2014, or 187 days after the NPR was issued.

On February 3, 2015, University of Utah Hospitals and Clinics filed a response to the jurisdictional challenge. On March 2, 2015, University of Utah Hospitals and Clinics requested to withdraw the RFBNA issue[2] from Case No. 14-2781.

Decision of the Board

The Board finds that it has jurisdiction over University of Utah Hospitals and Clinics' individual appeal because the appeal was timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) (2013), an appeal must be filed with the Board no later than 180 days after the Provider has received the final determination in dispute. The date of receipt is presumed to be five days after the date of issuance, unless the preponderance of evidence establishes that the determination was actually received on a later date.[3] For appeal requests filed after August 21, 2008, the date of filing is the date of receipt by the Board or the date of delivery by a nationally-recognized next-day courier.[4] Additionally,

> [i]f the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the reviewing entity is unable to conduct business in the usual manner, the

[2] Subsequent to the transfer requests, Issue No. 3, RFBNA, was the sole remaining issue in the appeal.
[3] 42 C.F.R. § 405.1801(a)(1)(iii) (2013) and Board Rule 4.3.
[4] 42 C.F.R. § 405.1801(a) (2013) and Board Rule 21.

> deadline becomes the next day that is not one of the aforementioned days.[5]

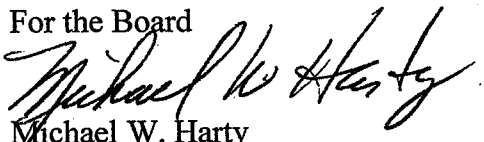
In the instant case, the NPR for University of Utah Hospitals and Clinics was issued on August 29, 2013, and it was presumed to have been received five days later on September 3, 2013. The appeal request was mailed via FedEx Overnight Delivery on Friday, February 28, 2014, but was not received by the Board until Tuesday, March 4, 2014. Thus, the date of filing was 182 days after the presumed date of receipt of the final determination. The 180th day on which the appeal request was due fell on a Sunday, March 2, 2014. As such, the deadline for filing the appeal request would have been the next day, Monday, March 3, 2014. However, the Centers for Medicare & Medicaid Services ("CMS") was closed on Monday, March 3, 2014, due to inclement weather which prevented the Board from conducting business in the usual manner. Thus, the deadline for filing the appeal request was extended to Tuesday, March 4, 2014.

Because University of Utah Hospitals and Clinics properly filed its appeal request with the Board on March 4, 2014, the Board finds that it was timely filed and the Board has jurisdiction over this appeal. The Board acknowledges the transfer of issues as noted above and closes the case as the last issue in the appeal – the RFBNA issue – was withdrawn on March 2, 2015.

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

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

For the Board



Michael W. Harty
Chairman

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

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

[5] 42 C.F.R. § 405.1801(d) (2013).

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RE: Susquehanna Health System 2014 Two-Midnight Group, Provider Nos. Various, FFY 2014, PRRB Case No. 14-4260GC
Essentia Health System 2014 Two-Midnight Group, Provider Nos. Various, FFY 2014, PRRB Case No. 14-4264GC
Sutter Health FY 2014 Two-Midnight Rule CIRP Group, Provider Nos. Various, FFY 2014, PRRB Case No. 14-4271GC
St. Joseph Health System 2014 Two-Midnight Group, Provider Nos. Various, FFY 2014, PRRB Case No. 14-4280GC
Toyon 2014 Two-Midnight Group, Provider Nos. Various, FFY 2014, PRRB Case No. 14-4305G
John Muir Health System 2014 Two-Midnight Group, Provider Nos. Various, FFY 2014, PRRB Case No. 14-4330GC
Hawaii Pacific Health System 2014 Two-Midnight Group, Provider Nos. Various, FFY 2014, PRRB Case No.14-4396GC
EJR of the 2-Midnight Issue

Dear Messrs. Knight and Snyder and Mses. Hartley and Kalafut:

Through correspondence dated April 14, 2015, the Provider Reimbursement Review Board (Board) notified the parties that it was considering issuing a decision regarding expedited judicial review (EJR) for the issue under appeal in the above-referenced appeals. The Board asked for the parties' comments and the Group Representative and Medicare Contractors responded, indicating agreement with the appropriateness of the Board's proposed action. Set forth below is the Board's determination with respect to its proposed EJR of the 2-midnight issue.

Background

Issue Under Appeal

"Whether [the Centers for Medicare & Medicaid Services] CMS' -0.2 percent payment adjustment related to the implementation of the two-midnight rule beginning October 1, 2013 is proper?"[1]

Statutory and Regulatory Background

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

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because the Medicare review contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[4]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and

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[1] Providers' Hearing Requests establishing group appeals (various dates).
[2] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*

necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[5]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[6] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment, it is the physician responsible for patient care who determines if the patient should be admitted.[7]

In the FFY 2014 IPPS proposed rule,[8] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[9]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition,

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[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.
[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. 50,908.

payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[11] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[12] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[14]

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

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

judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[15] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[16]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18]

Providers' Position

The Providers contend that the Secretary's conclusion that the $220 million projected increase in IPPS payments as a result of the implementation of the 2-midnight coverage policy is in error. The Providers maintain that the Secretary's actuarial analysis that gave rise to the 0.2 percent reduction is unsupported and insufficiently calculated given the small fraction of inpatient and outpatient claims that were examined for the purposes of estimating the number of encounters that would shift between inpatient and outpatient, and vice versa. The Providers assert that the IPPS payments should have been adjusted upward, not downward, to achieve budget neutrality.

Further, the Secretary did not provide a sufficient rationale for the use of the exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i). The Providers dispute the

[15] *Id.*
[16] *Id.* at 50,945.
[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.

contention that there is a widespread issue that justifies the use of an overall adjustment to IPPS rates. Further, they argue the Secretary has not demonstrated that such an adjustment is authorized under the statutory authority referenced.

The Providers believe that in order to correct and resolve this issue, the Secretary should reverse the 0.2 percent reduction related to the implementation of the 2-midnight rule. Instead, there should be an increase to IPPS payments, because the Providers believe that the IPPS payments will decrease at a substantially higher rate than OPPS payments will increase, resulting in a net overall aggregate decrease in Medicare payments.[19]

Decision of the Board

The Board has reviewed the Providers' requests for hearing and comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that each of the Providers in the cases referenced above timely filed their requests for hearing from the issuance of the August 19, 2013 Federal Register.[20] The amount in controversy in each case exceeds the $50,000 threshold necessary for a group appeal.[21] Consequently, the Board has determined that it has jurisdiction over the appeals. Further the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

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

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

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

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[19] Providers' Hearing Requests establishing group appeals (various dates).
[20] *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year-end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *District of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[21] *See* 42 C.F.R. § 405.1837(a)(3).

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating

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

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosure: 42 U.S.C. § 1395oo(f)(1)

cc: Kevin Shanklin, BCBSA

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Refer to:

CERTIFIED MAIL

JUN 05 2015

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

RE: Jurisdiction Determination for St. Luke's Roosevelt Hospital Center (33-0046)
FYE 12/31/1995 (participant #1) and
FYE 12/31/1996 (participant #2)
as participants in the Continuum Health Partners 1995-1998 Dual Eligible Days CIRP, PRRB Case No.: 09-2118GC

Dear Mr. Blumberg:

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

Background

The Providers filed an initial request for a group appeal on August 12, 2009. The group is appealing the Dual Eligible Days issue which is covered under Ruling 1498-R. The Schedule of Providers was filed on May 5, 2015. Although the Intermediary did not file a jurisdictional challenge in this group appeal, two of the participants are appealing from revised Notices of Program Reimbursement (RNPRs).

Board's Decision

The Board finds that it does not have jurisdiction over St. Luke's Roosevelt Hospital Center (33-0046) for FYEs 12/31/1995 and 12/31/1996. These two participants did not provide enough evidence to support an adjustment to the Dual Eligible Days issue from the RNPRs.

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

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

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

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

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

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

With regard to St. Luke's Roosevelt Hospital Center's FYE 1995 (participant #1), the RNPR indicates that it was issued to incorporate revisions to the unpaid Medicaid eligible days, partially paid eligible days and baby days with Medicaid eligible mothers. There is no mention of dual eligible days, nor did the Provider submit workpapers to establish that dual eligible days were reviewed during the reopening.

St. Luke's Roosevelt Hospital Center also appealed FYE 1996 (participant #2) from a RNPR. The RNPR was issued to incorporate revisions to the Medicaid eligible days and to correct an error for outpatient radiology Part B charges that were added to Inpatient Part B charges. Again, there is no mention of dual eligible days. Although worksheets were submitted they do not provide evidence that dual eligible days were reviewed during the reopening.

Because appeals from revised NPRs are limited to the specific matters considered in the revised determination, the Board finds that it does not have jurisdiction over the subject Provider for FYEs 1995 and 1996 because there was no evidence that dual eligible days were actually reviewed.

As the Board lacks jurisdiction over St. Luke's Roosevelt Hospital Center's (33-0046) appeals from its RNPRs for FYEs 1995 and 1996, Participant #s 1 and 2 are dismissed from this group appeal. Review of this determination is available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

The remaining participants in the group appeal are subject to remand pursuant to CMS Ruling 1498-R. Enclosed, please find the Board's remand under the standard procedure.

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: Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R
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)
Kyle Browning, Appeals Lead, National Government Services

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Refer to:

CERTIFIED MAIL

JUN 08 2015

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

RE: Lafayette Surgical Hospital
Provider No: 19-0268
FYE: 12/31/2012
PRRB Case No: 15-0489

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has reviewed the appeal request you submitted on behalf of Lafayette Surgical Hospital (Lafayette) for FYE 12/31/2012. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

Healthcare Reimbursement Services, Inc. (HRS) filed an individual appeal for Lafayette on November 26, 2014. The appeal is based on the Medicare Contractor's failure to issue a timely final determination. HRS included a copy of an unsigned copy of the cost report certification page as support.

The Board established case number 15-0489 and issued an Acknowledgement and Critical Due Dates letter on December 3, 2014. On February 2, 2015, the Board issued a Request for Additional Information, requesting copies of the documentation required to support filing from the Medicare Contractor's failure to issue a timely final determination (i.e., evidence of the date the Medicare Contractor received the as filed cost report and the date of the Medicare Contractor's acceptance of the same cost report). The Request for Information allowed 15 days for the information to be submitted and advised the appeal may be dismissed. To date, HRS has not submitted documentation to comply with the Board's request for additional information.

