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: 16-1903G
Certified Mail

OCT 04 2016

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

RE: QRS 2014 Two Midnight Rule Census IPPS Payment Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 16-1903G
EJR of the 2-Midnight Issue

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 10, 2016 request for expedited judicial review (EJR) (received August 11, 2016) and their September 12, 2016 response to the Board's September 2, 2016 request for additional information (received September 14, 2016. The Board decision with respect to the request for EJR is set forth below.

Background

Issue Under Appeal

The issue under appeal in this case is:

> Whether the provision in the FY 2014 IPPS Rule that imposes a .2 [percentage] decrease in the IPPS rates for all IPPS [inpatient prospective payment system] hospitals for each of the FYs [Federal fiscal years] 2014-2018 is procedurally invalid, arbitrary and capricious and outside the authority of CMS [the Centers for Medicare and Medicaid Services].[1]

Statutory and Regulatory Background

In the final inpatient prospective payment system (IPPS) rule for Federal fiscal year (FFY) 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed

[1] Providers' August 10, 2016 EJR Requests at 3.

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

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

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[5]

Medicare Part A

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

---

[2] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.

it is the physician responsible for patient care who determines if the patient should be admitted.[7]

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

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

---

[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.

not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

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

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[15] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[16]

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

---

[13] *Id.* at 50,927.
[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.

Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18]

Providers' Position

The Providers explain that, in the FFY 2014 IPPS final rule, the Secretary instituted the 2-midnight policy whereby a hospital stay will be deemed to inpatient-appropriate if the ordering physician reasonably expected the patient to be in the hospital at least over a 2 midnight period. The Secretary estimated that the 2-midnight policy would increase IPPS operating and capital by $220 million. Hospitals would not receive any of this increase because, using the authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(i) and 1395ww(g), the estimated increase was reduced by applying a 0.2 percent reduction to the IPPS standardized amount, the hospital-specific rates and capital payments to IPPS hospitals.

The final rule which gave rise to this reduction, stated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, a net gain of 40,000 inpatient encounters. The Providers believe these calculations were based on 2011 claims data in which the Secretary assumed that any hospital claims spanning 2 or more midnights would become inpatient claims under the 2-midnight policy and anything spanning less than 2 midnights would be outpatient claims. The Providers believe the Secretary made the following unjustified assumptions:

1. Hospitals will always bill stays lasting at least 2 midnights (and including observation or a major procedure) as inpatient claims;

2. Claims for stays lasting at least 2 midnights will always be paid and paid as inpatient;

3. Hospitals will always bill stays lasting less than 2 midnights (except for those involving surgery) as outpatient claims; and

4. Claims for stays lasting less than 2 midnights will always be paid and paid as outpatient.[19]

The Providers do not believe that these assumptions will necessarily prove valid in light of the "Part B Inpatient" policy. This policy provides that if a hospital bills a hospital encounter as an

[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] Providers' EJR request at 8.

inpatient stay, and it is subsequently determined that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated as an outpatient instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. The Providers do not believe that they will be able to rebill within that 12-month window because the audits that give rise to the need to rebill are not completed within 12 months of a discharge. Therefore, with respect to assumptions 1 and 2, above, it may not be true that hospitals will always bill as inpatient for stays spanning at least 2 midnights and it may not be true that Medicare will pay under Part A for such stays. Hospitals may be concerned that short stays, including those spanning 2 midnights, will be denied under Part A and that they will be unable to rebill under Part B in the 12-month window. As a result, they may bill the stays to Part B.[20]

Alternatively, a hospital may decide not to bill for an admission under Part A because they believe the medical record does not contain sufficient documentation to explain why the admitting physician had a reasonable explanation that the beneficiary was expected to stay through 2 midnights. This may cause the hospital to bill under Part B.[21]

Additionally, assumptions 3 and 4, may not be realized for other reasons. Hospitals may bill some stays lasting less than 2 midnights under Part A because of the physicians' belief, at the time of admission that the patient stay would exceed 2 midnights. These types of stays are not to be audited under the Secretary's policy. If the payment is allowed, it would increase the amount of Part A payment. However, if the Part A payment is denied, the amount of Part A payment would not increase, and there would likely not be a Part B payment to offset the loss because of the inability to rebill under Part B. The Providers believe that there may be other faulty assumptions that the Secretary relied upon, but are hidden by plain view because of lack of detail in the final rule.[22]

The Providers believe the Secretary's actions are arbitrary and capricious because the 2-midnight rule reduces IPPS payments as a result of the projected increase in Medicare Part A billing, but does not increase Part B payments which are projected to decrease significantly.[23] Further, the Providers argue the Secretary failed to adequately explain how she arrived at the supposed offset. The Providers assert that the Board lacks the authority to grant the relief sought: to declare the 0.2 percent decrease to the IPPS rates invalid; therefore, EJR is appropriate.

---

[20] *Id.* at 9.
[21] *Id.*
[22] *Id. at 10.*
[23] *Id. at 11.*

Decision of the Board

Jurisdictional Decision: Antelope Valley Medical Center, Dameron Hospital, Community Memorial Hospital of San Buenaventura

Antelope Valley Medical Center (Provider No. 05-0056, FYE 6/30/2014) (Schedule B)

The Board finds that it lacks jurisdiction over the Antelope Valley Medical Center's (provider number 05-0056) appeal because the Provider did not submit information demonstrating that it complied with the requirements of 42 C.F.R. § 405.1835(a)(1)(ii) and Quality Reimbursement Services (QRS) is not the designated representative of record. Consequently, the Board hereby dismisses Antelope Valley Medical Center from the appeal.

The Provider's appeal of its April 13, 2016 Notice of Program Reimbursement (NPR) for its fiscal year end June 30, 2014 cost report was received in the Board's offices on August 2, 2016. Fiscal year 2014 appeals are governed by the requirements of 42 C.F.R. § 405.1835(a)(1)(ii) dealing with protested amounts (costs which the Medicare Contractor cannot award). The regulation requires that:

> (a) Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if—
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—
>
> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).

Since the Provider did not furnish evidence that it had protested the 0.2 percent reduction to IPPS[24] on its as filed cost report as required by Board Rule 21.D.[25] which requires providers submit a copy of the page containing the cost report protested item, the Board concludes that it does not have jurisdiction over the issue.

