DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to: 13-0412

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CERTIFIED MAIL

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President
c/o Appeals Department
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Dallas, TX 75248-1372

Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
P.O. Box 8696
Madison, WI 53708-1834

RE: Jurisdictional Decision – Lafayette General Medical Hospital
Provider No.: 19-0002
FYE: 09/30/2007
PRRB Case No.: 13-0412

Dear Ms. Goron and Mr. Lamprecht,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The Board finds that it does not have jurisdiction over the SSI Realignment issue as it is duplicative of the Systemic Errors issue and no final determination has been issued. The Board's decision is set forth below.

Background

The Medicare contractor issued a Notice of Program Reimbursement (NPR) for FYE 09/30/2007 on July 25, 2012. Lafayette General Medical Hospital filed an appeal request with the Board in which it appealed six issues:

1. DSH/SSI (Systemic Errors)
2. Rural Floor Budget Neutrality Adjustment
3. DSH Payment/SSI Percentage (Provider Specific)
4. DSH – Medicaid Eligible Days
5. DSH – Medicare Managed Care Part C Days
6. DSH – Dual Eligible Days

Five of the six issues have since been dismissed, withdrawn or transferred to group appeals. The only issue that remains in case number 13-0412 is the SSI Percentage (Provider Specific) issue.

Medicare Contractor's Jurisdictional Challenge:

The Medicare Contractor submitted a challenge to the Board's jurisdiction over the SSI Percentage Provider Specific issue based on its contention that is not an appealable issue. The Medicare Contractor argues that this issue cannot be appealed because the decision to realign a

provider's SSI Percentage with its Fiscal Year End is through a provider's own election and is not a Medicare contractor's determination. According to the Medicare Contractor, because Lafayette General Medical Hospital is now requesting realignment of the SSI calculation, the issue is suitable for reopening but does not constitute an appealable issue. Only those determinations and calculations made by the Medicare Contractor can be appealed to the Board. Because the SSI realignment must be requested by the Provider and the Medicare Contractor has not, and cannot, make a determination in terms of the Provider's SSI realignment, the Medicare Contractor asks the Board to dismiss the issue from the appeal.

Provider's Response to Jurisdictional Challenge

Lafayette General Medical Hospital contends that it is not addressing a realignment of the SSI percentage but is addressing the various errors of omission and commission that do not fit into the Systemic Error category. Because the Medicare Contractor adjusted the Provider's SSI percentage and the Provider is now claiming dissatisfaction with the amount of DSH payments received, the Provider argues that the Board has jurisdiction over the SSI Percentage Provider Specific issue as a whole. The Provider argues that this data is necessary in order for it to prove that its SSI percentage was understated. Therefore, Lafayette General Medical Hospital requests that the Board dismiss the Medicare Contractor's jurisdictional challenge and find that the SSI Percentage Provider Specific issue as a whole is an appealable one.

Board's Decision

The Board finds that it does not have jurisdiction over the SSI Percentage Provider Specific issue as it is duplicative and there is no final determination. 42 C.F.R. § 405.1835 (2012) states,

> A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination only if . . . [t]he provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue. . .

In this case, the Provider does not appear to have requested a realignment of the SSI calculation and the Medicare Contractor has not made a final determination regarding the SSI realignment issue. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Without these requests it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers could appeal. Furthermore, even if a Provider had requested a realignment from the federal fiscal year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.

The Provider Specific issue also includes duplicative language of the already transferred Systemic Errors issue. The issue statement reads: "Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory Instructions...specifically the provider disagrees with the MAC's calculation of the computation of the DSH percentage." The

SSI (Systemic Errors) issue statement also contends that the "Secretary improperly calculated the Provider's DSH/SSI percentage." The SSI (Systemic Errors) issue was transferred to a group and no longer remains pending in this appeal. Therefore, because the SSI Percentage Provider Specific issue is duplicative of the Systemic Errors issue and the Medicare Contractor has not made a determination regarding SSI realignment from which Lafayette General Medical Hospital could be dissatisfied, the Board finds that it lacks jurisdiction over the issue in this appeal and dismisses the issue from case number 13-0412.

Accordingly, because the Provider Specific issue is the last remaining issue pending in this appeal, case number 13-0412 is dismissed.

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

Board Members Participating
Michael W. Harty
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

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: Wilson Leong, FSS

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Refer to: 11-0613GC

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Cahaba Safeguard Administrators, LLC
James Lowe
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RE: QRS BHCS 2005/2006 DSH Medicaid Eligible Observation Bed Days Group
Jurisdictional Challenge
PRRB Case Number: 11-0613GC

Dear Mr. Ravindran and Mr. Lowe,

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

Background

On May 18, 2011, Quality Reimbursement Services, Inc. ("QRS") filed the subject group appeal transferring Baylor University Medical Center, Provider Number 45-0021, Fiscal Year ("FY") June 30, 2005, from Case No. 08-1385 and Baylor Medical Center at Irving, Provider Number 45-0079, FY June 30, 2006, from Case No. 08-2835. The Provider Reimbursement Review Board ("Board") assigned Case No. 11-0613GC. QRS stated the issue as:

> "Whether the MAC [Medicare Administrative Contractor] accurately accounted for Observation Bed days associated with Medicaid eligible patients in the DSH Calculation. The Provider contends that Observation Bed days were not accurately determined by the MAC for Medicare DSH reimbursement purposes. See 68 Fed. Reg. at 45418-19. Because the Observation Bed days were not accurately accounted for, the Medicaid fraction of the Medicare DSH reimbursement calculation is understated. All cost reports filed after October 1, 2004, are required to include observation patient days for patients who are later admitted as inpatients. Some of these patients are low income Medicaid eligible patients and need to be accounted for in the Medicaid fraction of the Medicare DSH payment calculation set forth at 42 CFR § 412.106(b). CMS' policy is to add Observation Bed days into the denominator of the Medicaid fractions; therefore, it is necessary to include Title XIX Observation Bed days in the numerator as well."

On May 25, 2011, the Board dismissed Baylor University Medical Center, Provider Number 45-0021 from Case No. 11-0613GC. On August 30, 2011, QRS transferred Baylor All Saints Medical Center, Provider Number 45-0137, FY September 30, 2005 from Case No. 08-1681 to the subject group appeal.[1]

On May 4, 2016, the Board received the Medicare Contractor's Jurisdictional Challenge which alleges the Board does not have jurisdiction over the issue for both Providers remaining in the group appeal. On June 1, 2016, the Board received QRS' response to the Jurisdictional Challenge.

Medicare Contractor's Contentions

The Medicare Contractor challenges the Board's jurisdiction over the Observation Bed day issue for both Providers since the MAC did not make an audit adjustment to Observation Bed days in the providers' final cost reports. Also, the Providers' as filed cost reports did not include this issue as a protested amount.

The MAC accepted the as-filed numbers for the final cost report. The Providers cannot demonstrate dissatisfaction with the MAC final determination, as there was no MAC final determination for this issue. There was no audit adjustment, so the Providers are dissatisfied with its own reporting of Observation Bed days, not the MAC's determination of observation bed days.

The MAC cites to the Board's jurisdictional decision PRRB Case no. 07-2152. The contested issue in that decision was related to the misstatement of available beds and available bed days. The Board concluded the provider did not have a right to appeal the issue. In a more recent decision, St. Vincent Hospital (2013-D39), where the provider did not claim ambulatory surgery costs and organ acquisition costs, the Board denied jurisdiction of unclaimed costs. The MAC also, refers to the Board's decision in Danbury Hospital (2014-D4) where the Board denied jurisdiction on unclaimed costs related to additional Medicaid eligible days. The Board determined that there was no practical impediment that precluded the provider from claiming the additional Medicaid days. For the subject appeal there was no regulation that precluded the Providers from claiming the Observation Bed days in their as filed cost reports.

Providers Contentions

The Providers contend that the Board has jurisdiction over the DSH Medicaid Observation Bed Days issue. Pursuant to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988), the Providers claim that a provider may appeal a "self-disallowed" cost even if it failed to first present its claim in an as-filed cost report.[2] QRS contends that the presentment requirement does not apply in this instance pursuant to *Bethesda*.

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[1] *See* Scheduled of Providers.
[2] QRS jurisdictional response at 5 (May 31, 2016).

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) (2007) 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 received by the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider. The Board has *discretionary power* under 42 U.S.C. § 1395oo(d) after jurisdiction is established under 42 U.S.C. § 1395oo(a) to make a determination over all matters covered by the cost report. The Board can affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and make any other revisions on matters covered by the cost report even though such matters were not considered by the intermediary in making its final determination.

The Board concludes that it does not have jurisdiction over the Observation Bed Days issue for the Providers in the subject appeal pursuant to 42 U.S.C. § 1395oo(a). Also, the Board declines to hear these matters under its discretionary powers of review pursuant to 42 U.S.C. 1395oo(d)[3]. The Board finds that the Providers do not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the Observation Bed Days issue.

The crux of this dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which provides in relevant part:

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

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

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

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[3] Both Providers filed timely individual appeals that contained other jurisdictionally valid issues prior to transferring observation days issue to this group appeal.

The Medicare Contractor did not make a determination regarding the Observation Bed Days as the Providers failed to claim observation bed days in their DSH calculation on the as filed cost reports. The Providers received reimbursement in the manner they made a claim therefore, the Providers cannot claim dissatisfaction. The error was due solely to the Providers' negligence. Only in hindsight did the Providers determine that they should have reported Observation Bed Days differently and included those days in their DSH calculation.

In *Bethesda,* the provider failed to claim a cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court wrote:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[4]

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

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[5]

In this case, the Board has precisely the situation described by the Supreme Court as being "on different ground."[6] While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost unclaimed through inadvertence rather than futility, other appellate courts have done so. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Co. of Mary Hosp. v. Shalala* ("*Little Co. I*"),[7] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal

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[4] *Bethesda.* at 1258, 1259. (Emphasis added).
[5] *Id.* at 1259. (Emphasis added).
[6] Emphasis added.
[7] 24 F.3d 984 (7th Cir. 1994).

intermediary, which establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[8]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[9] In *Little Co. II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the Intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[10] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[11]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[12] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[13]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[14] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[15] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with

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[8] *Little Co. I,* 24 F.3d at 992.
[9] *Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999).
[10] *Little Co. II,* 165 F.3d at 1165.
[11] *Id.*
[12] 73 Fed. Reg. at 30196.
[13] 73 Fed. Reg. at 30203.
[14] *See Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).
[15] 492 F.3d 1065 (9th Cir. 2007).

which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal. The Ninth Circuit Court stated:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has *discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense ... even though that particular expense was not expressly claimed or explicitly considered by the intermediary.*[16]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[17] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[18] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[19] which were decisions issued in 2000 and 1987 respectively.[20]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[21] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 1395oo(d)] does not say that the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[22]

The First Circuit in *MaineGeneral* then found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims

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[16] *Id.* at 1068 (emphasis added).
[17] *See* 73 Fed. Reg. at 30197.
[18] 205 F.3d 493 (1st Cir. 2000).
[19] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[20] *See Loma Linda,* 492 F.3d at 1068.
[21] *St. Luke's*, 810 F.2d at 332.
[22] *Id.* at 327-328 (emphasis in original).

would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued."[23] Similarly, in *St. Luke's*, the First Circuit opined that, even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly.[24] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[25]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.*, unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[26] As in *MaineGeneral* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied, but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d), ...[27]

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[28]

Finally, and most recently, the D.C. District Court found in favor of the agency's interpretation

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[23] *MaineGeneral*, 205 F.3d at 501.
[24] *St. Luke's*, 810 F.2d at 327.
[25] *MaineGeneral*, 205 F.3d at 501.
[26] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].
[27] *Id.* at 79.
[28] *Id.* at 77.

of the dissatisfaction requirement in 1395oo(a) in *Saint Vincent Indianapolis Hospital v. Sebelius.* [29] Similarly, in that appeal, the PRRB determined that plaintiff "failed to meet the jurisdiction prerequisite of being 'dissatisfied' with the amount of Medicare payment because the 'errors and omissions' alleged by the provider in its appeal stemmed from its own 'negligence' in understanding the Medicare regulations governing the reimbursement of such costs" rather than the FI/MAC's action. The Court found that in reviewing both parties analysis of the statutory language and the relevant case law, that the Board's jurisdictional determination was applying the language of the Medicare Act and therefore the Court grants the agency's interpretation deference. Additionally, the Court found that the PRRB's ruling was based upon "a permissible construction of the statute", and therefore upheld the PRRB's dismissal.