On May 14, 2015, HRS requested that the Outlier Payments – Fixed Loss Threshold issue be transferred to case number 15-0570G (HRS 2012 Outlier Threshold Group). HRS did not supply a copy of the documentation required to support its initial filing from the Medicare Contractor's failure to issue a timely determination as an exhibit in the transfer request.

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 dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

42 C.F.R. § 405.1835(a)(3) states:

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

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

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

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

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

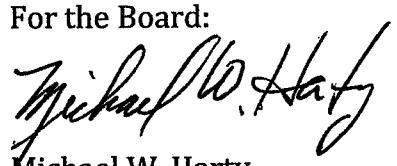
> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does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

Because the Provider has failed to submit the required documentation, the Board finds that the appeal request was not filed in conformance with 42 C.F.R. § 405.1835 and the Board Rules. Therefore, the Board hereby dismisses the individual appeal. As the Provider did not support a jurisdictionally valid individual appeal request, the Board also denies the Provider's request to transfer the Outlier Payments – Fixed Loss Threshold issue from this case to case number 15-0570G.

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

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

For the Board:



Michael W. Harty
Chairman

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

cc: Byron Lamprecht, Wisconsin Physicians Service
Kevin D. Shanklin, Executive Director, BCBSA

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CERTIFIED MAIL

JUN 08 2015

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

RE: Provider: New York Downtown Hospital
Provider No: 33-0064
FYE: 12/31/2004
PRRB Case No.: 13-3268

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (PRRB or Board) has conducted an own motion review of the above-referenced appeal. The Board finds that it lacks jurisdiction over New York Downtown Hospital's appeal from the revised Notice of Program Reimbursement (NPR) and dismisses the appeal as the rural floor budget neutrality adjustment (RFBNA) issue was not specifically revised in the reopening.

Background

On March 15, 2013, a revised NPR was issued to New York Downtown Hospital for the fiscal year ending (FYE) December 31, 2004. On September 04, 2013, New York Downtown Hospital filed an appeal of the revised NPR challenging "[w]hether the 'rural floor' budget neutrality adjustments as implemented by the Centers for Medicare and Medicaid Services ('CMS") violate the law's requirement of budget neutrality." The Board assigned case number 13-3268 to the appeal.

Decision of the Board

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.[1]

A revised NPR is considered a separate and distinct determination from which the provider may appeal.[2] A Provider's appeal of a revised NPR is limited to the specific issues revised on reopening and does not extend further to all determinations underlying the original NPR.[3]

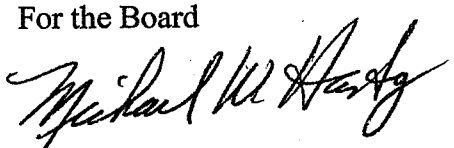
[1] 42 U.S.C. § 1395oo(a) (2012) and 42 C.F.R. §§ 405.1835-1840 (2012).
[2] 42 C.F.R. § 405.1889 (2012).

In this case, New York Downtown Hospital is appealing from an audit adjustment report (adjustments 4 and 5) that did not specifically adjust the RFBNA. The adjustment report shows an adjustment to the total disproportionate share hospital (DSH) percentage (adjustment 4) and an adjustment "[t]o adjust worksheet E-1 to properly reflect previous settlement amounts" (adjustment 5), but there is no adjustment specific to the RFBNA. New York Downtown Hospital did not supply supporting documentation (such as the audit work papers) to further determine the full scope of the issues reviewed within the revised NPR process. Further, the May 10, 2010 Notice of Reopening of Cost Report provided by New York Downtown Hospital in the appeal request (under tab 1) shows the cost report was reopened by the Medicare contractor "[d]ue to a recalculation of the hospital's SSI/Medicare Part A percentage by CMS." As the RFBNA issue was not specifically revised in the reopening, the Board finds that it lacks jurisdiction over New York Downtown Hospital's appeal from the revised NPR and dismisses the appeal as the RFBNA issue is the sole issue in the case.

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, Blue Cross & Blue Shield Association
Kyle Browning, National Government Services

[3] *See HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614 (D.C. Cir 1994); s*ee also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348, 357 (D.D.C. 2014) (holding that the Secretary's "issue-specific" interpretation of her NPR reopening regulations is reasonable and entitled to substantial deference).

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04-1730G

JUN 08 2015

CERTIFIED MAIL

Thomas P. Knight
President
1800 Sutter Street
Suite 600
Concord, CA 94520-2546

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

RE: Group Name: Toyon 1999 DSH Dual Eligible Days
Provider No.: Various
FYE: 12/31/1999
PRRB Case No.: 04-1730G

Dear Mr. Knight and Ms. Kalafut,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documentation submitted for Participant 6, Enloe Medical Center (hereinafter "Enloe") in the above-captioned case. The Board determined that it lacks jurisdiction over Enloe's appeal.

Background

The Board previously reviewed jurisdiction in the instant case in response to the Provider Representative's (Toyon) request to bifurcate the dual eligible days issue into two separate appeals for Part A exhausted benefits days and Part C days.[1] During that review process, the Board determined that it needed more information in order to make its jurisdictional determination related to one of the providers, Enloe. In its Jurisdictional Decision, issued on February 12, 2014, the Board requested that Enloe provide the following:

(1) Notice of Program Reimbursement ("NPR") immediately preceding the revised NPR ("RNPR") under appeal;
(2) Reopening Request, if applicable;
(3) Reopening Notice;
(4) RNPR Workpapers for the issue(s) under appeal; and,
(5) Applicable Cost Report Worksheets.[2]

[1] Participant 25 was removed from the appeal by the group representative; Participants 1, 3, 5, 6, 12-16, 18, 23, 24, and 26 remain in this appeal. A remand will be issued under separate cover.
[2] Bifurcation Letter from the Board at 4, Feb. 12, 2014.

The Board received Enloe's response on March 18, 2014.[3]

Board's Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2004), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if (1) it is dissatisfied with the final determination of the Contractor, (2) the amount in controversy is $10,000 or more (or $50,000 for a group), and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination. There is no dispute that the group appeal meets the amount in controversy requirement. There is also no issue with the timeliness of Enloe's appeal. However, there is a problem with the dissatisfaction requirement.

The Code of Federal Regulations provides an opportunity for a provider to obtain a RNPR through a reopening of its cost report.[4] 42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1837, 405.1875 and 405.1877 are applicable.

The Board Rules offer further clarification regarding RNPR appeals:

> The Board accepts jurisdiction over appeals from a [RNPR] where the issue(s) in dispute were specifically adjusted by that [RNPR]. The Board typically follows the courts by limiting the scope of such an appeal to only the revised issue(s). *See Anaheim Memorial Hospital v. Shalala*, 130 F.3d 845 (9th Cir. 1997).[5]

Here, Enloe appealed from a RNPR dated March 29, 2005.[6] This means that in order for the Board to have jurisdiction over Enloe's Dual Eligible days, Enloe must show that Dual Eligible days were adjusted in its RNPR. Enloe provided the following documents and responses to the Board's documentation request:

> (1) Request for NPR Immediately Preceding the RNPR under Appeal: "The Provider has reviewed their records and is unable to locate a copy of the NPR requested."
>
> (2) Reopening Request Preceding the RNPR: "We conclude

---

[3] *See* Enloe's Supplemental Documentation, Mar. 18, 2014.
[4] *See* 42 C.F.R. § 405.1885(a).
[5] Board Rule B.I.a.3 at 3, Mar. 1, 2002.
[6] *See id.* Tab 1 at 1. This RNPR was issued as a result of an Administrative Resolution ("AR") in Enloe's individual appeal, Case No. 02-1326. Enloe's individual case was closed by the Board on October 19, 2004.

this document is not applicable as the [RNPR] was issued as a result of an administrative resolution of Case No. 02-1326."

(3) Reopening Notice: "To the best of our knowledge, there was no reopening notice issued by the [Contractor] as this would not be their practice."

(4) RNPR Workpapers: "To the best of our knowledge, the [Contractor] did not furnish a copy of their final DSH payment calculation reflected in the [RNPR] dated March 29, 2005.

. . . .

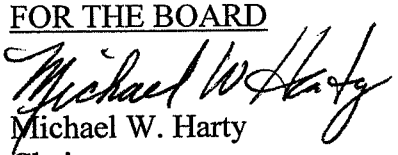
We contend the Board should require the current [Contractor], Noridian Healthcare Solutions, LLC[,] to locate and furnish a copy of their workpaper support pertaining to the [RNPR] dated March 29, 2005 in order to accurately document the jurisdiction facts in the Provider's appeal."

(5) Any Applicable Cost Report Worksheets: "Enclosed in Exhibit 3 is a copy of Worksheets S-3 Part I, E Part A and L."[7]

The Board finds that Enloe failed to prove that Dual Eligible days were adjusted in its RNPR. Thus, pursuant to 42 C.F.R. § 405.1889, the Dual Eligible days are beyond the scope of any appeal of the revised determination.[8] The Board finds that it lacks jurisdiction over Participant 6; therefore, Enloe is dismissed from 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 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

Brendan Stuhan, BCBSA
Associate Counsel
1310 G Street, NW - 20th Floor
Washington, DC 20005

[7] Enloe's Supplemental Documentation letter to the Board at 1-2, Mar. 18, 2014.
[8] *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).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Phone: 410-786-2671 Fax: 410-786-5298

CERTIFIED MAIL

JUN 08 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. 15-2039GC

Dear Mr. Seely:

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

PERTINENT FACTS:

On March 31, 2015, Baptist Health filed the above-referenced CIRP group appeal request. On the CIRP group appeal request Model B form, Baptist Health noted that the group was complete and fully formed. The two Providers forming the group appeal were:

1. *Baptist Medical Center – Jacksonville*, Provider No. 10-0088, FYE 9/30/2005 (transferred from Case No. 09-1108); and

2. *Baptist Medical Center – Nassau*, Provider No. 10-0140, FYE 9/30/2005 (transferred from Case No. 07-2523)

In a letter dated May 5, 2015, the Intermediary filed a letter with the Board stating that the Board previously remanded the DSH/SSI issue in both of the above-noted individual appeals pursuant to CMS Ruling 1498-R. Since the issue was already remanded in the two individual appeals, the transfer requests to form a new group appeal are invalid.

BOARD'S 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 a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary; the amount in controversy is $10,000 or more; and the request for hearing is received by the Board within 180 days of the date of receipt of the final determination.