In addition, QRS is not the designated representative for Antelope Valley Medical Center; Gong, Nash and Pascoe was designated by the Provider as its representative. Board Rule 5.4 requires a letter designating the provider representative be on the Provider's letterhead and be signed by an owner or officer of the provider. The letter must designating the provider representative must identify the fiscal year under appeal and contain the contact information for the representative. Since QRS is not authorize to file an appeal with the Board, this Provider's appeal does not comply with the Board's rules and it hereby dismisses the Antelope Valley from the appeal.

#1 Dameron Hospital and #2 Community Memorial Hospital of San Buenaventura

The letter authorizing QRS as the provider representative, for #1 Dameron Hospital (provider number 05-0122) and #2 Community Memorial Hospital of San Buenaventura (provider number 05-0394) was submitted by Nathan Consulting Group, not the Provider as required by Board Rule 5.4. Pursuant to the Board Rule 5.4, authorization for representation must be filed by the Provider on its letterhead and must be signed by an owner or officer of the provider. Representation cannot be designated by a third party. Since the letter authorizing representation does not comply with the Board's Rules, the Board hereby dismisses Dameron Hospital and Community Memorial Hospital of San Buenaventura from the appeal.

EJR Determination

The Board has reviewed the Providers' request for EJR and the Schedule of Providers with the associated jurisdictional documents. The Providers filed these appeals when the final Medicare contractor determinations for the Providers' 2014 cost report period were not issued within 12 months after the receipt of the cost reports by the contractors. The regulation, 42 C.F.R. § 405.1835(c) (2015), states in relevant part:

> *Right to hearing based on untimely contractor determination.* Notwithstanding the provisions of paragraph (a) of this section, a provider (but no other individual, entity, or party) has a right to a

[24] Protested Amounts are entered on Worksheet E, Part A Line 75 of the cost report. The Provider Reimbursement Manual (CMS Pub. 15-2) § 4030.1 requires that along with the entry on Line 75, the providers must also attach a scheduling showing the details of the protested amount and computations for the amounts claimed.
[25] The Board Rules can be found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.html.

> Board hearing, as a single provider appeal, for specific items for a cost reporting period if—
>
> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section);

With respect to jurisdiction, the Board concludes that each of the remaining Providers on the attached Schedule of Providers filed their request for hearing within 180 days of the 12 month period for issuance of a contractor determination. Further, the amount in controversy in the case exceeds the $50,000 threshold necessary for a group appeal.[26] Consequently, the Board has determined that it has jurisdiction over the appeal. Further the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

> 1) it has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;
>
> 2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount, there are no findings of fact for resolution by the Board;
>
> 3) it is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

[26] *See* 42 C.F. R. § 405.1837(a)(3).

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

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

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Jack Ahern, MBA

FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Geoff Pike, First Coast Service Options (Certified Mail w/Schedule of Providers)
Wilson Leong, FSS (w/Schedule of Providers)

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: 16-2113GC
Certified Mail

OCT 04 2016

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

RE: QRS BSWH 2014 Two Midnight Rule Census IPPS Payment Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 16-2113GC
EJR of the 2-Midnight Issue

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 12, 2016 request for expedited judicial review (EJR) (received August 15, 2016) and their September 9, 2016 response to the Board's September 2, 2016 request for additional information (received September 12, 2016). The Board decision with respect to the request for EJR is set forth below.

Background

Issue Under Appeal

The issue under appeal in this case is:

> Whether the provision in the FY 2014 IPPS Rule that imposes a .2 [percentage] decrease in the IPPS rates for all IPPS [inpatient prospective payment system] hospitals for each of the FYs [Federal fiscal years] 2014-2018 is procedurally invalid, arbitrary and capricious and outside the authority of CMS [the Centers for Medicare and Medicaid Services].[1]

Statutory and Regulatory Background

In the final inpatient prospective payment system (IPPS) rule for Federal fiscal year (FFY) 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for

[1] Providers' August 12, 2016 EJR Requests at 3.
[2] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

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

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[5]

Medicare Part A

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

In the FFY 2014 IPPS proposed rule,[8] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this

---

[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.
[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

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

---

[9] 78 Fed. Reg. 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.

The 2-Midnight Rule

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

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[15] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[16]

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

[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.
[17] *Id.* at 50,952-53.

projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18]

Providers' Position

The Providers explain that, in the FFY 2014 IPPS final rule, the Secretary instituted the 2-midnight policy whereby a hospital stay will be deemed to be inpatient-appropriate if the ordering physician reasonably expected the patient to be in the hospital over at least a 2 midnight period. The Secretary estimated that the 2-midnight policy would increase IPPS operating and capital by $220 million. Hospitals would not receive any of this increase because, using the authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(i) and 1395ww(g), the estimated increase was reduced by applying a 0.2 percent reduction to the IPPS standardized amount, the hospital-specific rates and capital payments to IPPS hospitals.

The final rule which gave rise to this reduction, stated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift inpatient to outpatient, a net gain of 40,000 inpatient encounters. The Providers believe these calculations were based on 2011 claims data in which the Secretary assumed that any hospital claims spanning 2 or more midnights would become inpatient claims under the 2-midnight policy and anything spanning less than 2 midnights would be outpatient claims. The Providers believe the Secretary made the following unjustified assumptions:

1. Hospitals will always bill stays lasting at least 2 midnights (and including observation or a major procedure) as inpatient claims;

2. Claims for stays lasting at least 2 midnights will always be paid and paid as inpatient;

3. Hospitals will always bill stays lasting less than 2 midnights (except for those involving surgery) as outpatient claims; and

4. Claims for stays lasting less than 2 midnights will always be paid and paid as outpatient.[19]

The Providers do not believe that these assumptions will necessarily prove valid in light of the "Part B Inpatient" policy. This policy provides that if a hospital bills a hospital encounter as an inpatient stay, and it is subsequently determined that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated as an outpatient instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. The

[18] *Id.* at 50,990.
[19] Providers' EJR request at 8.