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[30]

In the instant case, it is undisputed that the Providers did not include the Observation Bed Days correctly on their as-filed cost reports. Only in hindsight did the Providers determine that it could have included the Observation Bed Days in the DSH calculation, thereby increasing the amount of reimbursement. This case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[31] The Board notes that it has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeals of other issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction.[32] Therefore, the

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[29] *Saint Vincent Indianapolis Hospital v. Sebelius,* 2015 WL 5728372 (D.D.C 2015).

[30] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

[31] *Bethesda*, 485 U.S. at 404-405.

[32] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010). This would not be a case in which the Board would deviate from this

Board dismisses the Observation Bed Days from the Providers' individual appeals and hereby denies the transfer into the subject group appeal. The Board does not have jurisdiction under 42 U.S.C. § 1395oo(a) and declines to take discretionary jurisdiction under § 1395oo(d) to address items and services not claimed or not properly reported on the cost report where the failure to claim was due to inadvertence rather than futility.

As there are no Providers remaining in the group, the Board hereby closes this case and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating
Michael W. Harty
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L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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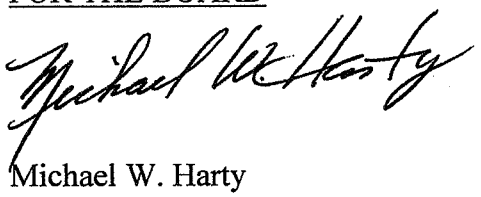
FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Federal Specialized Services
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RE: Request for Reopening of Bifurcation Denial
John Muir 2005 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2613GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the John Muir 2005 Disproportionate Share Hospital ("DSH") Dual Eligible Days Common Issue Related Party ("CIRP") Group's ("John Muir") request that the Board reconsider its April 29, 2015 ("Decision"). Within that Decision, the Board denied a request to bifurcate the participants' dual eligible days issue within this CIRP group appeal. Upon reconsideration, the Board hereby grants John Muir's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues within the instant appeal. The Board's decision is set forth below.

BACKGROUND

On July 25, 2008, the Board received John Muir's request to form a CIRP group appeal based on two participants. On July 29, 2015, the Board received John Muir's Schedule of Providers and Jurisdictional Documentation for 2 participants within the group.

On February 27, 2015, the group's representative, Toyon Associates, Inc. ("Toyon") submitted correspondence to the Board indicating that the group appeal was complete. Toyon also submitted two Schedules of Providers: one for dual eligible patients entitled to Part C and the second for dual eligible patients with no Part A paid claims. In a letter dated April 29, 2015, the Board issued a decision denying bifurcation of the two dual eligible days issue finding "that there is no mention of Medicare Part C days as a sub-issue in the group[]."

Subsequently, on July 5, 2016, the Board received the Providers' Request for Reopening of Bifurcation Denial.

Case No.: 08-2613GC

BOARD'S DECISION

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Although the Board initially denied the request for case bifurcation, upon reconsideration, the Board acknowledges that at the time that the providers' individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original common issue-related provider group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2613GC in violation of 42 C.F.R. § 405.1837(a)(2) and PRRB Rule 13.[1] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The Providers' Part C issue is now within newly formed PRRB Case No. 16-2087GC. The Providers' dual eligible Part A non-covered days issue has already been scheduled for hearing before the Board on August 9, 2016. The Board's Acknowledgment Letter for PRRB Case No. 16-2087GC is included as an enclosure along with this determination.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers dated July 29, 2015
Group Acknowledgment Letter for PRRB Case No. 16-2087GC

cc: Wilson Leong, Federal Specialized Services

[1] Both the regulation and Board Rule clearly state that a group appeal must only contain one issue.

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Refer to: 08-2642GC

CERTIFIED MAIL

AUG 03 2016

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Thomas P. Knight
President
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Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Reopening of Bifurcation Denial
Hawaii Pacific Health 2005 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2642GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in order to reconsider Toyon Associates, Inc.'s ("Toyon's") request for case bifurcation of the dual eligible Part A non-covered and Part C days issues in the Hawaii Pacific Health 2005 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days CIRP Group. The Board initially denied bifurcation in the appeal in its April 29, 2015 Decision. Upon reconsideration, the Board hereby grants bifurcation for the Providers in this appeal, as explained below.

Background

On July 25, 2008, the Board received Toyon's request to form a group based on two Providers. The Board received Toyon's Schedule of Providers and jurisdictional documentation for the group dated July 29, 2015 which consisted of two Providers. On May 26, 2015, the Board remanded the period from 7/1/2004 – 9/30/2004 for both participants pursuant to CMS Ruling 1498-R.

On February 27, 2015, Toyon submitted correspondence to the Board indicating that the group appeal was complete. Toyon also submitted two Schedules of Providers: one for dual eligible patients entitled to Part C and the second for dual eligible patients with no Part A paid claims. In a letter dated April 29, 2015, the Board issued a decision denying bifurcation of the two dual eligible days issue finding "that there is no mention of Medicare Part C days as a sub-issue in the group[]."

Subsequently, on July 5, 2016, the Board received the Providers' Request for Reopening of Bifurcation Denial.

Board's Decision

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

Although the Board initially denied the request for case bifurcation, upon reconsideration, the Board acknowledges that at the time that the providers' individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original common issue-related provider group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2642GC in violation of 42 C.F.R. § 405.1837(a)(2) and PRRB Rule 13.[1] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The Providers' Part C issue is hereby transferred to PRRB Case No. 16-0877GC, Hawaii Pacific Health 2005-2007 DSH Part C Days CIRP Group.[2] The Providers' representative is to submit an updated Schedule of Providers with the associated jurisdictional documentation in case number 16-0877GC to the Board and the Medicare contractor within 60 days of the date of this letter.

The Providers' dual eligible Part A non-covered days issue has already been scheduled for hearing before the Board on August 8, 2016.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

cc: Wilson Leong, Federal Specialized Services

[1] Both the regulation and Board Rule clearly state that a group appeal must only contain one issue.
[2] This group has been renamed to reflect the addition of the 2005 and 2007 FYEs to the appeal.

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Noridian Healthcare Solutions, LLC
Evaline Alcantara
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Reopening of Bifurcation Denial
Hawaii Pacific Health 2007 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 09-1662GC

Dear Mr. Knight and Ms. Alcantara:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in order to reconsider Toyon Associates, Inc.'s ("Toyon's") request for case bifurcation of the dual eligible Part A non-covered and Part C days issues in the Hawaii Pacific Health 2007 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days CIRP Group. The Board initially denied bifurcation in the appeal in its April 29, 2015 Decision. Upon reconsideration, the Board hereby grants bifurcation for the Providers in this appeal, as explained below.

Background

On May 6, 2009, the Board received Toyon's request to form a group based on two Providers. The Board received Toyon's Schedule of Providers and jurisdictional documentation for the group dated July 29, 2015 which consisted of two Providers.

On February 27, 2015, Toyon submitted correspondence to the Board indicating that the group appeal was complete. Toyon also submitted two Schedules of Providers: one for dual eligible patients entitled to Part C and the second for dual eligible patients with no Part A paid claims. In a letter dated April 29, 2015, the Board issued a decision denying bifurcation of the two dual eligible days issue finding "that there is no mention of Medicare Part C days as a sub-issue in the group[]."

Subsequently, on July 12, 2016, the Board received the Providers' Request for Reopening of Bifurcation Denial.

Board's Decision

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

Although the Board initially denied the request for case bifurcation, upon reconsideration, the Board acknowledges that both Providers in this group filed individual appeal requests which clearly identified both the HMO/Part C and Part A exhausted days. Their individual appeal requests both characterized the exhausted and Medicare HMO days as "dual eligible." The Providers' transfer requests and the CIRP group appeal request, did not, however, raise the Medicare HMO/Part C days issue. Therefore, the Board has determined that the Part C days issue remains in the Providers' individual appeals, PRRB Case Nos. 09-0367 and 08-2892.

The Board hereby reopens the Providers' individual appeals, PRRB Case Nos. 09-0367 and 08-2892 and transfers the Part C days issue to PRRB Case No. 16-0877GC, Hawaii Pacific Health 2005-2007 DSH Part C Days CIRP Group.[1] The Providers' representative is to submit an updated Schedule of Providers with the associated jurisdictional documentation in case number 16-0877GC to the Board and the Medicare contractor within 60 days of the date of this letter.

The Providers' dual eligible Part A non-covered days issue remains in this appeal, PRRB Case No. 09-1662GC and has already been scheduled for hearing before the Board on August 16, 2016.

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

Board Members
Michael W. Harty
Clayton J. Nix, Esq. (dissenting)
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD

Michael W. Harty
Chairman

cc: Wilson Leong, Federal Specialized Services

[1] This group has been renamed to reflect the addition of the 2005 and 2007 FYEs to the appeal.

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RE: Request for Reconsideration
Mid-Jefferson Hospital and Park Place Medical Center *as participants in*
Southwest Consulting Iasis Healthcare 03 DSH LDR Days CIRP Group
Provider Nos.: 45-0514 & 45-0518
FYE: 7/31/2003
PRRB Case No.: 09-0068GC

Dear Ms. Webster and Mr. Ward:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the request that the Board reconsider its February 20, 2015 Decision. Within that Decision, the Board denied jurisdiction over two Providers: Mid-Jefferson Hospital (provider number 45-0514, FYE 7/31/2003) and Park Place Medical Center (provider number 45-0518, FYE 7/31/2003) because the Providers appealed from revised Notices of Program Reimbursement ("NPR") that did not specifically adjust labor and delivery room days. Upon reconsideration, the Board finds that, based upon additional information the Providers submitted, the revised NPRs did adjust labor and delivery room days. The Board's decision is set forth below.

BACKGROUND

The Board received the appeal request for this group on October 6, 2008. On June 26, 2014, the Board sent a development letter to the Providers requesting additional information related to the revised NPR appeals of Mid-Jefferson Hospital and Park Place Medical Center. The Board received this information on July 23, 2014.

On February 20, 2015, the Board issued a decision denying jurisdiction over Mid-Jefferson Hospital and Park Place Medical Center based on a finding that each Provider appealed from a revised NPR that did not specifically adjust labor and delivery days as required by 42 C.F.R. §§ 405.1885, 1889. The Board remanded the remaining Providers pursuant to CMS Ruling 1498-R and closed the appeal. The Providers subsequently submitted this reconsideration request.