1. *Baptist Medical Center – Jacksonville*, Provider No. 10-0088, FYE 9/30/2005, Case No. 09-1108

The original appeal request was filed with the Board on August 15, 2008. The Provider appealed the DSH/SSI issue from an original NPR dated February 26, 2008. On August 28, 2014, the Board remanded the DSH/SSI issue back to the Intermediary.

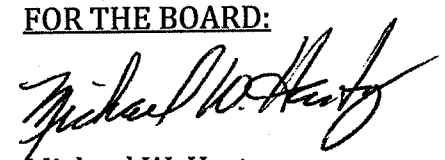
2. *Baptist Medical Center – Nassau*, Provider No. 10-0140, FYE 9/30/2005, Case No. 07-2523)

The original appeal request was filed with the Board on March 11, 2010. The Provider appealed DSH/SSI issue from an original NPR dated September 14, 2009. On July 1, 2014, the Board remanded the DSH/SSI issue back to the Intermediary.

In both of the above-noted individual appeals, the Providers did appeal the DSH/SSI issue; however, the Board remanded the DSH/SSI issue for both Providers back to the Intermediary prior to Baptist Health's CIRP group appeal request. Since the issue was already remanded in the two individual appeals, the transfer requests to form a new group appeal are invalid. The Board, therefore, finds that it does not have jurisdiction over this issue and dismisses CIRP Group Case No. 15-2039GC.

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: 08-1414

CERTIFIED MAIL

JUN 09 2015

Mercy Medical Center Merced
Eric S. Carino
Reimbursement Manager
2740 M Street
Merced, CA 95340

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

RE: Jurisdictional Determination
Mercy Medical Center
Provider No.: 05-0444
FYE: 06/30/2005
PRRB Case No.: 08-1414

Dear Mr. Carino and Ms. Kalafut,

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 Board received the Provider's hearing request on March 11, 2008, based on a revised Notice of Program Reimbursement ("NPR") dated October 5, 2007. The request contained the following issues: (1) Disproportionate Share ("DSH") – Medicaid Eligible Days, (2) DSH – Supplemental Security Income ("SSI") Ratio, (3) DSH – Dual Eligible Days, (4) DSH – Code 2 & 3 Eligible Days, and (5) DSH – Labor Room Days. On October 20, 2008, the Board received a request to add two issues to the case, including (6) Medicare Crossover Bad Debts, and (7) DSH Additional Medicaid Eligible Days.

On April 7, 2008 and July 14, 2011, the Board received requests to transfer four of the original issues to group cases:

- Issue 2, SSI Ratio, was transferred to case no. 07-1862G;
- Issue 3, Dual Eligible Days, was transferred to case no. 07-1865G;
- Issue 4, Code 2 & 3 Eligible Days, was transferred to case no. 08-0503G; and
- Issue 5, DSH – Labor Room Days, was transferred to case no. 09-1552GC.

On March 11, 2015 the Board sent the Provider a development letter requesting additional documentation needed to determine if the Board has jurisdiction over the remaining issues, DSH

– Medicaid Eligible Days (Issues 1 and 7) and Medicare Crossover Bad Debts (Issue 6). The Provider did not submit the requested documentation.

Board's Decision

The Board finds that it lacks jurisdiction over Mercy Medical Center Merced because the Provider is appealing from a revised NPR that did not directly adjust or consider the issues.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2007), 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 the notice of the intermediary's determination was mailed to the provider.

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

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

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective October 1, 2002, through May 22, 2008, stated:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

This regulation has also been addressed and explained in the decision HCA Health Services of Oklahoma v. Shalala, 27 F.3d 614 (D.C. Cir. 1994). In that case the Court held that when a Medicare contractor reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). In this case, the Court also held that "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

In its original hearing request, the Provider submitted the audit adjustment report which reflected that Medicaid days and the DSH percentage were adjusted, but bad debts were not adjusted.

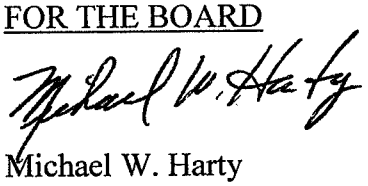
However, the Provider did not submit work papers created by the Medicare Contractor, and, therefore, there is insufficient evidence to determine if the additional Medicaid days or Medicare bad debts at issue were reviewed in the context of this revised NPR.

Because appeals from revised NPRs are limited to the specific matters considered in the revised determination, the Board finds that it does not have jurisdiction over the DSH – Medicaid Eligible Days issues (Issues 1 and 7) or the Medicare Crossover Bad Debt issue (Issue 6) and dismisses these issues from the appeal. Since these were the final issues remaining in the case, the Board closes case number 08-1414.

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 Benson, CPA

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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Refer to: 05-0377

JUN 09 2015

CERTIFIED MAIL

ProMedica Health System
Cynthia Kreiner
Director of Reimbursement
2142 N. Cove Boulevard
Toledo, OH 43606

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

RE: Jurisdiction Challenge – Fostoria Community Hospital
Provider No.: 36-0099
FYE: 12/31/2002
PRRB Case No.: 05-0377

Dear Ms. Kreiner and Ms. Cummings,

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 December 10, 2004, based on a Notice of Program Reimbursement ("NPR") dated June 18, 2004. The Provider appealed one issue, Ohio HCAP Days.[1] The case was accepted into the Administar pilot program. On June 7, 2010 the Ohio HCAP days were transferred to case number 09-0300GC. On June 28, 2011, the Medicare Contractor challenged the Board's jurisdiction over the Disproportionate Share Hospital ("DSH") – Medicaid eligible days issue.

The Board finds that it lacks jurisdiction over Fostoria Community Hospital (PN 36-0099, FYE 12/31/2002) because the Provider was unable to establish they faced a practical impediment in gaining Medicaid eligibility data from the State of Ohio.

Intermediary's Position

The Medicare Contractor 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 Medicare Contractor argues that it accepted the as-filed Medicaid days and therefore made no

[1] The Provider's appeal request cites one issue, however the issue description includes HCAP Days and Medicaid Eligible patient days which is the subject of this decision.

adjustment to the Medicaid days on the final settled cost report, and that the Provider was not precluded from claiming the additional payment for which it is now claiming in the appeal.

The Medicare Contractor analyzed the September 6, 1986 Federal Register commentary, and concludes that the Providers were in fact required to make a formal claim for DSH, and the eligible days issue should be reviewed the same as other unclaimed costs under *Bethesda Hospital et al. v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*"). Under *Bethesda*, if a Provider could have claimed a cost (in this case days), it was required to do so, and it failed to, it failed to meet the dissatisfaction requirements of 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840.

Provider's Position

The Provider did not respond to the jurisdictional challenge.

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 is required to establish a practical impediment existed in order for the Provider to later claim days it had not originally included on its cost report.

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."[2]

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2 *Barberton* at 4.

The Provider did not respond to the Medicare Contractor's 2011 jurisdictional challenge for the days at issue, nor did they supplement the record in response to Alert 10. As the Provider failed to document why the days under appeal were not included in its as-filed cost report and that a practical impediment was faced in reporting Medicaid eligible days, the Board finds that it lacks jurisdiction over the eligible days issue and dismisses the DSH-Medicaid eligible days issue from the case. Since this is the final issue in the case, the Board closes case number 05-0377.

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

Board Members
Michael W. Harty
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

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CERTIFIED MAIL

JUN 11 2015

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

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

RE: Bethesda Memorial Hospital
Provider No.: 10-0002
FYEs: 9/30/2003 and 9/30/2004
PRRB Case Nos.: 10-1364 and 11-0012

Dear Mr. Ravindran and Mr. Pike,

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

CN 10-1364 TIMELINE AND BACKGROUND

Bethesda Memorial Hospital (the Provider) filed an appeal on September 23, 2010 from a revised Notice of Program Reimbursement ("NPR") dated March 26, 2010. The appeal request contained three issues including DSH - Medicaid Eligible Days, DSH – Exhausted Medicare Benefits Medicaid Dual Eligible Days, and DSH – Medicaid Eligible Labor Room Days.

On May 16, 2011 the Provider submitted a request to transfer the DSH – Exhausted Medicare Benefits Medicaid Dual Eligible Days issue to PRRB Case No. 09-0377G – QRS 1995-2004 DSH Exhausted Medicare Benefits Medicaid Dual Eligible Days, and the DSH – Medicaid Eligible Labor Room Days issue to PRRB Case No. 08-2607G – QRS 2003 Medicare DSH Labor Room Day Group II. The Board dismissed the Provider from these group appeals on September 23, 2013 and December 13, 2013, respectively, because the Provider appealed from revised NPRs that did not adjust the days at issue.

On August 13, 2013, the Provider submitted supporting documentation related to the revised NPR pursuant to a Board request dated July 15, 2013.

The Medicare Contractor filed a jurisdictional challenge to the Medicaid eligible days issue on April 11, 2014. The Provider filed a responsive brief on May 12, 2014. The Provider filed a response to Board Alert 10 relative to this case on July 21, 2014.

CN 11-0012 TIMELINE AND BACKGROUND

Bethesda Memorial Hospital (the Provider) filed an appeal on October 7, 2010 from a revised Notice of Program Reimbursement ("NPR") dated April 20, 2010. The appeal request contained three issues

including DSH – Medicaid Eligible Days, DSH – Exhausted Medicare Benefits Medicaid Dual Eligible Days, and DSH – Medicaid Eligible Labor Room Days.

On May 16, 2011, the Provider submitted a request to transfer the DSH – Exhausted Medicare Benefits Medicaid Dual Eligible Days issue to PRRB Case No. 09-0377G – QRS 1995-2004 DSH Exhausted Medicare Benefits Medicaid Dual Eligible Days, and the Medicaid Eligible Labor Room Days issue to PRRB Case No. 07-2324G – QRS 04 Medicare DSH Labor Room Day Group. The Board dismissed the Provider from these group appeals on September 23, 2013 and September 5, 2013, respectively, because the Provider appealed from revised NPRs that did not adjust the days at issue.

The Medicare Contractor filed a jurisdictional challenge to the Medicaid eligible days issue on April 21, 2014. The Provider filed a responsive brief on May 13, 2014. The Provider did not file any response to Board Alert 10 relative to this case. The Provider filed a response to Board Alert 10 on July 21, 2014 for FYE 9/30/03, but did not reference FYE 9/30/04.