Providers do not believe that they will be able to rebill within that 12-month window because the audits that give rise to the need to rebill are not completed within 12 months of a discharge. Therefore, with respect to assumptions 1 and 2, above, it may not be true that hospitals will always bill as inpatient for stays spanning at least 2 midnights and it may not be true that Medicare will pay under Part A for such stays. Hospitals may be concerned that short stays, including those spanning 2 midnights, will be denied under Part A and that they will be unable to rebill under Part B in the 12-month window. As a result, they may bill the stays to Part B instead. [20]

Alternatively, a hospital may decide not to bill for an admission under Part A because they believe the medical record does not contain sufficient documentation to explain why the admitting physician had a reasonable explanation that the beneficiary was expected to stay through 2 midnights. This may cause the hospital to bill under Part B.[21]

With respect to assumptions 3 and 4, may not be realized for other reasons. Hospitals may bill some stays lasting less than 2 midnights under Part A because of the physicians' belief, at the time of admission that the patient stay would exceed 2 midnights. These types of stays are not to be audited under the Secretary's policy. If the payment is allowed, it would increase the amount of Part A payment. However, if the Part A payment is denied, the amount of Part A payment would not increase, and there would likely not be a Part B payment to offset the loss because of the inability to rebill under Part B. The Providers believe that there may be other faulty assumptions that the Secretary relied upon, but are hidden by plain view because of lack of detail in the final rule.[22]

The Providers believe the Secretary's actions are arbitrary and capricious because the 2-midnight rule reduces IPPS payments as a result in the projected increase in Medicare Part A billing, but does not increase Part B payments which are projected to decrease significantly.[23] Further, the Providers argue the Secretary failed to adequately explain how she arrived at the supposed offset. The Providers assert that the Board lacks the authority to grant the relief sought: to declare the 0.2 percent decrease to the IPPS rates invalid; therefore, EJR is appropriate.

Decision of the Board

The Board has reviewed the Providers' request for EJR and the Schedule of Providers with the associated jurisdictional documents. The Providers filed these appeals because the final Medicare Contractor determinations for the Providers' 2014 cost report periods were not issued within 12 months after the receipt of the cost reports by the contractors. The regulation, 42 C.F.R. § 405.1835(c) (2015), states in relevant part:

---

[20] *Id.* at 9.
[21] *Id.*
[22] *Id. at 10.*
[23] *Id. at 11.*

> *Right to hearing based on untimely contractor determination.* Notwithstanding the provisions of paragraph (a) of this section, a provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if—
>
> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section);

With respect to jurisdiction, the Board concludes that each of the Providers in the case referenced above timely filed their requests for hearing within 180 days of the 12 month period for issuance of a contractor determinations. Further, the amount in controversy in the case exceeds the $50,000 threshold necessary for a group appeal.[24] Consequently, the Board has determined that it has jurisdiction over the appeal. Further the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

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

[24] *See* 42 C.F.R. § 405.1837(a)(3).

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

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

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

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

Board Members Participating

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

FOR THE BOARD:

Michael W. Harty
Chairman

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

cc: Bruce Synder, Novitas Solutions(Certified Mail w/Schedule of Providers)
Wilson Leong, FSS (w/Schedule of Providers)

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: 16-2201GC
Certified Mail

OCT 04 2016

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

RE: QRS Multicare 2014 Two Midnight Rule Census IPPS
Payment Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 16-2201GC
EJR of the 2-Midnight Issue

Dear Mr. Kramer:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' August 18, 2016 request for expedited judicial review (EJR) (received August 19, 2016) and their September 9, 2016 response to the Board's September 2, 2016 request for additional information (received September 12, 2016). The Board decision with respect to the request for EJR is set forth below.

Background

Issue Under Appeal

The issue under appeal in this case is:

> Whether the provision in the FY 2014 IPPS Rule that imposes a .2 [percentage] decrease in the IPPS rates for all IPPS [inpatient prospective payment system] hospitals for each of the FYs [Federal fiscal years] 2014-2018 is procedurally invalid, arbitrary and capricious and outside the authority of CMS [the Centers for Medicare and Medicaid Services].[1]

Statutory and Regulatory Background

In the final inpatient prospective payment system (IPPS) rule for Federal fiscal year (FFY) 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for

[1] Providers' August 18, 2016 EJR Requests at 3.
[2] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

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

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[5]

Medicare Part A

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

In the FFY 2014 IPPS proposed rule,[8] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this

---

[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.
[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).

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

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

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

---

[9] 78 Fed. Reg. 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.

The 2-Midnight Rule

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

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[15] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[16]

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

---

[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.
[17] *Id.* at 50,952-53.

projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18]

Providers' Position

The Providers explain that, in the FFY 2014 IPPS final rule, the Secretary instituted the 2-midnight policy whereby a hospital stay will be deemed to be inpatient-appropriate if the ordering physician reasonably expected the patient to be in the hospital over at least a 2 midnight period. The Secretary estimated that the 2-midnight policy would increase IPPS operating and capital by $220 million. Hospitals would not receive any of this increase because, using the authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(i) and 1395ww(g), the estimated increase was reduced by applying a 0.2 percent reduction to the IPPS standardized amount, the hospital-specific rates and capital payments to IPPS hospitals.

The final rule which gave rise to this reduction, stated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift inpatient to outpatient, a net gain of 40,000 inpatient encounters. The Providers believe these calculations were based on 2011 claims data in which the Secretary assumed that any hospital claims spanning 2 or more midnights would become inpatient claims under the 2-midnight policy and anything spanning less than 2 midnights would be outpatient claims. The Providers believe the Secretary made the following unjustified assumptions:

1. Hospitals will always bill stays lasting at least 2 midnights (and including observation or a major procedure) as inpatient claims;

2. Claims for stays lasting at least 2 midnights will always be paid and paid as inpatient;

3. Hospitals will always bill stays lasting less than 2 midnights (except for those involving surgery) as outpatient claims; and

4. Claims for stays lasting less than 2 midnights will always be paid and paid as outpatient.[19]

The Providers do not believe that these assumptions will necessarily prove valid in light of the "Part B Inpatient" policy. This policy provides that if a hospital bills a hospital encounter as an inpatient stay, and it is subsequently determined that the inpatient stay was not reasonable and necessary and the beneficiary should have been treated as an outpatient instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. The

[18] *Id.* at 50,990.
[19] Providers' EJR request at 8.