PROVIDERS' REQUEST FOR RECONSIDERATION

Mid-Jefferson Hospital

The Providers' representative, Akin Gump Strauss Hauer & Feld, LLP ("Aking Gump"), argues that 27 labor and delivery room days were identified by the Provider in its revised DSH claim, and that the Board has jurisdiction over these 27 days as the MAC's adjustment removed them from the cost report. Akin Gump explains that the Provider's appeal from its original NPR was resolved administratively and only addressed Medicaid eligible days; labor and delivery room days were included in the original NPR and were not at issue in the prior appeal.

According to Akin Gump, no labor and delivery room ("L&D") days were disallowed in the original NPR, as Medicaid days were not adjusted. However, when the Medicare Contractor issued the revised NPR, it backed out 27 L&D Days that were claimed on the original cost report submission in the same adjustment that it allowed additional Medicaid eligible days. As part of the reopening, the Provider submitted a revised DSH claim for 1,145 Medicaid days, which included the 27 labor and delivery room days filed in the original cost report population. Exhibit 2 of the Providers' Request for Reconsideration identifies the 27 L&D days that were in the column included on the cost report and included in the first column of the revised NPR days; these days are subsequently removed from the last column. The Medicare Contractor settled the cost report to the number of Medicaid eligible days identified in the Provider's revised DSH claim, less labor and delivery room days, which were previously allowed by the Medicare Contractor. The revised NPR was the first time the Medicare Contractor removed the L&D Days from the cost report and all 27 had been claimed on the original cost report.

Park Place Medical Center

Akin Gump makes a very similar jurisdictional argument for Park Place Medical Center. It argues that the Board has jurisdiction over 111 labor and delivery room days that were identified in its revised DSH claim and which the Medicare Contractor removed.

The Provider's appeal from its original NPR resolved the Medicaid eligible days issue; labor and delivery room days were included in the original NPR and were not at issue in the appeal from the original NPR.

According to Akin Gump, the Provider filed its cost report with a total of 3,932 Medicaid days, including labor and delivery room days. The Medicare Contractor did not make an adjustment to labor and delivery room days or Medicaid eligible days in the original NPR. As part of the reopening, the Provider submitted a revised DSH claim for 4,213 Medicaid days, which included the 111 labor and delivery room days. The Medicare Contractor settled the cost report to 4,098 Medicaid days, thus removing the 111 labor and delivery room days. Exhibit 6 of the Request for Reconsideration identifies those days as being in the original NPR days and in the revised NPR total before being removed.

BOARD'S DECISION

The Board finds that the Providers have submitted additional documentation to establish that the L&D days were adjusted as part of the Providers' cost report reopenings. The documents show that new listing of Medicaid eligible days that the Providers submitted to the Medicare Contractor, and show labor and delivery room days backed out from the count.[1] It shows those days had been included in the original NPR. Based on the Providers' Administrative Resolutions and revised NPRs, the Board has determined that the L&D days were removed for the first time as part of the revised NPR appeal, therefore the Board finds that both Providers' revised NPR appeals have satisfied the requirements of 42 C.F.R. §§ 405.1885, 1889.

Accordingly, the Board hereby reopens case number 09-0068GC and finds that Mid-Jefferson Hospital (provider number 45-0514, FYE 7/31/2003) and Park Place Medical Center (provider number 45-0518, FYE 7/31/2003) have filed jurisdictionally valid appeals from revised NPRs. Remand of the Providers pursuant to CMS Ruling 1498-R will be addressed under separate cover.

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

FOR THE BOARD

Michael W. Harty
Chairman

cc: Wilson Leong, Federal Specialized Services

[1] Request for Reconsideration, Exhibits 2, 4, and 6.

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AUG 04 2016

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Bruce Synder
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Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Mercy Hospital and St. Peter's Hospital
Provider Nos.: 22-0066 & 33-0057
FYE: 12/31/2007
PRRB Case Nos.: 10-0373GC/13-2225GC/13-2226GC

Dear Mr. Keough and Mr. Snyder,

The Provider Reimbursement Review Board (the Board) has reconsidered its previous decisions regarding the transfer of the Medicare Part C issue for both Mercy Hospital and St. Peter's Hospital and hereby grants the transfer of the Medicare Part C days issue for both providers to PRRB appeal 13-2226GC. The Board's reconsideration decision is set forth below.

Background:

On January 11, 2010, the CHE 2007 DSH SSI Group was formed by Mercy Hospital (PN 10-0061), and assigned PRRB Case No. 10-0373GC. On December 21, 2012 and January 31, 2013, Mercy Hospital (PN 22-0066) and St. Peter's Hospital (PN 33-0057) (respectively) were directly added to the aforementioned group at the request of the Providers Representative. In April 2015, on its own motion, the PRRB conducted a review of PRRB Case No. 10-0373GC as it appeared that the issue in the group appeal was subject to CMS Ruling 1498-R . After concluding its review, the PRRB found that the initial provider, Mercy Hospital, (PN 10-0061) was subject to remand in accordance with 1498-R, but the remaining two Providers were not due to the date of issuance of the appealed NPRs (they included challenges to the SSI percentage issued in 2012 subsequent to the Ruling). The PRRB likewise determined that the two Providers should never have been directly added to the 10-0373GC group appeal since they were subject to post 1498-R rules, thereby making the issue on appeal different than that of the group. PRRB staff identified a Post 1498-R CHE 2007 DSH SSI group appeal, PRRB Case No. 13-2225GC, and transferred Mercy Hospital (PN 22-0066) and St. Peter's Hospital (PN 33-0057) to that appeal. The Board then remanded Mercy Hospital, 10-0061 and closed PRRB Case No. 10-0373GC.

Upon receiving notice of this transfer, the Providers requested that the PRRB transfer a second issue raised by both Providers concerning the SSI Fraction (Medicare Part C Days) to PRRB Case No. 13-2226GC. The Providers based this request on the issue statement[1] that was included with each direct add request. The issue statement reads, in part, as follows:

[1] The issues statements for both direct add request were identical.

> First the Providers contend that the SSI fraction is understated to the extent that CMS has not corrected systemic flaws in the data and match process used by CMS in determining the SSI fraction. Second, the Providers contend that the SSI fraction is understated because it includes days for patients who were not entitled to payment of benefits under Medicare Part A prospective payment system. The providers contend that days for patients who were not entitled to payment of benefits under Medicare Part A should be excluded from the SSI fraction in their entirety and included in the Medicaid fraction to the extent the patient is eligible for Medicaid *See Allina Health Servs. V. Sebelius,* 2012 WL 5565453, at *11-16 (D.D.C. Nov. 15, 2012) (vacating CMS's rule requiring part C days to be included in the SSI fraction because CMS did not provide adequate notice to hospitals regarding the change in interpretation adopted in 2004 and because the Secretary provided an insufficient explanation for the change.)

The PRRB denied the Providers request and its subsequent reconsideration because it found that when requested to be directly added into PRRB Case No. 10-0373GC, the Providers took on the issue statement that had initially been filed in 10-0373GC. In other words, the PRRB found that the Provider was subject to the issue statement of the group to which it had requested to be added. The PRRB found that although the Providers raised the Part C issue in the issue statement attached to the direct add requests (Model Form D's), those direct add requests could not add a 2nd issue to the group. As the group statement for PRRB Case No. 10-0373GC did not initially raise the SSI Fraction (Medicare Part C Days) issue, it could not be added at a later date.

Board's Decision

42 C.F.R. § 405.1837(a)(2) (2010) provides that, in a group appeal, "[t]he matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Further, 42 C.F.R. § 405.1837(b)(1)(i) provides that, in the mandatory use of group appeals:

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.

The Board finds that the Providers in question inappropriately requested to be directly added to a group appeal that did not raise a similar question of fact or interpretation of law that the Providers in question were appealing. In 2015, the Board staff identified the error in the Providers' request and attempted to identify the correct "Post Ruling" group to transfer to, which they identified as the SWC CHE 2007 Post 1498-R DSH SSI Baystate Errors CIRP Group (PRRB 13-2225GC)

The Providers later requested, and the Board denied, its request to transfer the Part C issue it raised in its "add requests" to the sister group for SSI part C, SWC CHE 2007 DSH SSI Fraction Part C Days CIRP

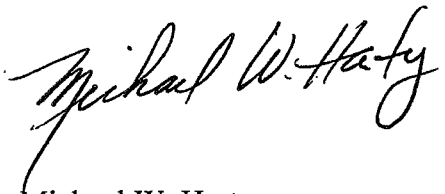
Group (13-2226GC). The Provider then asked for reconsideration, which the Board also denied. However, upon further review, the Board will grant a reconsideration of its previous decisions. The Board finds, based on the unique and distinct facts of these appeals, that it will grant the transfer of the Medicare Part C days issue from 13-2225GC to 13-2226GC.

While the Board has found in other decisions that a Provider does take on the issue statement of the group to which requests to be added, those cases can be distinguished from this case as these two providers were appealing a separate and distinct issue from that of the group from the start. Upon that determination the Board, based on its previous practice, could have chosen to set up individual appeals based on the issue statements submitted by the Providers. In that case, the Providers initial issue statements, which both raised the SSI Data Matching issue (the subject of 13-2225GC) and Part C Days in the SSI% (the subject of 13-2226GC) would have allowed for the transfers of both issues to the respective group appeals.

Based on previous communication in 13-2226GC from the Providers representative, 13-2226GC will now be deemed complete.[2] The parties will receive the customary Common Issue Related Party (CIRP) critical due date's letter for complete CIRP groups via electronic delivery.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq. (not participating)
Charlotte F. Benson, CPA
Jack Ahern, M.B.A. (not participating)

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: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

[2] On March 10, 2016 the Board received correspondence from the Providers representative that PRRB appeal 13-2226GC should not be deemed complete under 42 C.F.R 405.1837(e) as litigation regarding the Board's previous decisions excluding Mercy and St. Peters from this appeal was pending in the United States District Court for the District of Columbia.

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James Lowe
Cahaba Safeguard Administrators, LLC
2803 Slater Road, Suite 215
Morrisville, NC 27560-2008

RE: San Francisco General Hospital
Provider No.: 05-0228
FYE: 6/30/02
PRRB Case No.: 08-1622

Dear Mr. Young and Mr. Lowe,

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

Background

The Provider submitted a request for hearing on March 19, 2008, based on a Notice of Program Reimbursement ("NPR") dated September 26, 2007. The hearing request included seventeen issues, nine of which were subsequently transferred to group appeals and one of which was subsequently withdrawn. Three issues were fully resolved in a partial administrative resolution dated July 29, 2015. In addition, three issues were partially resolved (Issue 3, Issue 13, and Issue 15) in the same partial administrative resolution. Four issues remain in the appeal: 1) Issue 3 – Medicare Bad Debts – Additional Outpatient Crossover Bad Debts, 2) Issue 6 –TEFRA Target Rate Per Discharge, 3) Issue 13 – Additional Intern and Resident FTEs for IME, and 4) Issue 15 – Additional Intern and Resident FTEs for GME.

The Medicare Contractor submitted a jurisdictional challenge on August 31, 2015. The Medicare Contractor challenged jurisdiction on three issues: Issue 3 – Medicare Bad Debts, specifically additional bad debt[1] not originally claimed; Issue 13 – IME, specifically additional intern and resident FTEs not counted during audit; and Issue 15 – GME, specifically additional intern and resident FTEs not counted during audit. The Provider submitted a responsive brief on September 17, 2015.

[1] The Medicare Contractor challenged additional inpatient and outpatient crossover bad debt, but the Provider's Final Position Paper at pages 5 and 6 only argues additional outpatient crossover bad debt and requests that the Medicare Contractor incorporate an additional $15,192 in outpatient crossover bad debts into the cost report based on an updated bad debt listing.