MEDICARE CONTRACTOR'S CONTENTIONS

The Medicare Contractor states that the appeals are based on the revised NPRs that were issued on March 26, 2010 and April 20, 2010 respectively. The Medicare Contractor notes that the Provider states the issue in question as "Whether the MAC properly included all 'eligible' Medicaid days, regardless of whether such days were paid days, in the numerator of the Medicaid fraction of the DSH calculation."[1]

In reviewing the revised NPRs, the Medicare Contractor notes that the reopenings resulted in an additional 132 Medicaid eligible days for FYE 9/30/03 and 993 Medicaid eligible days for FYE 9/30/04.[2]

The Medicare Contractor contends that based on the Provider's description of the issue, it appears that the Medicaid eligible days in question in the appeals do not specifically relate to the change in the Medicaid days in the last NPRs. The Medicare Contractor's adjustments for Medicaid days are not the source of the Provider's complaints. The Provider is attempting to add additional Medicaid days that were not previously claimed or denied. Therefore, the Medicare Contractor did not make a determination with respect to the Provider for the days at issue in the appeals.[3]

PROVIDER'S CONTENTIONS

The Provider contends that it appealed revised NPRs that included corrections to the Medicaid proxy of the DSH calculation and adjustments that affected a net change in the number of Medicaid Eligible Days. Accordingly, the Provider is dissatisfied with the amount of DSH reimbursement that it received on the revised NPRs.[4]

The Provider contends that the Board has jurisdiction over the additional DSH/Medicaid Eligible Days that it is seeking in these appeals because they are nothing more than Medicaid Eligible Days, which

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[1] Medicare Contractor's Jurisdictional Briefs at 1.
[2] *Id.*
[3] *Id.* at 2.
[4] Provider's Jurisdictional Briefs at 1.

was the specific issue addressed during the reopenings of the cost reports. To distinguish among various Medicaid Eligible Days because some were previously submitted and some were not is arbitrary and capricious and lacks any rational basis. It is undisputed that the days are Medicaid Eligible Days and that the Medicare Contractor made an adjustment to Medicaid Eligible Days on the revised NPRs that the Provider has raised in the instant appeals. The Provider is dissatisfied with the amount of reimbursement based on the understatement of DSH/Medicaid Eligible Days and the days will still be understated without the inclusion of these additional DSH/Medicaid Eligible Days.[5]

BOARD'S DECISION

Pursuant to 42 U.S.C. § 1395oo(a) (2009) and 42 C.F.R. §§ 405.1835-405.1840 (2009), 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 Medicare Contractor, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date of receipt of the Medicare Contractor's final determination.

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

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

In accordance with 42 C.F.R. § 405.1889 (2009), 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.

The Board finds that it does not have jurisdiction over the Medicaid eligible days issue in the appeals because the Provider fails to meet the requirement that it be "dissatisfied" with the Medicare

---

[5] *Id.* at 1-2.

Contractor's final determinations in the revised NPRs. The Provider has not supplied any evidence in the record that the days in dispute were reviewed or revised as part of the revised NPRs under appeal.

As the Medicaid eligible days issue was the sole remaining issue in these appeals, the Board closes these cases and removes them from the Board's docket.

Review of these determinations 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. (dissenting)
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, Executive Director, Blue Cross Blue Shield Association

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Refer to: 06-0819

CERTIFIED MAIL JUN 15 2015

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

Re: Provider: Baptist Medical Center
Provider No.: 10-0088
FYE: 09/30/1995
PRRB Case No.: 06-0819

Dear Mr. Seely and Mr. Pike:

The Provider, Baptist Medical Center ("Baptist"), appealed its August 23, 2005 revised Notice of Program Reimbursement ("RNPR") to the Provider Reimbursement Review Board ("Board"). The Board determined that it lacks jurisdiction in this case because Baptist fails to meet the dissatisfaction requirement of 42 U.S.C. § 1395oo(a).

Background

Baptist timely appealed the following issues from its August 23, 2005 RNPR:

> (1) Whether Medicaid days used to compute the [DSH] Medicaid utilization in audit correctly included all allowable Medicaid eligible days even if unpaid.
>
> (2) Whether the Medicare Capital reimbursement calculation reflects the proper Medicare DSH adjustment factor as reflected in Issue #1 which requires adjustment as a flow through effect.[1]

The audit adjustments indicate that the RNPR was issued to implement an Administrative Resolution ("AR") in a previous appeal, Case No. 02-1944. The Board closed Case No. 02-1944 in June 2005.

[1] Request for Hearing at 2, Feb. 22, 2006.

Baptist filed its Final Position Paper on November 1, 2006, stating that, "[t]he provider had been consistently prohibited from including any Medicare/Medicaid dual eligible days."[2] It stated that, as a result, it has refrained from including those days on its cost report for inclusion in the Medicaid fraction.[3] Baptist also stated that it believes that "Medicaid eligible days with Medicare managed care eligibility should be included in the Medicaid fraction."[4] Further, Baptist stated that subsequent reviews has allowed it to identify "additional populations" of Medicaid eligible days, such as days "that are eligible for Medicaid in the state of Georgia, that [it was] previously unable to identify."[5] The estimated effect, Baptist stated, is a 10% increase in Medicaid days.[6]

The Medicare Administrative Contractor, then Strategic Government Initiatives, now First Coast Service Options ("First Coast"), addressed the additional Medicaid eligible days in its October 25, 2006 Final Position Paper. First Coast stated that Baptist is requesting additional days (Medicaid eligible and Medicare managed care days) from a RNPR based on an AR of a previous appeal.[7] First Coast wrote, "[o]n April 27, 2005, a signed [AR] agreement between the Provider and the [Contractor] was executed (Exhibit I-1). This agreement specifically indicated the amount of Medicaid days to be included . . . in the DSH computation . . . ."[8] First Coast stated that it properly effectuated the agreement by issuing the August 23, 2005 RNPR.[9] First Coast requests that the Board dismiss the instant case because Baptist already agreed to a resolution of those days. First Coast included a copy of the AR to show that the Medicaid eligible days issue was resolved; First Coast allowed an additional 785 days.

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2004), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is (1) dissatisfied with the final determination of the contractor, (2) the amount in controversy is $10,000.00 or more, and (3) the request for a hearing is filed within 180 days of the date the notice of the contractor's determination was mailed to the provider. Additionally, appeals stemming from RNPRs are governed by the following regulation, which applies in the instant case:

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[2] Baptist's Final Position Paper at 4, Nov. 1, 2006.
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *See* Strategic Government Initiatives (also referred to as First Coast Service Options) Final Position Paper, Oct. 25, 2006.
[8] *Id.* at 3.
[9] *Id.*

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable. (See § 405.1801(c) for applicable effective dates.)[10]

This regulation is interpreted to mean that a provider's appeal rights are derived from the items revised in a contractor reopening. Therefore, Baptist may only appeal those items that were revised in its RNPR.

Here, the parties agreed to the treatment of Medicaid eligible days and Capital DSH in the AR. The AR states that First Coast proposed an adjustment of 785 additional Medicaid eligible days for a total of 12,468 eligible days.[11] It further states that First Coast "propose[d] to revise the capital payment adjustment based on the DSH . . . adjustments."[12] The end of the AR reads: "The Provider's and [Contractor's] representatives[']signatures serve to execute this [AR]. The [P]rovider will withdraw all issues . . . " and consent to the dismissal of its appeal before the Board.[13] As agreed, First Coast issued the RNPR.

The Board finds that the AR in this case evidences the parties' intention to resolve the previously-appealed issues. Baptist cannot now appeal an issue it previously agreed to resolve. The Board concludes that Baptist cannot prove dissatisfaction with its adjustment to Medicaid eligible days or Capital DSH. Since dissatisfaction is a prerequisite to the Board's jurisdiction under 42 U.S.C. § 1395oo(a), the Board determines that it lacks jurisdiction in this case.

Additionally, the record does not support that Baptist is now appealing days previously disallowed. In fact, by Baptist's own admission, the 1,247 (estimated) "additional" days are days that it identified after the AR. It is clear, then, that the days in dispute were not considered as part of the RNPR and do not meet the requirements of 42 C.F.R. § 405.1889. Therefore, the Board also concludes that Baptist failed to prove these days were revised in its RNPR.

In light of the foregoing, the Board hereby dismisses the two issues and closes this case. Review of this jurisdictional decision is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1835(a) and 405.1877.

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[10] 42 C.F.R. § 405.1889 (2004).
[11] Strategic Government Initiatives Final Position Paper Ex. I-1 (AR) at 1.
[12] *Id.* at 2.
[13] *Id.*

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 Shanklin, Executive Director, BCBSA (without enclosures)

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Refer to: 09-2238

JUN 15 2015

CERTIFIED MAIL

Shaw Seely, CPA
Director of Reimbursement
Baptist Medical Center
800 Prudential Drive
Jacksonville, FL 32207

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

Re: Provider: Baptist Medical Center
Provider No.: 10-0088
FYE: 09/30/1999
PRRB Case No.: 09-2238

Dear Mr. Seely and Mr. Pike:

The Provider, Baptist Medical Center ("Baptist"), filed a timely appeal request with the Provider Reimbursement Review Board ("Board") on September 11, 2009, appealing its revised Notice of Program Reimbursement ("RNPR") issued March 17, 2009.[1] The Board determined that it lacks jurisdiction in this case because Baptist failed to prove that the issues under appeal were specifically revised in its RNPR, as required by 42 C.F.R. § 405.1889 (2008).

Background

Baptist appealed the following issues to establish the instant case:

(1) Prior Year Resident to Bed ratio;
(2) DSH/SSI%;
(3) Medicaid Eligible days;
(4) Part C days;
(5) Dual Eligible days;
(6) Exhausted Benefits days;
(7) No-Pay Part A days;

[1] *See* Baptist's Hearing Request, Sep. 11, 2009.

(8) Observation Bed days; and,
(9) Florida Charity Care days.[2]

Baptist failed to include in its appeal request a calculation demonstrating its amount in controversy. The Board sent an e-mail to Baptist requesting that it send a calculation to the Board within 30 days.[3] In response, Baptist submitted its calculation to the Board on September 22, 2009.