Providers do not believe that they will be able to rebill within that 12-month window because the audits that give rise to the need to rebill are not completed within 12 months of a discharge. Therefore, with respect to assumptions 1 and 2, above, it may not be true that hospitals will always bill as inpatient for stays spanning at least 2 midnights and it may not be true that Medicare will pay under Part A for such stays. Hospitals may be concerned that short stays, including those spanning 2 midnights, will be denied under Part A and that they will be unable to rebill under Part B in the 12-month window. As a result, they may bill the stays to Part B instead. [20]

Alternatively, a hospital may decide not to bill for an admission under Part A because they believe the medical record does not contain sufficient documentation to explain why the admitting physician had a reasonable explanation that the beneficiary was expected to stay through 2 midnights. This may cause the hospital to bill under Part B.[21]

With respect to assumptions 3 and 4, may not be realized for other reasons. Hospitals may bill some stays lasting less than 2 midnights under Part A because of the physicians' belief, at the time of admission that the patient stay would exceed 2 midnights. These types of stays are not to be audited under the Secretary's policy. If the payment is allowed, it would increase the amount of Part A payment. However, if the Part A payment is denied, the amount of Part A payment would not increase, and there would likely not be a Part B payment to offset the loss because of the inability to rebill under Part B. The Providers believe that there may be other faulty assumptions that the Secretary relied upon, but are hidden by plain view because of lack of detail in the final rule.[22]

The Providers believe the Secretary's actions are arbitrary and capricious because the 2-midnight rule reduces IPPS payments as a result in the projected increase in Medicare Part A billing, but does not increase Part B payments which are projected to decrease significantly.[23] Further, the Providers argue the Secretary failed to adequately explain how she arrived at the supposed offset. The Providers assert that the Board lacks the authority to grant the relief sought: to declare the 0.2 percent decrease to the IPPS rates invalid; therefore, EJR is appropriate.

Decision of the Board

The Board has reviewed the Providers' request for EJR and the Schedule of Providers with the associated jurisdictional documents. The Providers filed these appeals because the final Medicare Contractor determinations for the Providers' 2014 cost report periods was not issued within 12 months after the receipt of the cost reports by the contractor. The regulation, 42 C.F.R. § 405.1835(c) (2015), states in relevant part:

---

[20] *Id.* at 9.
[21] *Id.*
[22] *Id. at 10.*
[23] *Id. at 11.*

> *Right to hearing based on untimely contractor determination.* Notwithstanding the provisions of paragraph (a) of this section, a provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if—
>
> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section);

With respect to jurisdiction, the Board concludes that each of the Providers in the case referenced above timely filed their requests for hearing within 180 days of the 12 month period for issuance of a contractor determination. Further, the amount in controversy in the case exceeds the $50,000 threshold necessary for a group appeal.[24] Consequently, the Board has determined that it has jurisdiction over the appeal. Further the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

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

[24] *See* 42 C.F.R. § 405.1837(a)(3).

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

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

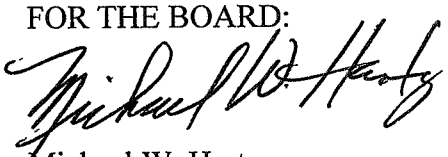
4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

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

Board Members Participating

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

FOR THE BOARD:



Michael W. Harty
Chairman

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

cc: Evaline Alcantara, Noridian Healthcare Solutions (Certified Mail w/Schedule of Providers)
Wilson Leong, FSS (w/Schedule of Providers)

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 OCT 04 2016

Maureen O'Brien Griffin
Hall, Render, Killian, Heath & Lyman
500 North Meridian Street
Suite 400
Indianapolis, IN 46204

RE: Hall Render 2007 DSH Medicare Fraction Medicare Advantage Days Group
Case No. 13-1168G

Hall Render 2007 DSH Medicaid Fraction Medicare Advantage Days Group
Case No. 13-2387G

Dear Ms. O'Brien Griffin:

The Provider Reimbursement Review Board (the Board) has reviewed your September 22, 2016 request seeking to consolidate the above-referenced group appeals which involve the inclusion/exclusion of Medicare Advantage Days in the Medicare and Medicaid fractions of the disproportionate share hospital (DSH) adjustment.

Consolidation of Medicare & Medicaid Fraction Groups

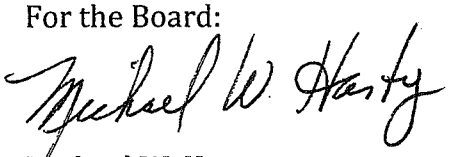
As noted in your correspondence, the Board has recently agreed with your position, that the issue of whether the Medicare Advantage Days should be counted in the Medicaid Fraction rather than the Medicare Fraction is one issue. Therefore, the Board is consolidating the Hall Render 2007 DSH Medicaid Fraction Part C Days Group, Case No. 13-2387G into the Hall Render 2007 DSH Medicare Fraction Part C Days Group, Case No. 13-1168G. Case No. 13-2387G is hereby closed. The group name for case no. 13-1168G has been modified to the Hall Render 2007 Medicare/Medicaid Fraction Part C Days Group. Please refer to only Case No. 13-1168G in future correspondence with the Board.

Group Completion

You previously advised the Board that case number 13-1168G was fully formed. The Parties are to adhere to the deadlines established in the December 22, 2015 REVISED Group Acknowledgement and Critical Due Dates (Optional Group) letter.

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: Byron Lamprecht, Wisconsin Physicians Service (J-5)
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:

OCT 0 6 2016

CERTIFIED MAIL

Northwell Health
James Petty
Assistant Vice President, Finance
972 Brush Hollow Road
Westbury, NY 11590

RE: Plainview Hospital, Provider No. 33-0331, FYE 12/31/2005
PRRB Case No. 16-2240

Dear Mr. Petty:

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

Pertinent Facts:

Northwell Health filed an individual appeal for Plainview Hospital on August 17, 2016. The appeal request did not include a copy of the final determination (the Notice of Program Reimbursement (NPR)). The Board established case number 16-2240 and issued an acknowledgement letter on August 22, 2016.

Board Determination:

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

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

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

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the

appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

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

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

Board Members Participating:
Michael W. Harty
Charlotte F. Benson, C.P.A.
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: National Government Services, Inc.
Pam VanArsdale
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

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

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:

16-0576 **Certified Mail** OCT 06 2016

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

Re: Thibodaux Regional Medical Center, Provider No. 19-0004, FYE 09/30/11,
Case No. 16-0576

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") is in receipt of the Provider's transfer requests. The background of the case and the decision of the Board are set forth below.