Medicare Contractor's Position

Issue 3 – Additional Crossover Bad Debts

The Medicare Contractor contends that Issue 3 – Medicare Crossover Bad Debts, specifically the portion of the issue pertaining to additional inpatient crossover and outpatient crossover bad debt, does not meet the jurisdictional requirements as an adjustment was not made for additional crossover bad debt amounts. The Medicare Contractor explains that the additional outpatient crossover bad debt amounts in question were not removed with the Issue 3 cited audit adjustments 19 and 21. An audit adjustment was not made to inpatient crossover bad debt. The additional bad debt amounts being challenged are above and beyond the bad debt amounts removed at audit.[2]

The Medicare Contractor argues that it accepted the as-filed numbers for the final cost report and did not disallow the additional crossover bad debt amounts that are in question. The Medicare Contractor explains that additional crossover bad debts were not identified within the description of Issue 3 in the Provider's appeal request or preliminary position paper. Additional crossover bad debt amounts were submitted during the appeal review process for Issue 3. The Medicare Contractor contends that the Provider cannot demonstrate dissatisfaction with the Contractor's final determination, as there was no Contractor final determination for the additional crossover bad debt amount now being claimed.[3]

The Medicare Contractor cites to the statute at 42 U.S.C. § 1395oo(a)(1)(A)(i) and the regulation at 42 C.F.R. § 405.1835(a)(1) concerning dissatisfaction. The Medicare Contractor explains that the Provider is not able to demonstrate that it meets the dissatisfaction requirement. The Provider did not preserve its right to claim dissatisfaction as it did not include a claim for the additional crossover bad debts now in question. There was no audit adjustment for the additional bad debt portion of Issue 3, so the Provider is dissatisfied with its own reporting of inpatient crossover and outpatient crossover bad debts, not the Medicare Contractor's determination.[4]

Lastly, the Medicare Contractor argues that the Provider also failed to preserve its right to claim dissatisfaction by including the reimbursement impact of the additional inpatient crossover and outpatient crossover bad debt as a protested amount on its filed cost report. CMS has historically set forth the rules governing items under protest in the Provider Reimbursement Manual ('PRM") (CMS Pub. 15-2) § 115 and specified what information providers are required to furnish for items under protest. This section of the manual was in effect prior to the Provider's cost reporting period at issue. It instructs the provider to specifically identify the disputed item and the amount for each issue. The Provider has failed to preserve its right to claim dissatisfaction by properly filing the reimbursement impact of either the additional inpatient crossover bad debt or the additional outpatient crossover bad debt as a Protested Amount.[5]

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[2] Medicare Contractor's jurisdictional challenge at 3.
[3] *Id.*
[4] *Id.* at 4-5.
[5] *Id.* at 5.

Issues 13 and 15 – Additional Intern and Resident FTEs for IME and GME

The Medicare Contractor contends that the Additional Intern and Resident FTEs portion of Issues 13 and 15 does not meet the jurisdictional requirements, as an adjustment was not made for the additional FTEs that the Provider now claims should have been included for IME and GME. The Medicare Contractor explains that it accepted the as-filed numbers for the cost report and did not make any adjustments related to the additional FTEs in question. Additional current year intern and resident FTEs were not identified as a part of these issues in the Provider's appeal request or preliminary position paper. Additional FTEs were submitted during the appeal review of these issues but were not previously included on the cost report nor removed with an audit adjustment.[6]

The Medicare Contractor cites to the statute at 42 U.S.C. § 1395oo(a)(1)(A)(i) and the regulation at 42 C.F.R. § 405.1835(a)(1) concerning dissatisfaction. The Medicare Contractor argues that the Provider cannot demonstrate dissatisfaction as the Contractor did not make a final determination. In this case, the Contractor did not make an adjustment to IME and GME for the additional FTEs that were not counted during audit. The Provider did not preserve its right to claim dissatisfaction as it did not include a claim for the specific FTEs now in question. There was no audit adjustment, so the Provider is dissatisfied with its own reporting of the intern and resident FTEs for IME and GME, not the Medicare Contractor's determination.[7]

Lastly, the Medicare Contractor contends that CMS has historically set forth the rules governing items under protest in the Provider Reimbursement Manual ('PRM") (CMS Pub. 15-2) § 115 and specified what information providers are required to furnish for items under protest. This section of the manual was in effect prior to the Provider's cost reporting period at issue. It instructs the provider to specifically identify the disputed item and the amount for each issue. The Provider has failed to preserve its right to claim dissatisfaction by properly filing the reimbursement impact of the additional IME and GME FTEs as a Protested Amount.[8]

The Medicare Contactor cited the Board's jurisdictional decision in PRRB Case No. 07-0916 St. Luke's Hospital issued February 5, 2014 in support of its position. The Medicare Contractor notes that in that case, the Provider inadvertently omitted the GME and IME FTEs in its cost report. The Board dismissed this issue from the appeal, as the Provider was not precluded by statute, regulation, or a manual provision from filing the FTEs on the cost report.[9]

Provider's Position

The Provider argues that its appeal of the issues under jurisdiction challenge is based on a final determination on the Provider's as-filed cost report. The Provider contends that the NPR issued on September 26, 2007 constitutes a final determination by the [Medicare Contractor] with respect to the Provider's cost report.[10]

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[6] *Id.* at 7.
[7] *Id.* at 7-9.
[8] *Id.* at 9.
[9] *Id.*
[10] Provider's responsive brief at 2.

The Provider argues that the [Medicare Contractor] posted adjustments to the Provider's items of costs claimed in the as-filed cost report, which satisfies the criteria of dissatisfaction at 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a). The Provider contends that in this case the Provider's claims that the [Medicare Contractor] jurisdictionally challenged were either contained in the body of the as-filed cost report and such claims were adjusted by the Contractor, and/or such claims were self-disallowed as protested amounts in the filed cost report, giving way to appeal rights.[11]

Issue 3 – Additional Crossover Bad Debts

The Provider contends that the [Medicare Contractor] made audit adjustments that revised the as-filed acute Part B Medicare bad debts from $177,803 to $97,076 per audit adjustment numbers 19, 20, and 21, therefore the Provider is afforded a right to appeal the additional Medicare bad debts based on these audit adjustments. The Provider states that under the [Medicare Contractor's] narrow interpretation of 42 C.F.R. § 405.1835(a)(1)(i) a Provider is entitled to appeal only those Medicare crossover bad debts (i.e. numerical values per the [Medicare Contractor's] interpretation in this case) that were specifically present in the filed cost report, irrespective of the fact that additional Medicare crossover bad debt that is unknown to the provider at the time of its cost report filing could be identified after the cost report is filed. The Provider contends that the [Medicare Contractor's] narrow interpretation is inconsistent with the regulatory language at 42 C.F.R. § 405.1835(a)(1)(i) which requires the Provider to make a claim for specific items(s), not specific numerical values, on its cost report where the Provider seeks payment (i.e. must include a claim of Medicare crossover bad debt on the filed cost report). The [Medicare Contractor's] narrow interpretation, if erroneously upheld, would trump the Board's statutory authority to modify a final determination of the [Medicare Contractor] for purposes of making a proper payment determination in situations where the proper numerical value is in dispute. This could potentially lead to payment inequities between a Provider and the Medicare Program.[12]

The Provider contends that 42 U.S.C. § 1395oo(a) of the statute gives the Board the power to affirm, modify, or reverse the final determination of the [Medicare Contractor] with respect to the cost report and make other revisions to matters covered by the cost report. There is no regulation cited by the [Medicare Contractor] that would prohibit the Board's authority in situations where an adjustment modification is necessary in order to reach a determination that is fair and equitable to the Provider and the Medicare Program. The Provider argues that the Supreme Court's decision in *Bethesda*[13] clearly states the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. In this matter, the Provider's appeal letter disputes the [Medicare Contractor's] final Medicare crossover bad debt determination because it does not comply with Medicare regulations.[14]

Issues 13 and 15 – Additional Intern and Resident FTEs for IME and GME

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[11] *Id.* at 3.
[12] *Id.* at 4-5 (Emphasis included).
[13] *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399 (1988).
[14] Provider's responsive brief at 5.

The Provider notes the [Medicare Contractor's] position that the Provider does not have a right to a hearing on the contested FTEs since the [Medicare Contractor] did not make an adjustment to disallow these FTEs and the Provider did not preserve its right to claim dissatisfaction since it did not file a claim for the contested FTEs. The Provider states that the [Medicare Contractor's] position was based on Medicare regulations in 42 C.F.R. § 405.1835(a)(1) Chapter IV, 10-1-08 Edition and Medicare Cost Reporting Instructions in CMS 15-2, § 115. The Provider contends that the [Medicare Contractor's] position is based on Medicare regulations that were not in effect during the Provider's cost reporting period. The [Medicare Contractor] should have used the Medicare regulations as set forth in 42 C.F.R. § 405.1835(a)(1) Chapter IV, 10-1-07 Edition. Under the latter regulations, the only criterion for a Provider's right to a hearing is that a [Medicare Contractor] determination has been made with respect to the Provider. The Provider contends that it met this criterion as the NPR issued on September 26, 2007 clearly states the [Medicare Contractor] has made a determination with respect to the Provider's cost report as defined in 42 C.F.R. § 405.1801(a)(2).[15]

The Provider argues that the [Medicare Contractor] posted adjustments to the Provider's reported IME/GME current year FTE counts in the final NPR. The Provider's dissatisfaction stems from the [Medicare Contractor's] issuance of the final NPR. The Provider's dissatisfaction is derived from the fact that if the Provider was allowed to include the additional IME/GME current year FTEs in its Medicare cost report, the Provider's IME and GME entitlement would increase substantially over what is currently present in the final NPR today.[16]

The Provider argues that the jurisdictional decision cited by the [Medicare Contractor] to support its position is not applicable to this case. In the instant case, the Provider actually claimed reimbursement for IME/GME in its as-filed cost report and the [Medicare Contractor] made adjustments to the as-filed FTEs.[17]

Board's Decision

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

The Board concludes that it does not have jurisdiction over the Additional Outpatient Crossover Bad Debts and the Additional Intern and Resident FTEs for IME and GME issues in this appeal because the Provider received reimbursement for the items and services as claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear these matters under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d).

The crux of the dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which provides in relevant part:

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[15] *Id.* at 7-8.
[16] *Id.* at 8-9.
[17] *Id.* at 9.

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

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

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

The Provider received reimbursement based on the way it claimed outpatient crossover bad debts and IME and GME FTE's on its as-filed cost report. Any reporting errors were due solely to the Provider's negligence. Only in hindsight did the Provider determine that it should have claimed these items differently, thereby increasing the amount of reimbursement.

In *Bethesda,* the provider failed to claim a cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court wrote:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[18]

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

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the intermediary*

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[18] *Bethesda.* at 1258, 1259. (Emphasis added).

> *reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[19]

In this case, the Board has precisely the situation described by the Supreme Court as being "on different ground."[20] While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost unclaimed through inadvertence rather than futility, other appellate courts have done so. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Co. of Mary Hosp. v. Shalala* ("*Little Co. I*"),[21] the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal intermediary, which establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[22]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[23] In *Little Co. II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the Intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[24] The Seventh Circuit noted:

> But while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence...[25]

Citing *Little Co. II,* the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[26] The Agency policy of presentment aims to prevent an end-run around the Intermediary. The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[27]

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[19] *Id.* at 1259. (Emphasis added).
[20] Emphasis added.
[21] 24 F.3d 984 (7th Cir. 1994).
[22] *Little Co. I,* 24 F.3d at 992.
[23] *Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999).
[24] *Little Co. II,* 165 F.3d at 1165.
[25] *Id.*
[26] 73 Fed. Reg. at 30196.
[27] 73 Fed. Reg. at 30203.