Baptist also failed to include a copy of its Audit Adjustment Report, although it acknowledged in its cover letter that, "[e]nclosed with this cover letter is 'Model Form A – Individual Appeal Request' and supporting documentation as specified in the [Board] Rules."[4] On November 19, 2014, the Board e-mailed Baptist for additional information.[5] This time, the Board requested a copy of the audit adjustment pages related to the issues in dispute.[6] Specifically, the e-mail stated: "Please submit the information checked above within 30 days of the date of this letter, or your appeal may be dismissed. Please consult the Board's instructions for the detailed explanations regarding the filing of this information."[7] In addition, the Board requested both copies of the parties' preliminary position papers and a copy of the Administrative Resolution, if applicable, in order to make a jurisdictional determination.[8]

Board Determination

The regulations provide an opportunity for a provider to appeal from a revised Notice of Program Reimbursement; however, different appeal rights apply. Pursuant to 42 C.F.R. § 405.1889 (2008):

> (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

[2] *See id.* Tab 3.
[3] Board's e-mail to Baptist, Sep. 17, 2009.
[4] *See* Baptist's Hearing Request Tab 3.
[5] Board's e-mail to Baptist, Nov. 19, 2014.
[6] *Id.* [For all of the issues, except DSH/SSI% (audit adjustment number 1 only) and Prior Year Resident to Bed ratio (audit adjustment numbers 1 and 2), Baptist referenced audit adjustment numbers 1 and 4.]
[7] *Id.*
[8] *Id.*

> 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.

Therefore, in order to have a valid appeal before the Board, Baptist must prove that the issues appealed were "specifically revised" in its March 17, 2009 RNPR. However, Baptist failed to submit the documentation necessary to make a jurisdictional determination.

The Board Rules and Model Form A's instructions clearly indicate that an adjustment must be identified in order for a provider to have a valid appeal. Board Rule 6.1 states that, "[t]o file an individual appeal (1) complete Model Form A – Individual Appeal Request – Initial Filing and (2) include all supporting documentation listed on the request."[9] Further, Board Rule 7.1(A) states, "[g]ive a concise issue statement describing the adjustment, including the adjustment number . . . "[10] Board Rule 7.1(B) provides: "If the Provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable."[11] These requirements are repeated on Model Form A:

> YOU MUST ATTACH THE FINAL DETERMINATION UNDER A **TAB LABELED 1.**
>
> . . . .
>
> UNDER A **TAB LABELED 3** YOU MUST SUBMIT A

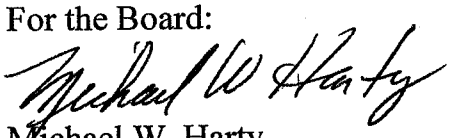
[9] Board Rule 6.1 at 5, Aug. 21, 2008.
[10] Board Rule 7.1 at 5.
[11] *Id.*

> STATEMENT FOR EACH ISSUE. The statement of the issue must conform to the requirements of the regulations found at 42 CFR § 405.1835 et seq. and the Board Rule's and include:
>
> . . . the audit adjustment numbers . . . [12]

Here, Baptist never submitted proof of the audit adjustments referenced in its appeal. The Board requested the supporting documentation to give Baptist an opportunity to supplement the record, but Baptist failed to submit the required information. Moreover, if Baptist did not have access to that information, it was required to explain to the Board why it lacked the information. Instead, Baptist noted the applicable audit adjustment numbers, but provided no way for the Board to verify the issues were specifically adjusted in the RNPR. Any supplemental documentation submitted at this stage would be untimely.

The Board determines that Baptist has failed to prove that the matters appealed were specifically revised in its RNPR, as required by 42 C.F.R. § 405.1889. The Board hereby dismisses the appeal and closes Case No. 09-2238. Review of this jurisdictional decision is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1835(a) 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 Shanklin, Executive Director, BCBSA (without enclosures)

[12] *See* Board Rules at 45 (Model Form A instructions).

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Refer to:

CERTIFIED MAIL JUN 15 2015

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

RE: Sutter Health 2003 DSH - Dual Eligible Days CIRP Group, PRRB Case No. 10-0424GC
Provider Nos.: (see attached Schedule of Providers)

Dear Mr. Jaeger:

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

Board Determination:

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

The Board finds that California Pacific Medical Center (participant #3) has not yet received its final determination and did not file a specific appeal request. Therefore, the Board is dismissing this participant from the group as premature.

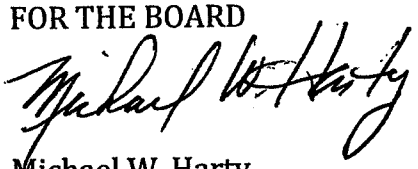
The Board also notes that St. Luke's Hospital (participant #13) did not supply any supporting documents with the Schedule of Providers. Therefore, this Provider has not documented that it preserved its right to claim dissatisfaction on this issue. The Board hereby dismisses this participant from the group as well.

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

Enclosed, please find a Standard Remand of the Dual Eligible Days issue pursuant to CMS Ruling 1498-R for the remaining participants in the group.

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
Standard Remand of Dual Eligible Days

cc: Kevin D. Shanklin, Executive Director, BCBSA
Donna Kalafut, Noridian Healthcare Solutions

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CERTIFIED MAIL

JUN 19 2015

Toyon Associates, Inc.
Sheryl N. Samonte
1800 Sutter Street
Suite 600
Concord, CA 94520-2546

RE: **Dominican Santa Cruz Hospital**
Provider Number: 05-0242
FYE: 6/30/2005
Case Number: 08-0020

Dear Ms. Samonte:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal on its own motion. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The Provider timely filed its individual appeal request on October 5, 2007, from an original Notice of Program Reimbursement (NPR) dated April 11, 2007. The Provider appealed the following issues:

1. Medicare Settlement Data
2. Medicare Bad Debts – Fee Reimbursed
3. Medicare Bad Debts – 2% Share of Cost Adjustment
4. DSH – Dual Eligible Days
5. DSH – Code 2 & 3 Eligible Days
6. DSH – Labor Room Days
7. DSH – SSI Ratio
8. Protested Amount – Unbilled Medicare Bad Debt Claims
9. PPS Standardized Amount
10. Protested Amount – Pension Expense

In a letter dated January 2, 2008, the Provider added Issue #11 - DSH – SSI Realignment.

On January 8, 2008, the Provider transferred the Protested Amount – Unbilled Medicare Bad Debt Claims (Inpatient) to Group Case No. 07-1725G and the Outpatient portion of the issue to Group Case No. 99-3527G.

In a separate letter dated January 8, 2008, the Provider transferred the following issues:

Issue #2 - Medicare Bad Debts – Fee Reimbursement issue to Group Case No. 08-0425G
Issue #4 - DSH – Dual Eligible Days issue to Group Case No. 07-1865G
Issue #6 - DSH – Labor Room Days issue to Group Case No. 08-0352G[1]
Issue #7 - DSH – SSI Ratio to Group Case No. 07-1862G

In a letter dated January 14, 2008, the Provider transferred Issue #5 – DSH – Code 2 & 3 Eligible Days Issue to Group Case No. 08-0503G.

On March 20, 2008, the Provider added Issue #12 – Protested Amount – Wage Index.

In the Provider's second Final Position Paper, which was filed on June 28, 2013, the Provider withdrew Issue #1 - Medicare Settlement Data and Issue #3 – Medicare Bad Debts – 2% Share of Costs. In addition, the Provider noted that the following issues had been transferred:

Issue #8 – Medicare Unbilled Crossover Bad Debts issue to Group Case Nos. 07-1725G (Inpatient) and 99-3527G (Outpatient)
Issue #9 – Rural Floor Budget Neutrality issue to Group Case Nos. 07-2260G (2004) and 07-2261G (2005)[2]
Issue #10 – Pension Costs issue to Group Case No. 07-0706G
Issue #12 – Wage Index issue to Group Case No. 04-0492G

On October 1, 2013, the Intermediary filed a jurisdiction challenge stating that the SSI Realignment issue was invalid as there was no determination or adjustment made by the Intermediary and it was not an appealable issue.

On October 23, 2008, the Provider filed a reply brief in response to the Intermediary's challenge regarding the SSI Realignment issue.

Board Determination:

In its description, of the SSI Ratio Alignment issue, the Provider stated:

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[1] In the Provider's Final Position Paper filed on April 18, 2008, the Provider states that the DSH – Labor Room Days issue was transferred to Group Case No. 07-2899G, which is a different group than was noted in their initial transfer letter dated January 8, 2008 (Group Case No. 08-0352G). Both groups are closed as they were remanded to the Intermediary; therefore, this discrepancy is moot.

[2] Since the cost reporting period overlaps two Federal fiscal years, the issue was transferred to both groups for each respective period.

> The Provider contends that the SSI ratio for Medicare disproportionate share hospital (DSH) entitlement purposes be based on its cost reporting year end rather than the Federal fiscal year end. *The Hospital is planning to request from CMS a recalculation of its SSI ratio to align with this cost reporting year end for the above-referenced cost reporting period....* (Emphasis added.)

The Board finds that it does not have jurisdiction over the SSI Realignment issue in this appeal, as this issue is premature. 42 C.F.R. §405.1835 states:

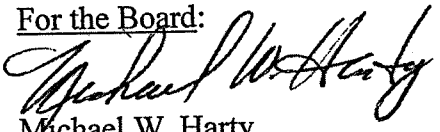
> The provider ... has a right to a hearing before the Board about any matter designated in §405.1801(a)(1), if ... [a]n intermediary determination has been made with respect to the provider.

In this case, there was no final determination made by the Intermediary and the Provider has not requested realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. The Board hereby denies jurisdiction over the SSI Realignment issue. Since there are no remaining issues in this appeal, the Board hereby closes this appeal and removes it from the Board's docket.

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, Esp.
L. Sue Andersen
Charlotte F. Benson

For the Board:



Michael W. Harty
Chairman

cc: Noridian Healthcare Solutions
Donna Kalafut
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Kevin D. Shanklin
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Certified Mail

JUN 19 2015

Christopher L. Keough, Esq.
Akin Gump Strauss Hauer & Feld, LLP
Robert S. Strauss Building
1333 New Hampshire Avenue, N.W.
Washington, D.C. 20036-1564

RE: Akin Gump 2015 PPS Rate Reduction Group Appeals
Provider Nos.: Various
FFY 2015
PRRB Case Nos.: See Attached List

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 1, 2015 request for expedited judicial review (EJR) (received June 2, 2015) for the group appeals on the attached list. The decision of the Board with respect to this request is set forth below.