Background

On December 31, 2015, the Board received the provider's individual appeal. On January 5, 2016, the Board issued an Acknowledgement and Critical Due Dates in accordance with Board Rule 9.[1] On July 20, 2016, the Board received requests to transfer the following six issues:

- DSH Medicaid Fraction Dual Eligible Days, Case No. 15-3031G
- DSH SSI Fraction Medicare Managed Care Part C Days, Case No. 15-3032G
- DSH SSI (Systemic Errors), Case No. 15-3037G
- DSH Medicaid Fraction Medicare Managed Care Part C Days, Case No. 15-3038G
- DSH SSI Fraction Dual Eligible Days, Case No. 15-3039G
- Outlier Payments – Fixed Loss Threshold, Case No. 15-3040G

Decision of the Board

The Board finds that the Provider's appeal request is jurisdictionally deficient as the Provider failed to submit the final determination under appeal.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835, a provider has a right to a hearing on a final contractor or Secretary determination for the provider's cost reporting period if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or

[1] Board Rule 9 states in part, "The Board will send an acknowledgement via e-mail indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient."

more ($50,000 for a group), and the request for a hearing is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

Pursuant to 42 C.F.R. § 405.1835(b), if a Provider's appeal request does not meet the requirements of paragraphs (b)(1) through (b)(3) of the same section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate. Paragraphs (b)(1) through (b)(3) state in part that the following must be included in the Provider's request:

> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of the same section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) A separate explanation for each specific item under appeal and a description of how the provider is dissatisfied with the specific aspects of the final determination.
>
> (3) A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements.

Because the Provider failed to submit the final determination under appeal, the Provider has not met the regulatory requirements for filing an appeal before the Board. Therefore, the Board hereby dismisses the Provider's appeal and closes Case No. 16-0576. In addition, because the Provider does not have a jurisdictionally valid appeal, the Board also denies the transfer of issues to Case Nos. 15-3031G, 15-3032G, 15-3037G, 15-3038G, 15-3039G and 15-3040G.

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

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, C.P.A.
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: Novitas Solutions, Inc.
Bill Tisdale
Director JH, Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

National Government Services, Inc.
Pam VanArsdale
Appeals Lead
MP: INA 101-AF-42
P.O. Box 6474
Indianapolis, IN 46206-6474

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

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

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

Internet: www.cms.gov/PRRBReview

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

CERTIFIED MAIL

OCT 11 2016

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

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

RE: Lake Charles Memorial Hospital
Provider No.: 19-0060
FYE: 12/31/2007
PRRB Case No.: 15-2748

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background

On December 12, 2014, the Medicare Contractor issued Lake Charles Memorial Hospital (the Provider) a Revised Notice of Program Reimbursement (NPR) for Fiscal Year End (FYE) 12/31/2007. On June 16, 2015, the Board received the Provider's Request for a Hearing appealing eight issues.

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 a Revised 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,

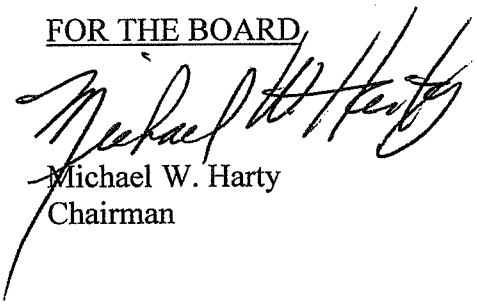
alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

In this case, the Medicare Contractor issued the Provider's Revised NPR on December 12, 2014. For an appeal to have been timely filed, the Board must have received the appeal request no later than June 15, 2015. However, the Board did not receive the Provider's Request for a Hearing until June 16, 2015, which was one day past the allowed filing date. Because the Provider's Request for a Hearing was not timely received by the Board within 180 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 15-2748 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 Participating
Michael W. Harty
Jack Ahern, MBA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Wilson Leong, Esq., CPA, FSS

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

10-1009

CERTIFIED MAIL OCT 14 2016

Stephanie A. Webster
Akin Gump Strauss Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Suite 400
Washington DC, 20036-1564

Pam VanArsdale
National Government Services, Inc.
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis IN, 46206-6474

RE: Women and Infants' Hospital of Rhode Island
Provider No.: 41-0010
FYE: 09/30/2006
PRRB Case No.: 10-1009

Dear Ms. Webster and Ms. VanArsdale,

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

Background

The Provider, Women and Infants' Hospital of Rhode Island, submitted a Request for a Hearing for its cost report on May 7, 2010 based on a Notice of Program Reimbursement ("NPR") dated November 9, 2009. The Provider transferred the Labor and Delivery Room days issue in this appeal to Case No. 10-1394G and the only remaining issue in the appeal is for Medicaid Eligible Days in the Disproportionate Share Hospital payment adjustment – hereinafter referred to as DSH Medicaid Eligible Days.

The Medicare Contractor filed Jurisdictional Challenges over the DSH Medicaid Eligible Days issue on both May 20, 2011 and August 25, 2011, alleging that that no adjustment had been made regarding this item and there was no final determination.[1] The Provider filed responses to the Jurisdictional Challenges on both May 17, 2011 and on September 12, 2011.[2] The Provider has also filed a response to Alert 10 regarding this issue.

[1] Both Jurisdictional Challenges are the same.

[2] The Provider was represented by King & Spaulding LLP during the time it submitted the first Opposition to the Medicare Contractor's Jurisdictional Objection. However, the Provider switched representation to Akin Gump Strauss Hauer & Feld LLP and submitted the second Response to the Jurisdictional Objection. The Provider notes on the cover page of the second filing that it has responded to the May objection and believes that the Medicare Contractor's latest objection should be denied for the same reasons previously discussed in the earlier filing.

Medicare Contractor's Contentions

For fiscal year 2006, the Medicare Contractor contends that it did not adjust DSH Medicaid Eligible Days on the cost report and this issue was not part of the final determination; the only adjustments that related to the DSH calculation were adjustments to the SSI Percentage. Since the Medicare Contractor accepted the number of Medicaid days claimed by the Provider on its submitted cost report, the Medicare Contractor contends that the Board lacks jurisdiction over the Medicaid eligible days issue in accordance with 42 C.F.R. § 405.1811.