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[28] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[29] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal.
The Ninth Circuit Court stated:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has *discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense ... even though that particular expense was not expressly claimed or explicitly considered by the intermediary.*[30]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[31] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[32] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[33] which were decisions issued in 2000 and 1987 respectively.[34]

MaineGeneral involved hospitals that listed zero for reimbursable bad debts on their cost reports. The providers did not discover mistakes in their as-filed cost reports until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not claimed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the

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[28] *See Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).
[29] 492 F.3d 1065 (9th Cir. 2007).
[30] *Id.* at 1068 (emphasis added).
[31] *See* 73 Fed. Reg. at 30197.
[32] 205 F.3d 493 (1st Cir. 2000).
[33] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[34] *See Loma Linda,* 492 F.3d at 1068.

as-filed cost reports, despite there being no legal impediment. The First Circuit in *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstances.[35] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 1395oo(d)] does not say that the Board *must* consider matters not considered by the intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[36]

The First Circuit in *MaineGeneral* then found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued."[37] Similarly, in *St. Luke's*, the First Circuit opined that, even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and, like many similar powers of courts and agencies, should be exercised only sparingly.[38] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[39]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.,* unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[40] As in *MaineGeneral* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied,

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[35] *St. Luke's*, 810 F.2d at 332.
[36] *Id.* at 327-328 (emphasis in original).
[37] *MaineGeneral*, 205 F.3d at 501.
[38] *St. Luke's,* 810 F.2d at 327.
[39] *MaineGeneral*, 205 F.3d at 501.
[40] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].

but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. That court wrote:

> The Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d), ...[41]

Similar to the Ninth Circuit in *Loma Linda*, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[42]

Finally, and most recently, the D.C. District Court found in favor of the agency's interpretation of the dissatisfaction requirement in 1395oo(a) in *Saint Vincent Indianapolis Hospital v. Sebelius.*[43] Similarly, in that appeal, the PRRB determined that plaintiff "failed to meet the jurisdiction prerequisite of being 'dissatisfied' with the amount of Medicare payment because the 'errors and omissions' alleged by the provider in its appeal stemmed from its own 'negligence' in understanding the Medicare regulations governing the reimbursement of such costs" rather than the FI/MAC's action. The Court found that in reviewing both parties analysis of the statutory language and the relevant case law, that the Board's jurisdictional determination was applying the language of the Medicare Act and therefore the Court grants the agency's interpretation deference. Additionally, the Court found that the PRRB's ruling was based upon "a permissible construction of the statute", and therefore upheld the PRRB's dismissal.

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services on the cost report. The Board *may* then hear the appeals of claims inadvertently omitted or mistakenly reported on the cost report, but the Board is *not required* to hear those claims.

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[44] However, the

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[41] *Id.* at 79.
[42] *Id.* at 77.
[43] *Saint Vincent Indianapolis Hospital v. Sebelius,* 2015 WL 5728372 (D.D.C 2015).
[44] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

Provider is located in the Seventh Circuit and, as such, *Little Co. I* and *Little Co. II* apply to this appeal and serve as controlling precedent for the Board.[45]
In the instant case, it is undisputed that the Provider did not include the additional outpatient crossover bad debts and the additional intern and resident FTEs for IME and GME in its as-filed cost report. Only in hindsight did the Provider determine that it could have reported the outpatient crossover bad debts and current year IME and GME FTE counts differently, thereby increasing the amount of reimbursement. This case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[46] The Board should note that it has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeals of other issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction.[47]

The Provider attempts to argue in relation to the Bad Debt issue, that the Provider was not aware of the crossover bad debt in question at the time that the cost report was filed. Its argument is similar to that raised in the *Barberton*[48] case, in that there was a practical impediment to the provider being able to identify the reimbursement claim at the time of the cost report filing. The Board is not swayed by this argument as the Provider has failed to document that any of the bad debt claims in question (roughly 15k) were only identified after the cost report was filed and could not have been claimed. If the Provider had not identified the patients Medicaid eligibility before the cost report was filed, the Provider could have 1.) followed traditional bad debt procedures and billed the patient which could have resulted in a traditional bad debt, or 2.) waited until the Medicaid coverage was determined, billed at that point, and written it off in the year the Medicaid denial came in. As the Provider has not documented in fact that there was a practical impediment, the Board deems it as unclaimed cost that the provider failed to document in its cost report.

Therefore, the Board dismisses Issue No. 3 – Medicare Bad Debts – Additional Outpatient Crossover Bad Debts and the additional intern and resident FTEs component of Issue No. 15 – Indirect Medical Education (IME) Payments – IME FTE Count and Issue No. 16 – Graduate Medical Education (GME)

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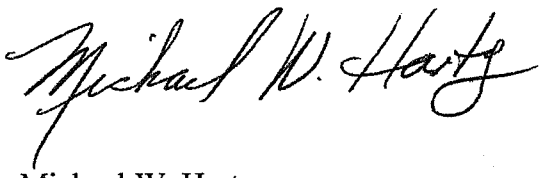
[45] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor Room Days Groups v. Blue Cross Blue Shield Ass'n*, CMS Administrator Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009) (stating "as the *Alhambra* [*Hosp. v. Thompson*, 259 F.3d 1071 (9th Cir. 2001)] case is binding in the circuit in which the Providers are entitled to seek judicial review, the Administrator hereby affirms the Board's decision . . . with respect to the LDRP days. The Board's decision is affirmed only on the limited ground that there is binding law in the Ninth Circuit . . . . The decision does not affect the Secretary's ability to continue to defend this issue in other circuits . . . ."); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, CMS Administrator Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008) (stating that "[i]n the absence of a controlling decision by the Supreme Court, the respective courts of appeals express the law of the circuit" with citation to *Hyatt v. Heckler*, 807 F.2d 376, 379 (4th Cir. 1986)). Further, the Board notes that, while the Provider could appeal the Board's decision in the D.C. District Court, the D.C. Circuit has not yet reviewed and ruled on this issue. *See Jordan Hosp. v. Blue Cross Blue Shield Ass'n.* CMS Administrator Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007) (stating with respect to a provider located in Massachusetts that "under § 1878(f)(1), the District of Columbia is the judicial district in which this Provider may file suit and, thus, *St. Elizabeth's* [*Med. Ctr. of Boston v. Thompson*, 396 F.3d 1228 (D.C. Cir. 2005)] is binding case law here"). Accordingly, the Board applies the law of the Seventh Circuit as controlling precedent.
[46] *Bethesda*, 485 U.S. at 404-405.
[47] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010). This would not be a case in which the Board would deviate from this practice.
[48] *Barberton Citizens Hospital v. CGS Administrators,* PRRB Dec. No. 2015-D5 (March 19, 2015) ("*Barberton*").

Payments – GME FTE Count from the appeal. The Board does not have jurisdiction under 42 U.S.C. § 1395oo(a) or § 1395oo(d) to address items and services not claimed or not properly reported on the cost report where the failure to claim was due to inadvertence rather than futility.

Issue No. 6 – TEFRA Target Rate Per Discharge remains in the appeal. This case is scheduled for a live hearing on August 22, 2016. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

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

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: Federal Specialized Services
Wilson C. Leong, Esq., CPA
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AUG 08 2016

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

Danene Hartley
Appeals Lead
Palmetto GBA c/o National Government Services
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Wheaton Franciscan Healthcare
Provider No.: 52-0136
FYE: 6/30/10
PRRB Case No.: 15-0021

Dear Mr. Ravindran and Ms. Hartley,

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

Background

The Provider submitted a request for hearing on October 6, 2014, based on a Notice of Program Reimbursement ("NPR") dated April 10, 2014. The hearing request included nine[1] issues, six of which were subsequently transferred to group appeals. The Provider abandoned the DSH – SSI Realignment issue in its Final Position Paper submitted on April 28, 2016. Two issues remain in the appeal: Issue No. 1 - DSH – Medicaid Eligible Days and Issue 2a – DSH SSI – Provider Specific.

The Medicare Contractor submitted a jurisdictional challenge on these issues on September 16, 2015.[2] The Provider submitted a responsive brief on October 14, 2015.

Medicare Contractor's Position

Issue 1 – DSH – Medicaid Eligible Days

The Medicare Contractor contends that the Provider's right to a Board hearing derives from a Contractor determination, which is defined at 42 C.F.R. § 405.1801(a)(1) as "...a determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period..." The Medicare Contractor's position is that §§ 405.1801 and 405.1803 require an

[1] The request for hearing listed eight issues. The DSH – Provider Specific issue also contained the DSH – SSI Realignment issue bring the total to nine.
[2] The Medicare Contractor also challenged the DSH – SSI Realignment issue. As the Provider has abandoned the issue it need not be addressed herein.

identifiable adverse finding, with a corresponding reduction in reimbursement, in order to request a Board hearing under section 405.1835(a). The Medicare Contractor asserts that jurisdiction is rooted in "an identifiable adverse finding" indicated in the Notice of Program Reimbursement.[3]

Since the Medicare Contractor accepted the Medicaid Eligible Unpaid Days submitted for the desk review by the Provider, the Medicare Contractor contends that the Board lacks jurisdiction over this matter in accordance with 42 C.F.R. § 405.1811. Additionally, the Medicare Contractor contends that the Provider failed to include a protested amount related to Medicaid Eligible Unpaid Days on its as filed cost report.[4]

The Medicare Contractor states that the Provider is requesting through the appeal process that an additional 50 Medicaid days should be added to the numerator of the Medicaid fraction for this cost reporting period. The Medicare Contractor notes that the Provider has not specified or identified the claims associated with the 50 days that it is requesting to be included for this appeal.

Lastly, the Medicare Contractor contends that the Provider also failed to claim or establish that a practical impediment prevented the Provider from identifying and claiming the requested days that have been appealed. The Provider has not supplied a detailed listing of the days in question nor identified any impediments that prevented the Provider from submitting additional days prior to the issuance of the finalized cost report.[5]

Issue 2A – DSH SSI – Provider Specific

The Medicare Contractor contends that the Provider requested that the DSH SSI - Systemic issue be transferred to PRRB Case No. 13-3267GC – QRS WFHC 2010 DSH/SSI CIRP Group. The Medicare Contractor argues that the DSH SSI – Provider Specific issue and the DSH SSI – Systemic issue are considered the same issue by the PRRB, and as such, the issue cannot be in two open cases at the same time.[6]

Provider's Position

Issue 1 – DSH – Medicaid Eligible Days

The Provider contends that the Board does have jurisdiction pursuant to Board Rule 7.2(B) and under the provisions of 42 U.S.C. § 1395oo. The issuance of the NPR and timely appeal properly triggers the Board's jurisdiction over this appeal. Further, in virtually all instances there are in fact adjustments to the Provider's DSH and such adjustments are enough to warrant Board jurisdiction over this appeal issue. However, the Provider contends that the adjustment is not required, as DSH is not an item that has to be adjusted or claimed on the cost report. Accordingly, the presentment requirement does not apply, but should the Board determine it does apply, the Provider contends this requirement is not valid.[7]

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[3] Medicare Contractor's jurisdictional challenge at 2.
[4] *Id.*
[5] *Id.* at 6.
[6] *Id.* at 7.
[7] Provider's responsive brief at 6-7.