Issue

The Providers are seeking a correction of their Medicare payment rates per discharge for operating and capital related costs of inpatient services furnished during FFY 2015. In the final IPPS rule for FFY 2014, the Secretary effected a 0.2 percent reduction to the standardized amount[1] paid for operating costs under IPPS, the hospital-specific rates for some sole community hospitals (SCHs) and Medicare-dependent, small rural hospitals (MDHs),[2] and the Federal rate

[1] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* OFFICE OF INSPECTOR GENERAL, MEDICARE HOSPITAL PROSPECTIVE PAYMENT SYSTEM: HOW DRG RATES ARE CALCULATED AND UPDATED (Aug. 2001), http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[2] Although payments to most hospitals under IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital-specific rate, which is determined from their costs in a base year. SCHs receive payment on the higher of the hospital-specific rate based on their updated costs in a base year (the highest of FY 1982, FY 1987, FY 1996, or FY 2006) or the IPPS Federal rate based on their standardized amount, whichever yields the greatest payment. MDHs received the higher of the Federal rate or the Federal rate plus 50 percent of the amount by which the Federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. For discharges occurring on or after October 1, 2007, but before October 1, 2013, a MDH would receive the higher of the Federal rate or the Federal rate plus 75 percent of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987 or FY 2002 hospital-specific rate. *See* 78 Fed. Reg. 50,496, 50,509 and 50,987 (Aug. 19, 2013). The MDH provision was to expire on September 30, 2013; however, the Bipartisan Budget Act of 2013, Pub.L. No. 113-67, § 1106, 127 Stat. 1165, 1197 (2013), amended 42 U.S.C. § 1395ww(d)(5)(G) by extending the deadline to April 1, 2014. The statutory provision for payments to MDHs expired on March 31, 2015 (*see* 80 Fed. Reg. 24,324, 24,336, 24,478 and 24,483 (Apr. 30, 2015)).

for capital costs.[3,4] The Secretary applied this reduction to the payment rates in connection with CMS' adoption of a policy known as the "2-midnight rule." In the final IPPS rule for FFY 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in FFY 2014 and, therefore, continued to apply the reduction for the FFY 2015 period.[5] The Providers believe that the payment rate reduction should be set aside because it exceeds the Secretary's statutory authority under the prospective payment statute (42 U.S.C. §§ 1395ww(d) and 1395ww(g)), is contrary to the plain language and intent of the statute, and is arbitrary, capricious, not based upon substantial evidence, and otherwise contrary to the law.[6]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[7] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[8]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because the Medicare review contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[9]

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[3] *See* 78 Fed. Reg. at 50,746-54.
[4] More specifically, *see* 78 Fed. Reg. at 50,949 (The Secretary believes "that *all* hospitals, LTCHs and CAHs, with the exception of IRFs, would appropriately be included in our final polices regarding the 2-midnight admission guidance and medical review criteria for determining the general appropriateness of inpatient admission and Part A payment" (emphasis added)).
[5] *See* 79 Fed. Reg. 49,854, 50,382-83 (Aug. 22, 2014); *see also Cape Cod Hosp. v. Sebelius,* 630 F.3d 203, 205 (D.C. Cir. 2011) (explaining that, except as otherwise adjusted in the final rule, the standardized amount is calculated by carrying forward the previous fiscal year's standardized amount).
[6] *See* 5 U.S.C. § 706.
[7] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[8] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[9] *Id.*

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Medicare Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[10]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[11] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[12]

In the FFY 2014 IPPS proposed rule,[13] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[14]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions

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[10] *Id.*
[11] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[12] 78 Fed. Reg. at 50,907-08.
[13] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[14] 78 Fed. Reg. 50,908.

were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[15]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[16] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[17] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[18]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[19]

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[15] *Id.*
[16] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[17] 78 Fed. Reg. at 50,909.
[18] *Id.* at 50,927.
[19] *Id.* at 50,944.

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[20] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[21]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[22] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[23]

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[20] *Id.*
[21] *Id.* at 50,945.
[22] *Id.* at 50,952-53.
[23] *Id.* at 50,990.

Providers' Request for EJR

The Providers request that the Board grant EJR with respect to the correction of their Medicare payment rates per discharge for operating and capital-related costs of IPPS services furnished in FFY 2015. In the final IPPS rule for FFY 2014, the Secretary effected a 0.2 percent reduction to the standardized amount paid for operating costs under IPPS, the hospital-specific rates for some SCHs and MDHs, and federal payment rate for capital costs.[24] In the final IPPS rule for 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 period.[25]

The Providers are not contesting the coverage change, but contend that, even if the coverage change is appropriate, the payment reduction should be set aside because it exceeds the Secretary's statutory authority under the PPS statute, 42 U.S.C. §§ 1395ww(d) (inpatient PPS)and 1395ww(g) (capital PPS), is contrary to the plain language and intent of the statue, and is arbitrary, capricious, not based on substantial evidence, and otherwise contrary to the law.[26]

Background

Under both inpatient and capital PPS, Medicare pays prospectively established rates for each patient case. In addition to a base payment rate per discharge, payment adjustments are provided for extraordinarily costly "outlier" cases, indirect medical education costs, and costs for treating a disproportionate share of low-income patients.[27]

Under PPS for operating costs, the payment per discharge is the product of the national payment rate (a base rate called the standardized amount), a "wage index" value reflecting labor costs in each hospital's area relative to a national average, and a weighting for the diagnosis related group (DRG) assigned to the patient's illness or condition for that discharge. The statute prescribes the calculation of the base rate (*i.e.*, the standardized amount) in precise detail, specifically detailing what the rate "is equal to" for a fiscal year based on specific, precisely defined determinations that the Secretary "shall" make.[28] The standardized amount is not created from scratch each year, but is instead carried forward with adjustments made, reversed or modified from year to year.[29]

In addition, the standard payment rate is subject to several upward payment adjustments and exceptions for special cases that are extraordinarily costly (outliers) and for particular categories of hospitals that reasonably incur higher than average costs per case (e.g., graduate medical education and disproportionate share hospitals).[30] In addition, the statute exempts some types of

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[24] *Id.* at 50,496, 50,746, 50,952-54 and 50,990.
[25] *See* 79 Fed. Reg. 49,854, 50,382-83 (Aug. 22, 2014).
[26] *See* 5 U.S.C. § 706.
[27] 42 U.S.C. § 1395ww(d).
[28] 42 U.S.C. §§ 1395ww(d)(1) and (3) (the capital PPS amount is similarly based on a Federal payment per discharge that is established in 42 U.S.C. § 1395ww(g)).
[29] *See Cape Cod Hosp.*, 630 F.3d at 205-06.
[30] 42 U.S.C. § 1395ww(d)(5).

hospitals (SCHs and MDHs) from the standard payment rate so they may receive greater payment based on their individual "hospital-specific" cost per discharge.[31] The statute also grants the Secretary authority to establish other appropriate adjustments and exceptions by regulations.[32] Congress enacted that provision to permit additional adjustments and exceptions, for special cases or discrete types of hospitals with special circumstances, to ensure payment equity in the IPPS payment system.[33]

The 0.2 Percent Payment Rate Reduction

The final IPPS rule for FFY 2014 reduced the standardized amount for operating costs, the federal rate for capital costs, and the hospital-specific rates for SCHs and MDHs by 0.2 percent.[34] The Providers believe that the continued application of the 0.2 percent payment reduction in FFY 2015 violates the Medicare statute and exceeds the Secretary's statutory authority. The Providers contend that the statute precisely prescribes the calculation of the standardized amount for operating costs,[35] the federal rate for capital costs,[36] and the hospital-specific rates for SCHs and MDHs,[37] and those provisions do not provide or allow for the Secretary's 0.2 percent reduction. The 0.2 percent reduction also exceeds the Secretary's authority to adopt additional adjustments and exceptions under section 1395ww(d)(5)(I) of the statute, and violates the language and intent of that provision and the IPPS statute as a whole. [38]

The Providers believe the 0.2 percent reduction is also arbitrary and capricious and not a reasonable interpretation of the statute because it constitutes an unacknowledged and unexplained departure from the Secretary's prior, more limited application, of the adjustments and exceptions authority under section 1395ww(d)(5)(I). The Secretary has never before interpreted that section to effect a global payment rate reduction applicable to all cases, all types of hospitals, and to prospective payment rates for both operating and capital costs, as well as the hospital-specific rate for exception hospitals.

Further, the Providers do not believe the Secretary provided an adequate justification for the global reduction in the payment rate per discharge, nor do they believe there is an adequate explanation for the 0.2 percent reduction. In particular, the Providers do not believe the Secretary has adequately explained how the agency derived the estimates that were used to calculate the 0.2 percent reduction. Since the Board lacks the authority to eliminate the 0.2 percent reduction, the Board should grant the Providers' request for EJR.

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[31] *Id.* at §§ 1395ww(d)(5)(B) and (F).
[32] *Id.* at § 1395ww(d)(5)(I).
[33] *See* H.R. REP. NO. 98-47, at 195 (1983), *reprinted in* 1983 U.S.C.C.A.N. 404, 485.
[34] 78 Fed. Reg. at 50,746,50,952-54, 50,990.
[35] 42 U.S.C. §§ 1395ww(d)(1) and (3).
[36] *Id.* at § 1395ww(g).
[37] *Id.* at §§ 1395ww(d)(5)(D) and (G).
[38] 42 U.S.C. § 1395ww(d).

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for EJR. The documentation shows the estimated amount in controversy for each group appeal exceeds the $50,000 required threshold, although the actual final amounts are subject to recalculation by the Medicare Contractor.

The Board finds that:

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

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount, the hospital-specific rate for some SCH and MDH hospitals, and the Federal rate of capital cost issues, there are no findings of fact for resolution by the Board;

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

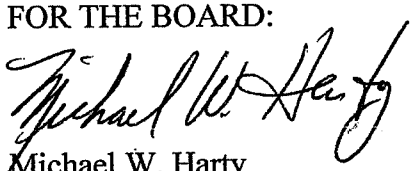
4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital-specific rate for some SCH and MDH hospitals, and the Federal rate of capital cost is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases on the attached list.