The Medicare Contractor's position is that 42 C.F.R. §§ 405.1801 and 405.1803 imply a requirement of an identifiable adverse finding along with a corresponding reduction in reimbursement in order to request a Board hearing under Section 405.1841(a). The Medicare Contractor asserts that the Provider had ample time to establish a method for accumulating its own Medicaid eligible paid and unpaid days, or to timely make a request to its State agency for a Medicaid eligible unpaid days listing, prior to submission of its Medicare cost report.[3] HCFA Ruling 97-2 states that Medicaid eligible unpaid, as well as Medicaid paid days, may be included in the DSH calculation effective February 27, 1997.

In support of its position, the Medicare Contractor points to the Board's decision in *Maple Crest Care Center v. Mutual of Omaha Insurance Company*, PPRB Decision No. 2003-D4, PRRB Case No. 01-0320 in which the Provider requested an appeal for the reclassification of costs for which no audit adjustment was made by the Intermediary. The Board ruled, "There was nothing in the statute, regulations, or manual provisions that prevented the Provider from making the cost report elections in the manner it requested through the reopening request." The Board in this case found that it lacks jurisdiction over an appeal issue where the provider appeals its own classification of certain costs and statistics.[4]

The Medicare Contractor argues that since it made no adjustment to Medicaid Eligible Days in the Disproportionate Share Hospital payment calculation, this issue was not part of its final determination. It is clear that the requisite "determination of the Secretary" under § 1878(a)(1)(A)(ii) of the Social Security Act does not exist in this case. As outlined in 42 CFR § 405.1811 and Section C.VI. of Part I of the PRRB Instructions, the Medicare Contractor asserts that the Board lacks jurisdiction over an issue that is not part of the final determination.[5]

Provider's Contentions

The Provider, in its Response to the Medicare Contractor's Jurisdictional Objection, contends that the Board should grant jurisdiction consistent with *Bethesda Hospital et al. v. Bowen*, 485 U.S. 399 (1988) ("*Bethesda*"), in which the Supreme Court dealt with the Board's authority to hear appeals on matters that were not include on the cost report and were not the subject of an adverse determination. The Provider also argues that the Board has jurisdiction over the entirety of the DSH payment calculation because the Board has jurisdiction "to make any other revisions

[3] Medicare Contractor Jurisdictional Briefs at 2.
[4] *Id.*
[5] *Id.* at 6.

on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the Medicare Contractor in making such final determination."[6]

The Provider also contends that it was not required to formally claim DSH and the Medicare Contractor incorrectly assumed that an audit adjustment is required for an appeal. The Provider argues that a revision was made to the DSH payment on cost report Worksheet E, Part A, line 4.04 which was driven by the change to the Provider's SSI fraction.[7]

The Provider also filed a response to Alert 10 which was a generic document discussing the difficulties of all providers across the country trying to obtain timely, accurate eligibility information at the time the cost report is due. The Provider states the biggest concern is the issue of retroactive application of the new practical impediment standard. The Provider claims that at the time they filed their cost report, the standard was that they could revise their lists of Medicaid patient days after they filed their cost reports. Though the Alert 10 response filed was not specific to this Provider, it addresses the concerns of all Southwest Consulting Associates ("SCA") clients, and what SCA finds when it does subsequent DSH runs for hospitals all over the country.[8]

Board's Decision

The Board majority finds that it has jurisdiction over the Medicaid Eligible Days issue, which is the sole remaining issue in this appeal. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2009), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it has jurisdiction over this issue pursuant to the rationale in *Barberton Citizens Hosp. vs. CGS Administrators,* PRRB Dec. No. 2015-D5 (March 19, 2015) ("*Barberton*"). In this decision the Board stated, "pursuant to the concept of futility in *Bethesda,* the Board has jurisdiction of a hospital's appeal of additional Medicaid eligible days for the DSH adjustment calculation if that hospital can establish a "practical impediment" as to why it could not claim these days at the time that it filed its cost report."[9]

The Provider's appeal request for the DSH Medicaid Eligible Days issue states that only paid Medicaid days were allowed, and the Medicare Contractor excluded "eligible" days where payment was not made. There were 36,688 Medicaid Days (paid and eligible) on the finalized cost report, and no adjustment was made to the DSH days. In its final position paper the Provider identified 2,651 days in dispute, for a total of 39,339 Medicaid Eligible Days.[10]

---

[6] Provider's Opposition to Medicare Contractor's Jurisdictional Objection at 7; *see* 42 U.S.C § 1395oo(d).
[7] *Id.* at 15.
[8] Provider's Response to Alert 10; Declaration of Michael G. Newell.
[9] *Barberton* at 4.
[10] Provider's Final Position Paper, Exhibit P-3.

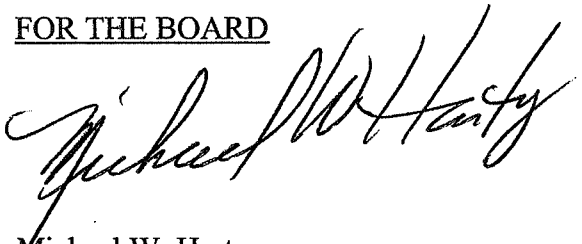
The Board issued Alert 10 on May 23, 2014, which gave the Provider the opportunity to supplement the records of appeals pending before the Board that included the Medicaid Eligible Days issue. Alert 10 specifies that the Board was interested in receiving certain information, including, "[a] detailed description of the process that the provider used to identify and accumulate the actual Medicaid paid and unpaid eligible days that were reported and filed on the Medicare cost report at issue." Alert 10 was issued in response to an earlier decision issue by the Board, *Danbury Hosp. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 2014-D3 (Feb. 11, 2014), so the Board did not use the term "practical impediment." However, the Board has since looked at the Alert 10 responses from providers in determining whether there was in fact a practical impediment.

The Board majority finds the Provider has identified the difficulties that it faced due to retroactive eligibility and matching concerns regarding Medicaid Eligible Days. Accordingly, the Board majority accepts the Provider's general explanation as sufficient to establish a practical impediment and grants jurisdiction over the Medicaid Eligible Days issue. The case will remain pending a hearing which is set for October 19, 2016.