The Provider argues that the practical impediment standard as articulated by the PRRB is subjective and subject to arbitrary and capricious agency action. The Provider argues that the practical impediment requirement is an inherently subjective requirement. The practical impediment standard is vague and, therefore, whether it is satisfied is left to the unfettered subjective opinion of the trier of fact. Absent clear, objective standards, this exercise is susceptible to arbitrary and capricious agency action. The Provider also argues that the practical impediment standard is not supported by the Medicare Act and undermines HCFA Ruling 97-2.[8]

Issue 2A – DSH SSI – Provider Specific

The Provider contends that the SSI – Provider Specific issue and the SSI – Systemic issue are separate and distinct issues, and that the Board should find jurisdiction over the SSI – Provider specific issue. The Provider argues that it is addressing various errors of omission and commission that do not fit into the "systemic errors" category. Accordingly, this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2010 as a result of its understated SSI percentage.[9]

The Provider argues that it is entitled to appeal an item that it is dissatisfied with. The Provider states that it can submit data to prove its SSI percentage was understated. However, to this point, the Provider has been unable to do so as CMS had not released the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") data. The Provider has not yet received its MEDPAR data, and has been unable to reconcile its record with that of CMS, and specifically identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year when it determined the Provider's SSI percentage.[10]

Board's Decision

Issue 1 – DSH – Medicaid Eligible Days

The Provider is appealing from a 6/30/2010 cost report, which means that it either had to claim the cost at issue or it is subject to the protest requirement in order for the Board to have jurisdiction.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider **has preserved its right to claim dissatisfaction . . . by . . . [i]ncluding a claim for specific item(s) on its cost report . . . or . . . self-disallowing the specific item(s) by . . . filing a cost report under protest.**[11]

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[8] *Id.* at 9-11.
[9] *Id.* at 17-18.
[10] *Id.* at 18.
[11] 42 C.F.R. § 405.1835(a) (emphasis added).

The Board concludes that it does not have jurisdiction over the Medicaid eligible days issue in this appeal and dismisses it from the appeal. The Board finds that the Provider did not establish that it included a claim for the specific Medicaid eligible days in question as required by 42 C.F.R. § 405.1835(a). In fact, the Provider has not supplied any listing of the additional Medicaid eligible days it claims it is entitled to. The Provider also did not protest these days on its cost report. Additionally, in reviewing the audit adjustment report, the Board could not find where the Medicare Contractor made any specific adjustment to the number of Medicaid days reported on the cost report. The Provider cites Adjustment 20, however that adjustment to the SSI% and allowable disproportionate share percentage is separate and distinct from Medicaid days reported on cost report Worksheet S-3.

Issue 2A – DSH SSI – Provider Specific

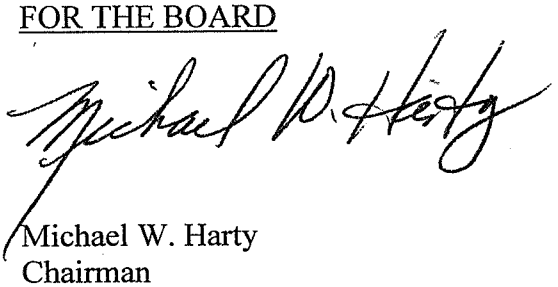
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

The Board concludes that it does not have jurisdiction over Issue 2A – DSH SSI – Provider Specific, and dismisses it from the appeal, as it is the same issue that the Provider is appealing in PRRB Case No. 13-3267GC – QRS WFHC 2010 DSH/SSI CIRP Group.

As no issues remain in the appeal, the Board hereby closes the case and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

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: Federal Specialized Services
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Corinna Goron
President
c/o Appeals Department
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17101 Preston Road, Suite 220
Dallas, TX 75248-1372

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

RE: Lima Memorial Hospital
Provider No.: 36-0009
FYE: 12/31/2010
PRRB Case No.: 14-1628

Dear Ms. Goron and Ms. Cummings,

The Provider Reimbursement Review Board (the Board) has reviewed the SSI Ratio Realignment issue in the above-referenced appeal. The Board's jurisdiction decision is set forth below.

Background

The Provider submitted a request for hearing on January 6, 2014, based on a Notice of Program Reimbursement ("NPR") dated October 24, 2013. The hearing request included one issue, the Rural Floor Budget Neutrality Adjustment ("RFBNA") issue. Subsequently, the Provider added Medicare Disproportionate Share Hospital ("DSH") Payments – SSI Ratio Alignment to Provider's Cost Reporting Year ("SSI Realignment") and the Medicaid Eligible Days issues to the appeal. The Provider transferred the RFBNA issue to a group appeal and withdrew the Medicaid Eligible Days issue. As a result, the sole issue remaining in the appeal is as follows: Medicare Disproportionate Share Hospital (DSH) Payments – SSI Ratio Alignment to Provider's Cost Reporting Year. In addition, the Provider directly filed the SSI Systemic Errors issue into Group Appeal 14-1806G, HRS 2010 DSH SSI Percentage (Baystate) Group.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board concludes that it does not have jurisdiction over the SSI Realignment issue because the issue is duplicative of the SSI Systemic errors issue and there is no final determination from which the Provider is appealing.

The Board finds that the SSI Realignment issue is duplicative of the SSI percentage issue that the Provider is appealing in the HRS 2010 DSH SSI Percentage (Baystate) Group, case number 14-1806G. In its hearing request, the Provider claimed that "the MAC did not determine Medicare DSH reimbursement in accordance with Statutory instructions" and that the "SSI percentage... was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." The SSI percentage group also argues that the SSI percentage was incorrectly computed. Therefore, the Board finds that part of the SSI Realignment issue statement to be duplicative of the SSI issue the Provider is challenging in a group appeal.

In the same issue statement, the Provider introduced the SSI Provider Specific issue by "preserv[ing] its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[1] Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Furthermore, even if a Provider had requested a realignment from the federal fiscal year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835, the Board has jurisdictional authority only to hear appeals concerning costs claimed on a timely filed cost report if the provider is dissatisfied with the final determination of the Medicare Contractor. Having not submitted a request for SSI percentage realignment to the Medicare Contractor, there is no final determination from which the Provider can demonstrate its dissatisfaction. The Board concludes that it has no jurisdiction to decide this SSI Realignment issue.

As this was the sole issue remaining in the appeal, the Board closes case number 14-1628 and removes it from the Board's docket.

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

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

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: Wilson C. Leong, Esq., CPA, FSS

[1] Provider's Request to Add Issue(s) to an Individual Appeal at Exhibit 1.

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

RE: Lima Memorial Hospital
Provider No.: 36-0009
FYE: 12/31/2009
PRRB Case No.: 14-0603

Dear Ms. Goron and Ms. Cummings,

The Provider Reimbursement Review Board (the Board) has reviewed the SSI Ratio Realignment issue in the above-referenced appeal. The Board's jurisdiction decision is set forth below.

Background

The Provider submitted a request for hearing on November 8, 2013, based on a Notice of Program Reimbursement ("NPR") dated July 31, 2013. The hearing request included two issues SSI Ratio Alignment to Provider's Cost Reporting Year and Rural Floor Budget Neutrality Adjustment ("RFBNA"). The Outlier Payments issue was added to the appeal thereafter. The Provider subsequently transferred the Outlier Payments and RFBNA issues to group appeals. As a result, the sole issue remaining in the appeal is the Medicare Disproportionate Share Hospital (DSH) Payments – SSI Ratio Alignment to Provider's Cost Reporting Year ("SSI Realignment"). In addition, the Provider directly filed the SSI Systemic Errors issue into Group Appeal 14-0709G.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board concludes that it does not have jurisdiction over the SSI Realignment issue because the issue is duplicative of the SSI Systemic errors issue and there is no final determination from which the Provider is appealing.

The Board finds that the SSI Realignment issue is duplicative of the SSI percentage issue that the Provider is appealing in the HRS 2009 DSH/SSI Percentage group, case number 14-0709G. In its hearing request, the Provider claimed that "the MAC did not determine Medicare DSH reimbursement in accordance with Statutory instructions" and that the "SSI percentage . . . was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." The SSI percentage group also argues that the SSI percentage was incorrectly computed. Therefore, the Board finds that part of the SSI Realignment issue statement to be duplicative of the SSI issue the Provider is challenging in a group appeal.

In the same issue statement, the Provider introduced the SSI Provider Specific issue by "preserv[ing] its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[1] Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Furthermore, even if a Provider had requested a realignment from the federal fiscal year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835, the Board has jurisdictional authority only to hear appeals concerning costs claimed on a timely filed cost report if the provider is dissatisfied with the final determination of the Medicare Contractor. Having not submitted a request for SSI percentage realignment to the Medicare Contractor, there is no final determination from which the Provider can demonstrate its dissatisfaction. The Board concludes that it has no jurisdiction to decide this SSI Provider Specific issue.

As this was the sole issue remaining in the appeal, the Board closes case number 14-0603 and removes it from the Board's docket.

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

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

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: Wilson C. Leong, Esq., CPA, FSS

[1] Provider's Request to Establish an Individual Appeal at Exhibit 3.

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AUG 11 2016

CERTIFIED MAIL

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

RE: Sanford Medical Center, Provider No. 43-0027, FYE 04/30/2009,
PRRB Case No. 13-2650

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal in preparation of scheduling the case for a hearing date. Upon review, the Board notes that most issues in the case have been transferred to group appeals. The pertinent facts and the Board's determination regarding the remaining issues are set forth below.

Pertinent Facts:

Quality Reimbursement Services, Inc. (QRS) filed an appeal on behalf of the Provider on August 7, 2013, which included the following issues:

- DSH SSI (Provider Specific)
- DSH SSI (Systemic Errors)
- Medicaid Eligible Days
- Managed Care Part C Days
- Dual Eligible/Exhausted Part A Days
- Outlier Fixed Loss Threshold

The Board assigned case number 13-2650 to the individual appeal in an Acknowledgement letter dated August 12, 2013.

On March 6, 2014 QRS filed "Requests to Transfer Issue to A Group Appeal" (Model Form D's) for the following issues:

- DSH SSI (Systemic) to case no. 13-3931G
- SSI Fraction Medicare Managed Care Part C Days to case no. 13-3928G
- Medicaid Fraction Medicare Managed Care Part C Days to case no. 13-3941G
- Medicaid Fraction Dual Eligible/Exhausted Part A Days to case no. 13-3942G
- SSI Fraction Dual Eligible/Exhausted Part A Days to case no. 13-3944G
- Outlier Payment-Fixed Loss Threshold to case no. 14-0728G

Subsequently, on June 30, 2014 QRS withdrew the Medicaid Eligible Days issue from the appeal.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (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.

Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

The Board finds regarding Issue No. 1, the DSH SSI Provider Specific issue, that it has jurisdiction over this issue as there were adjustments to the SSI percentage (Adjs. 5, 47, 67 & 81), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that Issue No. 1 is duplicative of Issue No. 2, the DSH SSI Percentage (Systemic Errors) issue that was transferred to a group case. The basis of both Issue Nos. 1 and 2 in this appeal is that the SSI percentage is improperly calculated due to errors in accumulating the underlying data. Therefore, the SSI (Provider Specific) and the SSI (Systemic) issues have been consolidated as a single SSI Accuracy issue, which has been transferred to case number 13-3931G. Since there are no remaining issues in the individual appeal, case number 13-2650 is hereby closed.

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

Board Members Participating:
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:

Michael W. Harty
Chairman

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

cc: James Ward, Noridian Healthcare Solutions, LLC (J-F)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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CERTIFIED MAIL

AUG 11 2016

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

RE: Sanford Medical Center, Provider No. 43-0027, FYE 04/30/2008
PRRB Case No. 13-0923

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal in preparation of scheduling the case for a hearing date. Upon review, the Board notes that most issues in the case have been transferred to group appeals. The pertinent facts and the Board's determination regarding the remaining issues are set forth below.