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1877 and 405.1877
List of PPS Rate Reduction Group Cases with Schedules of Providers

cc: Danene Hartley, Nat'l Gov't Servs. (Certified Mail w/Case Listing and Schedules)
Bruce Snyder, Novitas Solutions (Certified Mail w/Case Listing and Schedules)
Bill Tisdale, Novitas Solutions (Certified Mail w/Case Listing and Schedules)
Byron Lamprecht, Wis. Physicians Serv. (Certified Mail w/Case Listing and Schedules)
Cecile Huggins, Palmetto GBA (Certified Mail w/Case Listing and Schedules)
James Ward, Noridian Healthcare (Certified Mail w/Case Listing and Schedules)
Kyle Browning, Nat'l Gov't Servs. (Certified Mail w/Case Listing and Schedules)
Donna Kalafut, Noridian Healthcare (Certified Mail w/Case Listing and Schedules)
Geoff Pike, First Coast Serv. Options (Certified Mail w/Case Listing and Schedules)
Lee Crooks, Noridian (Certified Mail w/Case Listing and Schedules)
Kevin Shanklin, Blue Cross & Blue Shield Ass'n (w/Case Listing and Schedules)

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Refer to: 10-1115

CERTIFIED MAIL

JUN 25 2015

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

RE: Oakland Regional Hospital
Provider No.: 23-0301
FYE: 12/31/2007
PRRB Case No.: 10-1115

Dear Mr. Soltis and Mr. Lamprecht:

This case involves Oakland Regional Hospital's ("Oakland's") appeal of its Medicare overpayment for the fiscal year ending ("FYE") on December 31, 2007. The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal and dismisses Oakland's request for hearing ("RFH") for lack of jurisdiction over the issues being appealed.

Pertinent Facts

On June 2, 2008, the Medicare Contractor[1] received Oakland's cost report for FYE December 31, 2007. On June 19, 2008, the Medicare Contractor issued Oakland a letter stamped "FIRST REQUEST" ("First Overpayment Letter") in which the Medicare Contractor states that Oakland's FYE December 31, 2007 cost report reflects an overpayment.[2] In the First Overpayment Letter, the Medicare Contractor claims that an overpayment amount of $1,504,051.45 (principal plus interest) is due in full to the Centers for Medicare & Medicaid Services ("CMS") unless Oakland requests an extended repayment plan.

On August 18, 2008, the Medicare Contractor issued Oakland a tentative settlement notice for FYE December 31, 2007, indicating that CMS owed Oakland a payment of $67,200.[3] Along with the tentative settlement notice, the Medicare Contractor attached its "Acute Tentative Settlement Calculation Form, Summary Worksheet" ("Summary Worksheet") and work papers. The Summary Worksheet states, in the first line, that Oakland's as-filed Medicare Part A cost report liability is $1,506,000; the tentative settlement amount is $1,438,800 due to CMS;

[1] Initially, Oakland's Medicare Contractor was United Government Services, which became National Government Services, Inc. The Medicare contract was later transitioned to Wisconsin Physicians Service, who is currently handling the appeal. These parties are collectively referred to as the "Medicare Contractor."
[2] RFH Tab A.
[3] *Id.* at Tab B.

Oakland's "As-Filed Payments" are $1,506,000; and the additional amount due to Oakland is $67,200.

On July 29, 2009, the Medicare Contractor issued Oakland its notice of program reimbursement ("NPR") for FYE December 31, 2007.[4] In this NPR, CMS calculates an underpayment for Oakland in the amount of $13,739.

On May 14, 2010, the Medicare Contractor issued Oakland a letter stamped "SECOND REQUEST" ("Second Overpayment Letter").[5] In its Second Overpayment Letter, the Medicare Contractor states that it had not received repayment of Oakland's FYE December 31, 2007 overpayment amount or an application for an extended repayment plan as specified in the First Overpayment Letter. The Medicare Contractor also states that "[t]he outstanding amount due for this overpayment is $1,604,002.83 which includes a principal amount of $1,496,327.08 and interest assessed in the amount of $107,675.75." The Medicare Contractor goes on to state that Oakland's "payments have been withheld and are being applied against the overpayment."

On June 25, 2010, the Board received Oakland's request for hearing ("RFH") filed in response to CMS' Second Overpayment Letter. In its RFH, Oakland seeks Board review of its Medicare overpayment and, in relief, requests the following: reversal of the overpayment; affirmation of its underpayment as set out in its July 29, 2009 NPR; an order for CMS to "cease and desist" the withholding of Medicare payment; and the return of all money that CMS has withheld.

Oakland's RFH

Oakland argues that "42 CFR §405.1803(a) requires that the [Medicare contractor] must within a reasonable time (as described in Sec. 405.1835(a)(3)(ii)) i.e., 12 months, furnish the provider with appropriate written notice reflecting the [Medicare contractor's] determination." Oakland states that such notice must not only explain the Medicare contractor's determination, but also relate it to the provider's total reimbursement for the cost reporting period being reviewed. Oakland states that the regulations require the Medicare contractor to include appropriate references to law, regulations, CMS Rulings, or program instructions within its determination in order to explain why the Medicare contractor's reimbursement amount differs from the provider's for the cost reporting period under review. Finally, Oakland claims that CMS' First Overpayment Letter "failed completely to include the required elements . . ." as set out prior, and, therefore, the First Overpayment Letter was not a final determination and "not actionable by Medicare nor appealable by Petitioner."

Oakland contends that while its July 29, 2009 NPR "was a determination that could be appealed[,]" it was satisfied with the Medicare Contractor's determination that it was underpaid for FYE December 31, 2007, and did not appeal that determination. Oakland states that it then "inexplicably" received the Second Overpayment Letter dated May 14, 2010 and that this notice also "lacked the required elements of a valid NPR."

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[4] *Id.* at Tab C.
[5] *Id.* at Tab D.

Oakland claims that CMS is "improperly and illegally withholding payment from [Oakland] because there has been no determination of the alleged overpayment by [CMS]." Oakland argues that "[t]he only appropriate NPR in this matter was that of July 29, 2009 setting forth an *underpayment* by Medicare (emphasis in original)."

Oakland also claims that CMS is withholding Oakland's Medicare payment based upon the Second Overpayment Letter, but the Second Overpayment Letter was not timely because the "alleged notice upon which the alleged overpayment is based is beyond 12 month's from [the Medicare Contractor]'s receipt of [Oakland]'s cost report . . ." In support of this argument, Oakland cites to the regulatory provision at 42 C.F.R. § 405.1803(a).

Jurisdictional Challenge and Oakland's Response

On March 19, 2014, the Board received Blue Cross and Blue Shield Association's ("BCBSA's") Jurisdictional Challenge that it filed on behalf of the Medicare Contractor. In its Jurisdictional Challenge, BCBSA argues that the Board does not have jurisdiction over this appeal because Oakland's RFH was not timely filed.[6] BCBSA also states that the "'demand letter' does not represent a final determination for purposes of a cost report appeal."

In its response to BCBSA's Jurisdictional Challenge, Oakland summarizes its argument by stating that it never received a "timely or proper NPR identifying an overpayment to the Provider."

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.371, Medicare payments to providers may be offset or recouped by a Medicare contractor if it has been determined that the provider has been overpaid and § 405.374 provides an opportunity for provider rebuttal to the Medicare contractor. However, the issuance of a demand letter and the determination to withhold or recoup overpayment amounts is not within the scope of permissible Board review.

Pursuant to 42 U.S.C § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2008), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if the provider has preserved its right to claim dissatisfaction with the final determination of the Medicare contractor; the amount in controversy is $10,000 or more; and the request for hearing is filed within 180 days of the date of receipt of the final determination.

Under 42 C.F.R. § 405.1835(b)(2), a provider's request for hearing must include, among other requirements, an explanation of the provider's dissatisfaction with the Medicare contractor's determination for each specific item at issue. For each disputed item, this explanation must include an account of why the provider believes Medicare payment is incorrect and how and why

[6] BCBSA argues that the Medicare Contractor issued Oakland's NPR on July 29, 2010, but the NPR is dated July 29, 2009. The incorrect date on BCBSA's Jurisdictional Challenge appears to be a typographical error.

the provider believes Medicare payment must be determined differently. 42 C.F.R. § 405.1835(b)(2)(i)-(ii). The Board may dismiss, with prejudice, a hearing request that does not meet the regulatory requirements. 42 C.F.R. § 405.1835(b).

Under 42 C.F.R. § 405.1835(a)(3)(ii), a Medicare contractor's determination is not timely if it is not issued, through no fault of the provider, within 12 months of the Medicare contractor's receipt of the provider's perfected or amended cost report. As such, pursuant to section 1878(a)(1)(B), (a)(2) and (a)(3) of the Social Security Act, a provider also has a right to a hearing before the Board if the provider does not receive a Medicare contractor's final determination on a timely basis, the amount in controversy is $10,000 or more, and the request for hearing is filed within 180 days after the expiration of the 12 month period for issuance of the Medicare contractor's determination.

In the present case, Oakland filed its FYE December 31, 2007, cost report on June 2, 2008. This June 2, 2008 cost report showed that CMS overpaid Oakland for the fiscal year at issue and prompted the Medicare Contractor to issue Oakland the June 19, 2008 First Overpayment Letter. On July 29, 2009, the Medicare Contractor issued Oakland its NPR for FYE December 31, 2007. The July 29, 2009 NPR demonstrated an underpayment to Oakland, and Oakland states that it was satisfied with this NPR, therefore it did not file an appeal at that time. However, once Oakland received its Second Overpayment Letter on May 14, 2010, it filed the present appeal with the Board. Oakland challenges that its May 14, 2010 Second Overpayment Letter contains "the required elements" of a valid NPR or final determination and claims that it never "received a timely or proper NPR identifying an overpayment to the Provider."

Oakland's June 25, 2010 RFH was submitted based on CMS' Second Overpayment Letter, not its July 29, 2009 NPR. Despite Oakland's attempt to categorize CMS' Second Overpayment Letter as a "final determination" with which it is dissatisfied and from which it may appeal, this letter reflects CMS' attempt to recoup the overpayment *reported by Oakland.* Oakland's overpayment at issue here was not calculated or determined by the Medicare Contractor, instead it resulted from Oakland's own calculations in its as-filed cost report. Therefore, because Oakland's RFH is based upon the CMS' demand for repayment in the Second Overpayment Letter, Oakland has not challenged specific costs that have been adjusted on a final determination of the Medicare Contractor, nor is Oakland able to explain how and why Medicare payment must be determined differently—both prerequisites to obtaining Board jurisdiction for an appeal based on provider dissatisfaction.[7]

Nevertheless, pursuant to the statute governing Board jurisdiction of provider appeals, Oakland had the right to request a hearing before the Board as its FYE December 31, 2007 NPR was not issued in a timely manner.[8] However, in order for Oakland's RFH to itself be considered timely,

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[7] 42 C.F.R. § 405.1835(a)(1) and (b)(2).