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

Board Members:
Michael W. Harty
Clayton J. Nix, Esq. (dissenting)
Charlotte F. Benson, CPA
L. Sue Andersen, Esq.
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: Federal Specialized Services, Wilson C. Leong, Esq., CPA

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

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

Refer to: 14-1813G

OCT 24 2016

CERTIFIED MAIL

King & Spalding, LLP
Mark Polston
1700 Pennsylvania Avenue, NW
Suite 200
Washington, DC 20006-4706

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

RE: King & Spalding 2009 Low Income Pool Sec. 1115 DSH Waiver Days Group Jurisdictional Challenge
PRRB Case Number: 14-1813G

Dear Mr. Polston and Mr. Pike,

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 FACTS –

The Board established a group appeal on January 17, 2014 for the King & Spalding 2009 Low Income Pool Sec. 1115 DSH Waiver Days issue. The group issue statement reads, in part, as follows:

> The Providers are appealing the Intermediary's exclusion of days associated with the Section 1115 waiver program known as the Florida Low-Income Pool ("LIP") from the numerator of the Medicaid fraction of the Medicare DSH payment.

ARGUMENTS

Medicare Contractor's Arguments in Jurisdictional Challenge

The Medicare Contractor is challenging jurisdiction over all 9 Providers included in this group appeal. The Medicare Contractor contends that the Providers cite to adjustments that did not specifically relate to the issue for this group appeal and therefore do not provide a basis for appeal.[1]

[1] *See* Medicare Contractor's Jurisdictional Challenge at 1 (June 30, 2016).

In addition, the Medicare Contractor argues that according to 42 CFR § 405.1835(a)(1)(ii), for cost reports ending on or after December 31, 2008, a provider must file an item under protest to preserve appeal rights if the issue is being self-disallowed. The Medicare Contractor contends that if the Providers are claiming LIP Section 1115 waiver days, they should have filed these days under protest when they filed their cost reports.[2]

Providers' Response to Jurisdictional Challenge

The Providers contend that under 42 CFR § 412.106(b)(4)(ii) days attributable to "populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act can count as a "Medicaid day".

The Providers assert that the Board has jurisdiction over the 1115 waiver days issue for two reasons. First, the Supreme Court in *Bethesda Hospital*[3] has made clear that providers can "claim dissatisfaction, within the meaning of the statue, without incorporating their challenges in the cost reports filed with their fiscal intermediaries." Second, the ultimate issue in this case is the Medicare Contractor's calculation of the DSH payment, which the Medicare Contractor did adjust and from which each Provider filed a valid appeal.

The Provider argues that one Provider, Bethseda Memorial Hospital, participant #1, did file a protested amount for LIP.[4] Additionally, the Providers reason that even if the Medicare Contractor did not specifically adjust the DSH LIP days, it made a determination as to the number of Medicaid days to be included in the Medicaid fraction when it calculated the Providers' DSH payment.

The Intermediary believes that the Board lacks jurisdiction because the Providers did not include or protest the exclusion of Section 1115 Medicaid days on their as-filed cost reports.[5] The Providers argue that the Supreme Court, and several other lower courts, have already rejected this interpretation of the provisions of the Medicare statute that set forth a provider's right to seek Board review for its 'dissatisfaction" with its overall Medicare reimbursement.[6]

The Providers further argue that jurisdiction over the section 1115 DSH LIP days issue exists – regardless of any protested amounts included by the Providers or specific adjustments to such days by the Intermediary – on the bases of section 1395oo(d), which extends Board jurisdiction to the entire cost report if jurisdiction is proper for one issue.[7]

---

[2] *Id.* at 2.
[3] *Bethesda Hospital Association v. Bowen*, 484 U.S. 339, 405 (1988).
[4] Provider's response to Jurisdictional Challenge at 3; tabs 1 and 5 (July 29, 2016) documents that participant #1, Bethesda Memorial, Provider Number 10-0002, FYE 9/30/09, did file a protested amount for the LIP 1115 waiver days on W/S E Part A of its as-filed cost report which was removed with Adjustment 29.
[5] *Id.* at 15-16.
[6] *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988). *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).
[7] Providers' response to Jurisdictional Challenge at 22 (July 29, 2016). Providers' Supplemental Jurisdictional Brief at 1-3 (September 26, 2016)

BOARD'S DECISION

Pursuant to 42 C.F.R. § 405.1835(a)(i) –(ii) (2009), "[a] provider . . . has a right to a Board hearing . . . only if— (1) [t]he 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 . . . ." Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2009). Thus, when a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."[8]

The Board finds that it does not have jurisdiction over the LIP 1115 Waiver days issue for the eight[9] of the nine Providers because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i)–(ii) (2009). Because the Providers' cost reports were for Fiscal Year End (FYE) 09/30/2009, the Providers were required to either claim the days, ie. make a specific claim on their cost report, or file a cost report with a protested amount for items the provider deemed to be self-disallowed costs.

There is no evidence in the record that the eight Providers claimed the LIP 1115 Waiver days, and the Providers admitted as much by stating that they were not required to claim them or report as a protested amount. In addition, the Providers cite to audit adjustments that adjusted Medicaid days, however there is no documentation in the record that the adjustments adjusted or excluded the LIP waiver days. The Providers included documentation behind Tab E of the Schedule of Providers the calculation of reimbursement amounts that show LIP 1115 waiver days as additional Medicaid days that were not included on the as-filed cost report. Absent specific evidence that LIP waiver days were protested, the Board concludes that the eight Providers failed to file the LIP 1115 Waiver days issue under protest and that the Providers failed to preserve their rights to claim dissatisfaction under 42 C.F.R. § 405.1835(a)(1)(ii) (2009).[10]

The Board hereby dismisses the eight Providers from this case. Since there is only participant #1 remaining in the subject appeal, the Board will transfer Bethesda, fiscal year 2009 to Case No. 15-0446G. The Board will rename Case No. 15-0446G to King & Spalding 2009 - 2011 Low

---

[8] 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

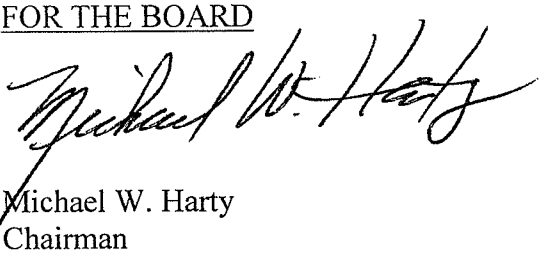
[9] The Providers submitted documentation in its jurisdictional response to show that Participant # 1, Bethseda Memorial Hospital, did file its cost report with a protested amount for 1115 Waiver Days and the Medicare Contractor removed the protested amount. *See* Providers' response to Jurisdictional Challenge at tabs 1 and 5.