Pertinent Facts:

Quality Reimbursement Services, Inc. (QRS) filed an appeal on behalf of the Provider on February 27, 2013, which included the following issues:

- DSH SSI (Provider Specific)
- DSH SSI (Systemic Errors)
- Medicaid Eligible Days
- Managed Care Part C Days
- Dual Eligible/Exhausted Part A Days
- Outlier Fixed Loss Threshold

The Board assigned case number 13-0923 to the individual appeal in an Acknowledgement letter dated March 5, 2013.

On October 24, 2013 QRS filed "Requests to Transfer Issue to A Group Appeal" (Model Form D's) for the following issues:

- DSH SSI (Systemic) to case no. 13-2694G
- Medicare Managed Care Part C Days to case no. 13-2306G
- Dual Eligible/Exhausted Part A Days to case no. 13-2693G
- Outlier Payment-Fixed Loss Threshold to case no. 13-3418G

Subsequently, on June 30, 2014 QRS withdrew the Medicaid Eligible Days issue from the appeal.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (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.

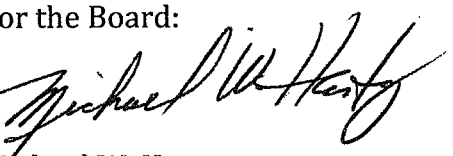
Additionally, PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

The Board finds regarding Issue No. 1, the DSH SSI Provider Specific issue, that it has jurisdiction over this issue as there were adjustments to the SSI percentage (Adjs. 44 & 72), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that Issue No. 1 is duplicative of Issue No. 2, the DSH SSI Percentage (Systemic Errors) issue that was transferred to a group case. The basis of both Issue Nos. 1 and 2 in this appeal is that the SSI percentage is improperly calculated due to errors in accumulating the underlying data. Therefore, the SSI (Provider Specific) and the SSI (Systemic) issues have been consolidated as a single SSI Accuracy issue, which has been transferred to case number 13-2694G. Further, according to the cover letter to the preliminary position paper, the only other issue briefed by the Provider was Medicaid Eligible Days, which was withdrawn on June 14, 2014. Since there are no remaining issues in the individual appeal, case number 13-0923 is closed.

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

Board Members Participating:
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:



Michael W. Harty
Chairman

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

cc: James Ward, Noridian Healthcare Solutions, LLC (J-F)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670
Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to:

CERTIFIED MAIL

AUG 11 2016

Toyon Associates, Inc.
Sandra Lee
Assistant Director – Client Services
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

RE: **Transfer Requests:**
Enloe Medical Center
Provider No: 05-0039
FYE: 06/30/2008
PRRB Case No: 13-1455

Dear Ms. Lee:

The Provider Reimbursement Review Board ("Board") is in receipt of your correspondence dated July 26, 2016 for the above-referenced individual appeal. In your letter, you requested to transfer the following issues to various group appeals:

Issue	PRRB Group Appeal
3B: DSH – Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/12 for LIP Payments	16-2125G
4B: DSH – Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 for LIP Payments	16-2126G
6B: DSH – Accuracy of CMS Developed SSI Ratio Issued 3/16/12 for LIP Payments	16-2123G

Pertinent Facts:

On April 4, 2013, the Board received the Provider's request to appeal its Notice of Program Reimbursement dated October 12, 2012 which included the following issues:

1	Medicare Settlement Data
2	DSH – Additional Medicaid Eligible Days
3	DSH – Inclusion of Medicare Dual Eligible Part A Days in SSI Ratio Issued 3/16/12 (this issue included LIP Payments)
4	DSH – Inclusion of Medicare Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 (this issue included LIP Payments)
5	DSH – SSI Ratio Alignment to Provider's Cost Reporting Year
6	DSH – Accuracy of CMS Developed SSI Ratio Issued 3/16/12 (this issue included LIP Payments)
7	DSH – SSI MMA Section 951 Applicable to SSI Ratio Issued 3/16/12
8	Rural Floor Budget Neutrality Adjustment

The Board acknowledged the Provider's request on April 12, 2013 and assigned it case number 13-1455. On November 14, 2013, the Provider requested to transfer Issue 3A to case number 13-3695G, Issue 4A to case number 13-3694G, Issue 6A to case number 13-3698G and Issue 7 to case number 13-3693G. Additionally, on December 12, 2014, the Provider submitted correspondence requesting to withdraw Issue 1A: Medicare Settlement Data, Issue 4B: DHS – Inclusion of Medicare Dual Eligible Part C Days in SSI Ratio Issued March 16, 2012 for LIP Payments and Issue 8: Rural Floor Budget Neutrality.

On January 28, 2015, a Partial Administrative Resolution, signed by both Parties, was submitted to the Board and indicated the following:

- Issue 1: Withdrawn from appeal in Provider's Final Position Paper.
- Issue 2: Parties agree to resolve this issue.
- Issue 3A: Transferred to case number 13-3695G.
- Issue 3B: DSH – Dual Eligible Part A Days in SSI Ratio Issued 3/16/12 for LIP Payments is being challenged by the Medicare Contractor.
- Issue 4A: DSH –Transferred to case number 13-3695G
- Issue 4B: DSH – Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 for LIP Payments was withdrawn from the appeal.
- Issue 5: Provider agrees to withdraw this issue.
- Issue 6A: DSH –Transferred to case number 13-3696G.
- Issue 6B: DSH – Accuracy of CMS Developed SSI Ratio Issued 3/16/12 for LIP Payments is being challenged by the Medicare Contractor.
- Issue 7: Transferred to case number 13-3693G
- Issue 8: Withdrawn from appeal.

Therefore, based on the above, the only issues remaining in case number 13-1455 on January 28, 2015 were Issue 3B and Issue 6B, which were both being challenged by the Medicare Contractor. In addition, the Provider's Supplemental Position Paper submitted on April 7, 2016 and the postponement request dated July 18, 2016, also list Issues 3B and 6B as the only remaining issues in case number 13-1455.

On June 6, 2016, the Board issued its decision with regard to the Medicare Contractor's jurisdictional challenge over Issues 3B and 6Bd. The Board determined that it had jurisdiction to hear the two LIP issues, the Provider had filed its appeal request timely, met the amount in controversy requirement and met the dissatisfaction requirement..

Decision of the Board:

Pursuant to 42 U.S.C. § 1395oo(a) and42 C.F.R. §§ 405.1835 – 405.1840 (2015), 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 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.

Upon review of the record, the Board finds that the Provider raised the DSH – Dual Eligible Part A Days in SSI Ratio Issued 3/16/12 for LIP Payments, DSH – Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 for LIP Payments and DSH – Accuracy of CMS Developed SSI Ratio Issued 3/16/12 for LIP Payments issues. However, the Provider withdrew the DSH – Inclusion of Dual

Eligible Part C Days in SSI Ratio Issued 3/16/12 for LIP Payments issue prior to requesting to transfer the same issue to a group appeal.

The Board hereby denies the transfer of the DSH – Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 for LIP Payments as it is not currently part of case number 13-1455.

The Board acknowledges the transfers of the DSH – Inclusion of Dual Eligible Part A Days in SSI Ratio Issued for LIP Payments to case number 16-2125G and the DSH – Accuracy of CMS Developed SSI Ratio Issued 3/16/12 for LIP Payments issue to case number 16-2123G. As there are no further issues remaining in the individual appeal, the Board hereby closes case number 13-1455.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.18575 and 405.1877.

Board members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: James Lowe
Cahaba Safeguard Administrators, LLC
2803 Slater Road
Suite 215
Morrisville, NC 27560-2008

Wilson C. Leong, Esq., CPA
PRRB Appeals
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058

Dylan Chinea
Manager – DSH Practice Group
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

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Refer to:

CERTIFIED MAIL

AUG 11 2016

West Virginia United Health Systems
Nancy Repine, Assistant Vice President
Finance Planning & Reimbursement
3040 University Avenue
Morgantown, WV 26505

RE: City Hospital, Provider No. 51-0008, FYE 12/31/2011, PRRB Case No. 15-2254

Dear Ms. Repine:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal and notes that you have transferred all issues, except the Supplemental Security Income (SSI) (provider specific) issue, to group appeals. The pertinent facts with regard to the case and the Board's determination are set forth below.

Pertinent Facts:

West Virginia Healthcare (WVU Health) filed an appeal on behalf of the Provider on April 15, 2015, which included the following issues:

- DSH SSI (Provider Specific)
- DSH SSI (Systemic Errors)
- DSH SSI Fraction Medicare Managed Care Part C Days
- DSH SSI Fraction Dual Eligible/Exhausted Part A Days
- DSH Medicaid Fraction Medicare Managed Care Part C Days
- DSH Medicaid Fraction Dual Eligible/Exhausted Part A Days

The Board assigned case number 15-2254 to the individual appeal in an Acknowledgement letter dated April 22, 2015.

On December 24, 2015 WVU Health authorized Quality Reimbursement Services, Inc. (QRS) to file "Requests to Transfer Issue to a Group Appeal" (Model Form D's) for the following issues:

- DSH SSI (Systemic) to case no. 16-0638GC
- SSI Fraction Medicare Managed Care Part C Days to case no. 16-0639GC
- SSI Fraction Dual Eligible/Exhausted Part A Days to case no. 16-0640GC
- Medicaid Fraction Medicare Managed Care Part C Days to case no. 16-0641GC
- Medicaid Fraction Dual Eligible/Exhausted Part A Days to case no. 16-0644GC

Subsequently, on December 31, 2015 WVU Health filed the cover letter to the preliminary position paper with the Board. In the cover letter, WVU Health advised that "[a]ll issues,

other than the SSI Provider Specific issue that has been addressed . . . are being transferred to relevant QRS group appeals."[1]

Board Determination:

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

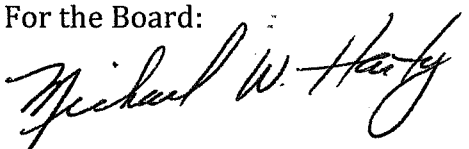
Additionally, Board Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

The Board finds that it has jurisdiction over the DSH SSI (provider specific) issue as there were adjustments to the SSI percentage (Adjs. 22, 24, 25) and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds this issue is duplicative of the DSH SSI Percentage (systemic errors) issue that was transferred to a group case. The basis of both issues (Issue Nos. 1 and 2) in this appeal is that the SSI percentage is improperly calculated due to errors in accumulating the underlying data. Therefore, the SSI (provider specific) and the SSI (systemic) issues have been consolidated as a single SSI Accuracy issue, which has been transferred to case number 16-0638GC. Since there are no remaining issues in the individual appeal, case number 15-2254 is hereby closed.

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

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

For the Board:



Michael W. Harty
Chairman

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

cc: Laurie Polson, Appeals Lead, Palmetto GBA c/o NGS
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[1] Provider Preliminary position paper, December 22, 2015

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Refer to: 16-2035
Certified Mail

AUG 12 2016

Kirti Shah, MD
Nephron Corporation
605 Old Norcross Road
Lawrenceville, GA 30046-4315

RE: Snellville Dialysis Center
Provider No. 11-2827
FYE 12/31/2013
PRRB Case No. 16-2035

Dear Dr. Shah:

The Provider Reimbursement Review Board (Board) has reviewed the hearing request submitted for the above-referenced Provider. The Board's decision with respect to jurisdiction and the request for expedited judicial review (EJR) is set forth below.