[8] As BCBSA's jurisdictional challenge notes, the Medicare Contractor received Oakland's cost report on June 2, 2008. Therefore, pursuant to 42 C.F.R. § 405.1835(a)(3)(ii), the Medicare Contractor had until June 2, 2009 to issue Oakland a timely NPR.

it must have been filed by November 30, 2009.[9] Here, the Board received Oakland's RFH on June 25, 2010, well beyond the allowable time frame to file such an appeal.

The Board, therefore, has no basis for jurisdiction in this appeal and, hereby dismisses Case No. 10-1115.

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

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

For the Board:

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, Executive Director, Blue Cross and Blue Shield Association

[9] 42 C.F.R. § 405.1835(a)(3)(ii).

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JUN 25 2015

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Geoff Pike
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532 Riverside Avenue
Jacksonville, FL 32231-0014

Re: Provider: Baptist Medical Center
Provider No.: 10-0088
FYE: 09/30/1998
PRRB Case No.: 09-0858

Dear Mr. Seely and Mr. Pike:

The Provider, Baptist Medical Center ("Baptist"), appealed its 2008 revised Notice of Program Reimbursement ("RNPR") to the Provider Reimbursement Review Board ("Board"). The Board determined that it lacks jurisdiction in this case because Baptist failed to meet (1) the requirement that an issue be specifically revised pursuant to 42 C.F.R. § 405.1889 and (2) the dissatisfaction requirement of 42 U.S.C. § 1395oo(a).

Background

Baptist appealed several issues to the Board for fiscal year 1998. Subsequent to the Board establishing Case No. 02-1710, Baptist and the Medicare Administrative Contractor, First Coast Service Options, Inc. (hereinafter "First Coast"), entered into an Administrative Resolution ("AR") regarding the issues in the appeal.[1] Both parties signed the AR in June 2008. As a result, the Board closed Case No. 02-1710 in December 2009.

The AR states that the parties entered " . . . into this [AR] for the purpose of setting forth the basis for resolving the issues that are pending before the [Board]."[2] The

[1] Administrative Resolution between Baptist and First Coast, Jun. 2008 ("AR").
[2] AR at 1.

AR states that the parties agreed to resolve the case regarding the following:

(1) IME and GME FTE Count
(2) DSH Medicaid Eligible days
(3) Outlier Reimbursement
(4) Laboratory Provider Component Hours and RCE Disallowance
(5) Collection Expense
(6) Employee Health Insurance Costs and Charges
(7) Worksheet L Capital payments
(8) Inpatient Part B 5.8% Reduction
(9) Inclusion of Medicare MSP LCC Days in GME Reimbursement
(10) Emergency Room Square Feet Statistics
(11) Revenue Classification on Worksheet G-2
(12) DSH SSI Percentage[3]

As part of the AR, Baptist agreed to transfer Outlier Reimbursement and DSH SSI Percentage to group appeals.[4] Baptist also agreed to withdraw the issues of Collection Expense, Employee Health Insurance Costs and Charges, Inclusion of Medicare MSP LCC Days in GME Reimbursement, and Revenue Classification on Worksheet G-2.[5] The remaining issues were adjusted pursuant to the AR. The AR also states that "[t]he Provider will withdraw all issues and request this [Board] case dismissed. The [Contractor] will reopen, settle and make payment to the Provider within 180 days of signing of this [AR]. If the [Contractor] fails to properly effectuate this [AR] the Provider may reinstate the appeal."[6]

To implement the AR, First Coast issued a RNPR on August 11, 2008.[7] Baptist filed a timely appeal of its RNPR with the Board, establishing the instant case. Baptist appealed three issues, generally: (1) DSH Medicaid Eligible days; (2) DSH SSI; and, (3) Capital DSH.[8] Baptist identified the substantive issues as:

1. Whether Medicaid days used to compute the [DSH]

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[3] *See id.* at 1-3.
[4] *Id.* at 2, 3.
[5] *Id.* at 2-3.
[6] *Id.* at 4.
[7] *See* RNPR, Aug. 11, 2008 *attached to* Baptist's Appeal Request Tab 1, Feb. 10, 2009.
[8] *See* Baptist Appeal Request Tab 3, Ex. C (Table of Issues and Amounts).

Days" and "DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payer Days and No Pay Part A Days)" to group appeals 14-3534GC and 14-3531GC, respectively.[15] This time Baptist listed adjustment numbers 1, 5, and 11 in its transfer requests.[16] Prior to the transfer requests, Baptist submitted proof of its Preliminary Position Paper; Baptist briefed all three of the appealed issues.[17]

Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2007), 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 (1) dissatisfied with the final determination of the contractor, (2) the amount in controversy is $10,000 or more, and (3) the request for a hearing is filed within 180 days of the date that the notice of the contractor's determination was mailed to the provider. Additionally, appeals stemming from RNPRs have a different set of regulations that apply in the instant case:

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 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. [18]

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[15] Baptist's Transfer Requests, May 21, 2014. It should be noted that Baptist is the only provider currently in the group appeals (Case Nos. 14-3531GC and 14-3534GC).
[16] *See id.*
[17] *See* Baptist's Preliminary Position Paper, Oct. 5, 2009.
[18] 42 C.F.R. § 405.1889; *see also* 42 C.F.R. § 405.1887(d), which states, "[a] reopening by itself does not extend

This regulation is interpreted as meaning that a provider's appeal rights are derived from the items revised in a contractor reopening. Therefore, Baptist may only appeal those items that were revised in its RNPR.

In this case, DSH SSI was not revised during First Coast's reopening.[19] Moreover, since the Board Rules require specificity in appealing multi-component issues, an adjustment to DSH, generally, does not provide appeal rights to all of the DSH components. Board Rule 8.1 states:

> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7. . . .[20]

Board Rule 8.2 identifies DSH as a multi-component issue.[21] Therefore, SSI must be separately revised in a RNPR in order for a provider to have a valid appeal; however, Baptist's Audit Adjustment Report does not show an SSI adjustment. More recently, 42 C.F.R. § 405.1889 was addressed in *Emanuel Medical Center, Inc. v. Sebelius,* No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). In that case, the court held that the "issue-specific" interpretation of the RNPR regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered. The Board finds that it lacks jurisdiction over SSI and hereby dismisses this issue from the case.

Although Medicaid Eligible days and Capital DSH were revised in Baptist's RNPR, the Board finds that Baptist fails to satisfy the requirement that it be "dissatisfied with the final determination."[22] In *Illinois-Masonic Medical Center v. Sebelius*, 859 F. Supp. 2d 137, 145 (D.D.C. 2012), the court upheld the decision to deny jurisdiction because the provider signed an AR and then attempted to appeal an additional set of days

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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).

[19] In fact, per the AR, Baptist stated it was transferring the DSH SSI issue from its original appeal (Case No. 02-1710) to a group appeal. Baptist cannot appeal the same issue in more than one appeal. *See* Board Rule 4.5 at 3, Aug. 21, 2008.

[20] Board Rule 8.1 at 6-7.

[21] Board Rule 8.2 at 7.

[22] *See* 42 C.F.R. § 405.1889.

that were never presented to the contractor for consideration.[23] The additional 2,244 Medicaid eligible days sought by the provider in that case were outside the scope of review of the RNPR, which was based on an AR.[24] Per that AR, the provider submitted 230 days to be reviewed by the contractor; the contractor allowed 24 of those days.[25] Additionally, the court held, as a result of signing the AR, the provider disclaimed any dissatisfaction with the contractor's determination in the RNPR.[26] *Illinois-Masonic* explained that a provider who agreed to the adjustments cannot demonstrate that it was dissatisfied with the matters addressed in the RNPR.[27] In *Illinois-Masonic*, as in the instant case, the contractor expressly stated it was revising the determination to specifically incorporate the AR.[28]

Here, the parties agreed to the treatment of Medicaid Eligible days and Capital DSH. Further, Baptist makes no indication that the Medicaid Eligible days it is appealing from its RNPR were ever presented to First Coast. The AR states that First Coast reviewed Baptist's additional documentation and " . . . corrected the Medicaid days and resultant percentage change."[29] As agreed, 2,213 additional Medicaid Eligible days were submitted and allowed. Also as agreed, the change in Medicaid Eligible days caused the DSH percentage to increase from 11.72% to 13.68%.[30] The record does not support that the Provider is now appealing days previously denied. In fact, Exhibit D in Baptist's Appeal Request provides an estimate of 5%, not a specific number of days.[31] As of the date of the preliminary position paper, the Provider still did not have a list of days.

Additionally, Baptist and First Coast agreed that the reimbursement effect of $15,793.00 would resolve the Capital DSH issue.[32] The AR states: "Worksheet L calculation changed due to changes above, resulting in an increase in the payment amount."[33] Utilizing the AR process, the parties intended to resolve all of Baptist's previously-appealed issues. Further, by signing the AR, Baptist consented to the dismissal of its appeal before the Board.[34] The Board, therefore, finds that Baptist failed to prove its dissatisfaction with First Coast's treatment of Medicaid Eligible days and Capital DSH.

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[23] *Illinois-Masonic Medical Center v. Sebelius*, 859 F. Supp. 2d 137, 145 (D.D.C. 2012).
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.* (holding that the Secretary's interpretation—that the scope of the RNPR was limited by operation of the AR—was reasonable).
[28] *Id.* at 146.
[29] AR at 2.
[30] *Id.*
[31] Baptist Appeal Request Tab 3, Ex. D.
[32] AR at 3.
[33] *Id.*
[34] *Id.* at 4.

Conclusion

Since dissatisfaction is a prerequisite to Board jurisdiction under 42 U.S.C. § 1395oo(a), the Board determined that it lacks jurisdiction over Medicaid Eligible days and Capital DSH. As those were the sole issues under appeal relating to DSH eligible days, the Board also denies Baptist's requests to transfer DSH Medicare HMO days and Dual Eligible days as the Provider has failed to submit documentation that those days were adjusted as part of the RNPR and if so, how they were dissatisfied with their resolution of those days. As Baptist is the sole Provider in Case Nos. 14-3534GC and 14-3531GC, those appeals are now dismissed.

Additionally, since SSI was not revised in the RNPR, the Board finds that it lacks jurisdiction over SSI. With these findings, the Board dismisses this case. Review of this jurisdictional decision is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1835(a) and 405.1877.

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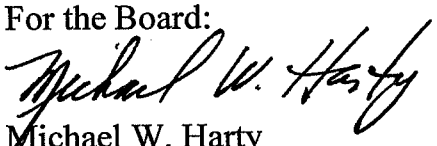
For the Board:



Michael W. Harty
Chairman

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

cc: Kevin Shanklin, Executive Director, BCBSA (without enclosures)