Jurisdiction

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 by the provider. The regulation, 42 C.F.R. § 405.1835(b)(3), which deals with the contents of a hearing request, requires that a copy of the intermediary or Secretary determination under appeal be included with the hearing request. The Provider's hearing request stated that "[w]e are waiting for the official NPR [Notice of Program Reimbursement]." Since the Provider has not received its final determination as required for Board jurisdiction, the Board hereby dismisses the appeal. The Provider may resubmit its appeal upon receipt of the NPR.

Expedited Judicial Review

In addition, the Provider's request for hearing indicated that it included a request for EJR.[1] The threshold requirement for granting a request for EJR is Board jurisdiction over the appeal. *See* 42 C.F.R. § 405.1842(a). Since the Provider has not received a final determination of reimbursement required for Board jurisdiction, the Board has concluded that it lacks jurisdiction

[1] The Board notes although the Provider checked the box on Model Form A indicating it was requesting EJR, the hearing request did not include the separate document setting for the basis for EJR. *See* 42 C.F.R. § 405.1842(d) and Board Rule 42.2. The Board's Rules can be found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB_Instructions.html.

over the appeal. Since the Board lacks jurisdiction over the appeal, the Provider's request for EJR is denied.

Protected Health Information

Upon review of the initial appeal request, we note that page 3 of Exhibit 4, Bad Debt Workpaper B.2.1, contains patient names and other identifying information.

Protected health information ("PHI") is any information about health status, provision of health care, or payment for health care that can be linked to a specific individual. Because the record in the Board proceedings may be disclosed to the public, any PHI contained in the Parties' documents must be redacted pursuant to the Privacy Act, 5 U.S.C. § 552a. See Board Rule 27.6.H - Confidential Information, which outlines the format the Provider must follow when submitting confidential information. Therefore, we are returning the unredacted document to you.

Review of the jurisdictional determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte Benson, CPA
Jack Ahern, MBA

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877,
PHI

cc: Barb Hinkle, Cahaba GBA
Wilson Leong, FSS

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Refer to:

CERTIFIED MAIL

AUG 15 2016

Mercy Health
Blake Cosper
Regional Director, Reimbursement
Revenue Integrity & Reimbursement
1235 E. Cherokee
Springfield, MO 65804

RE: Mercy Hospital Springfield
Provider No. 26-0065
FYE 06/30/2009
Case No. 13-0913

Dear Mr. Cosper:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal and notes that you have transferred all issues to group appeals. The pertinent facts with regard to the case and the Board's determination are set forth below.

Pertinent Facts:

Mercy Health filed an appeal on behalf of the Provider on February 27, 2013, which included the following issues:

- DSH SSI Days
- Dual Eligible/Exhausted Part A Days
- Managed Care Part C Days

The Board assigned case number 13-0913 to the individual appeal in an Acknowledgement letter dated March 5, 2013.[1]

On March 6, 2014, you authorized QRS to file "Requests to Transfer Issue to a Group Appeal" (Model Form D's) for the following issues:

- DSH SSI to case no. 13-3955GC
- Dual Eligible/Exhausted Part A Days to case no. 14-0455GC
- Medicare Managed Care Part C Days to case no. 13-3954GC

[1] This appeal was initially input as a FYE 2008 case but upon review it was determined that two appeal requests were bound together when submitted. It was later determined that this case was for FYE 2009 based on supporting documents and clarification from Provider. An earlier appeal had already been established for FYE 2008 to which the Board assigned case number 13-0743.

Subsequently, on February 24, 2014, the Medicare Contractor filed a jurisdictional challenge over SSI Realignment. The Medicare Contractor argues that the issue is suitable for reopening but is not an appealable issue as there has been no request for a realigned SSI percentage made by the hospital.

Board Determination:

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

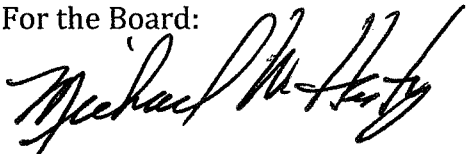
The Board finds that the Provider did not actually raise SSI Realignment in this case. In its description of the SSI issue, the Provider states

> [t]he Provider retains the right to evaluate the propriety of requesting a change in the time period upon which the SSI calculation is based from the federal fiscal year to the provider's cost reporting period in accordance with 42 CFR § 412.106(b)(3).... **This appeal, however, does not represent any formal request to have the data calculated on a hospital year end at this time.**[2] (emphasis added)

Therefore, the Medicare Contractor's challenge over jurisdiction is moot. Since there are no remaining issues in the individual appeal, case number 13-2650 is hereby closed.

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

For the Board:



Michael W. Harty
Chairman

[2] Provider's appeal request at tab 3, page 2. Feb. 26, 2013.

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CERTIFIED MAIL

AUG 15 2016

Julie Jacobs
Warren General Hospital
2 Crescent Park West
Warren, PA 16365

Bruce Snyder
JL Provider Audit Manager
Novitas Solutions, Inc.
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Warren General Hospital
Provider No.: 39-0146
FYE: 06/30/2009
PRRB Case No.: 14-1191

Dear Ms. Jacobs and Mr. Snyder,

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

Background

On May 29, 2013, Novitas Solutions, Inc. issued Warren General Hospital (the Provider) an original Notice of Program Reimbursement (NPR) for Fiscal Year End (FYE) 06/30/2009. On December 3, 2013, the Board received the Provider's Request for Hearing appealing the Rural Floor Budget Neutrality Adjustment issue.

Board's Decision

The Board finds that it does not have jurisdiction over this individual appeal because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed no later than 180 days after the provider has received its final determination.
42 C.F.R. § 405.1835(a)(3)(i) states that:

> Unless the provider qualifies for a good cause extension...the date of receipt by the Board of the provider's hearing request is...[n]o later than 180 days after the date of receipt by the provider of the intermediary or Secretary Determination.

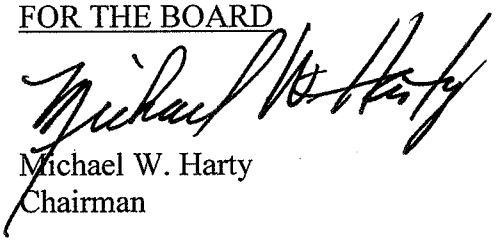
For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2)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

date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

In this case, Novitas Solutions, Inc. issued the Provider's NPR on May 29, 2013. For an appeal to have been timely filed, the appeal request must have been received by the Board no later than December 2, 2013. However, the Board did not receive the Provider's Request for Hearing until December 3, 2013, which was one day past the allowed filing date. Because the Provider's Request for Hearing was not received by the Board within 185 days as required by 42 C.F.R. § 405.1835 and 42 C.F.R. § 405.1801(a)(1)(iii), the Board finds that this appeal was not timely filed. Case number 14-1191 is dismissed and removed 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.

FOR THE BOARD



Michael W. Harty
Chairman

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

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CERTIFIED MAIL

AUG 15 2016

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

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

RE: Bayfront Medical Center
Provider No.: 10-0032
FYE: 12/31/2010
PRRB Case No.: 14-4277

Dear Ms. Erde and Mr. Pike,

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

Background

On March 14, 2014, First Coast Service Options, Inc. issued Bayfront Medical Center (the Provider) an original Notice of Program Reimbursement (NPR) for Fiscal Year End (FYE) 12/31/2010. On September 16, 2014, the Board received the Provider's individual appeal request.

Board's Decision

The Board finds that it does not have jurisdiction over this individual appeal because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed no later than 180 days after the provider has received its final determination.
42 C.F.R. § 405.1835(a)(3)(i) states that:

> Unless the provider qualifies for a good cause extension…the date of receipt by the Board of the provider's hearing request is…[n]o later than 180 days after the date of receipt by the provider of the intermediary or Secretary Determination.

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

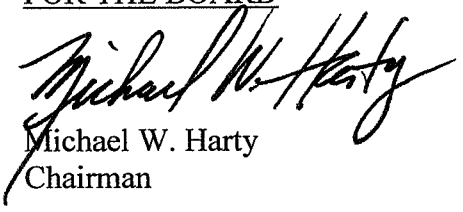
date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

In this case, First Coast Service Options, Inc. issued the Provider's NPR on March 14, 2014. For an appeal to have been timely filed, the appeal request must have been received by the Board no later than September 15, 2014. However, the Board did not receive the Provider's Individual Appeal Request until September 16, 2014, which was one day past the allowed filing date. Because the Provider's Individual Appeal Request was not received by the Board within 185 days as required by 42 C.F.R. § 405.1835 and 42 C.F.R. § 405.1801(a)(1)(iii), the Board finds that this appeal was not timely filed. Case number 14-4277 is dismissed and removed 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
Michael W. Harty
Jack Ahern, MBA
Charlotte F. 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

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Refer to:

AUG 30 2016

CERTIFIED MAIL

Quality Reimbursement Services, Inc.
Delbert W. Nord, Senior Consultant
112 N. University Rd., Suite 308
Spokane Valley, WA 99206

RE: Sisters of Mercy Health System 2010 SSI CIRP Group, Case No. 12-0367GC

Dear Mr. Nord:

The Provider Reimbursement Review Board (the Board) has reviewed the above-referenced Common Issue Related Party (CIRP) group in response to your May 20, 2016 request for reconsideration and reinstatement. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

Quality Reimbursement Services, Inc. (QRS) filed a CIRP group appeal for Sisters of Mercy Health System on May 25, 2012. The Board established case number 12-0367GC and issued an acknowledgement letter on June 1, 2015. The appeal was based on the Medicare Contractor's failure to issue timely determinations. Initially, QRS did not include evidence of the date the Medicare Contractor received the filed/amended cost reports nor did it supply the date of the Medicare Contractor's acceptance of the same cost reports for 10 of the 12 participants in the group.

On September 2, 2015, the Board advised that the information submitted with the original group request did not comply with 42 C.F.R. § 405.1835(a)(3)(ii) in that it did not evidence the Medicare Contractor's receipt and acceptance of the cost report. On November 30, 2015, QRS responded and submitted information, but still did not provide evidence of the Medicare Contractor's receipt of the cost report for participants 3 through 12.

On May 6, 2016 the Board dismissed participant 2 from the group because its appeal it did not timely file its appeal based on the evidence submitted and dismissed participants 3 through 12 for failure to provide sufficient documentation to support timely filings. The Board also remanded participant 1 pursuant to CMS Ruling 1498-R.

By letter dated May 20, 2016, QRS requested the Board to reconsider its determination and reinstate the group.

Through various email correspondence, the Board was able to obtain the STAR screens for participants 4 through 10 (See tab A) and certification of the cost report received and acceptance dates from the MAC for participants 3, 11 and 12 (see tab B).

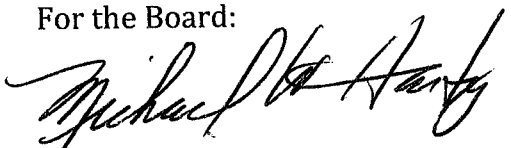
Board Determination:

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

After reviewing the facts in this case, the Board grants reinstatement of the case for participants 3 through 12. Based on the new information received from the Medicare Contractors, the Board finds it has jurisdiction over these providers that timely appealed from the date of submission of their cost reports.[1] These providers are subject to remand under CMS Ruling 1498R. Enclosed, please find the Board's Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R. With the issuance of the remand, there are no remaining matters for adjudication and the group is hereby closed.

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

For the Board:



Michael W. Harty
Chairman

Enclosure: Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R

cc: Byron Lamprecht, Wisconsin Physicians Service
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[1] Participants 9 and 11 actually appealed from the amended cost report receipt date, but those cost reports were ultimately accepted.