[10] *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*" *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges. Here, the Providers have not documented that it would have been futile to claim these days, as the Provider itself argues that the regulations and CMS guidance allow for the inclusion of these type of days. Therefore, these Providers would stand on "separate" ground than those in *Bethesda*, as it was not futile (i.e., the provider was barred by neither statute nor regulation) to make the claim. Under the 2008 regulation, the Board is not able to grant jurisdiction over the days without the specific claim, but under the *Bethesda* test, the Providers still fail.

Income Pool Sec. 1115 DSH Waiver Days Group. The Board hereby closes Case No. 14-1813G. 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, 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: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

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

Internet: www.cms.gov/PRRBReview

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

Refer to: 14-3341G

OCT 24 2016

CERTIFIED MAIL

King & Spalding, LLP
Mark Polston
1700 Pennsylvania Avenue, NW
Suite 200
Washington, DC 20006-4706

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

RE: King & Spalding 2010 Low Income Pool Sec. 1115 DSH Waiver Days Group
Jurisdictional Challenge
PRRB Case Number: 14-3341G

Dear Mr. Polston and Mr. Pike,

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 FACTS

The Board established a group appeal on April 28, 2014 for the King & Spalding 2010 Low Income Pool Sec. 1115 DSH Waiver Days issue. The group issue statement reads, in part, as follows:

> The Providers are appealing the Intermediary's exclusion of days associated with the Section 1115 Medicare waiver program known as Florida Low-Income Pool ("LIP") from the numerator of the Medicaid fraction of the Medicare DSH payment.

ARGUMENTS

Medicare Contractor's Arguments in Jurisdictional Challenge

The Medicare Contractor states that all 10 participating providers have fiscal year ends of 09/30/2010. The Providers are appealing the LIP section 1115 waiver days. However, the various audit adjustments cited by the Providers relate to the DSH calculation but are not specific to the issue in the group appeal. The Providers did not identify this issue as having been filed as a protested amount for any of the providers in the group appeal.

The Medicare Contractor argues that the Providers are claiming additional days that were not part of any adjustments. Also, according to 42 CFR § 405.1835(a)(1)(ii), for cost reports ending on or after December 31, 2008, a provider must file an item under protest to preserve appeal

rights if the issue is being self-disallowed. The Medicare Contractor contends that if the Providers are claiming LIP Section 1115 waiver days, they should have filed these days under protest when they filed their cost reports.[1]

Providers' Response to Jurisdictional Challenge

The Providers argue that the Board has jurisdiction over the 1115 Waiver days issue under *Bethesda. Bethesda* made clear that providers can "claim dissatisfaction, within the meaning of the statute, without incorporating their challenges in the cost report filed with their fiscal intermediaries." The Providers assert that had they claimed the 1115 Waiver days on their as-filed cost reports, contrary to the Secretary's policy, the MAC undoubtedly would have disallowed the days.

The D.C. District Court recently upheld this principle in *Banner Heart Hospital v. Burwell.* "Where the intermediary has no authority to address a claim, such as when a purely legal challenge to a regulation is at issue, the provider cannot be deem to be 'satisfied' simply because such challenge is not reflected in the cost report."[2]

The Providers contend that even if the MAC did not specifically adjust the DSH LIP days, the MAC necessarily made a determination as to the number of Medicaid days to be included in the Medicaid fraction.

BOARD DECISION

Pursuant to 42 C.F.R. § 405.1835(a)(i) –(ii) (2009), "[a] provider . . . has a right to a Board hearing . . . only if— (1) [t]he 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 . . . ." Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2009). Thus, when a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."[3]

The Board finds that it does not have jurisdiction over the 1115 Waiver days issue for 9 of the 10 providers[4] because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i)–(ii) (2009). Because the Providers' cost reports were for Fiscal Year End (FYE) 09/30/2010, the Providers were required to either claim the days, ie. make a specific claim

---

[1] *See* Medicare Contractor's Jurisdictional Challenge at 2-3. (August 8, 2016)
[2] *See* Providers' Supplemental Jurisdictional Brief at 1-3 (September 26, 2016).
[3] 42 C.F.R. § 405.1835(a)(1)(ii) (2009).
[4] Provider's response to Jurisdictional Challenge at 3; tab 1 (August 29, 2016) documents that participant #1, Bethesda Memorial, Provider Number 10-0002, FYE 9/30/10, did file a protested amount for the LIP 1115 waiver days on W/S E Part A of its as-filed cost report which was removed with Adjustment 18.

on their cost report, or file a cost report with a protested amount for items the provider deemed to be self-disallowed costs.

There is no evidence in the record that the nine Providers claimed 1115 Waiver days on their as-filed Medicare cost reports or that they were a protested amount. In addition, the Providers failed to cite to any audit adjustments removing protested amounts for the LIP waiver days or included documentation that the Providers in fact included the LIP waiver days as a protested item. Absent specific evidence that LIP waiver days were protested, the Board concludes that the Providers failed to file the 1115 Waiver days issue under protest and that the Providers failed to preserve their rights to claim dissatisfaction under 42 CFR § 405.1835(a)(1)(ii) (2009). Review of the Schedule of Providers actually shows that the 1115 Waiver days are additional Medicaid Eligible days that the Providers are requesting and that the Providers did not file their as-filed cost reports under protest as required under 42 C.F.R. § 405.1835(a)(i) –(ii) (2009).[5]

Only one participant remains in Case No. 14-3341G. Therefore, the Board will transfer participant # 1, Bethesda Memorial Hospital, Provider No. 10-0002, fiscal year 9/30/2010 to Case No. 15-0446G. The Board renamed Case No. 15-0446G to King & Spalding 2009 - 2011 Low Income Pool Sec. 1115 DSH Waiver Days Group. The Board hereby, closes Case No. 14-3341G.

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, 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 C. Leong, Esq., CPA, Federal Specialized Services

---

5 *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*" *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges. Here, the Providers have not documented that it would have been futile to claim these days, as the Provider itself argues that the regulations and CMS guidance allow for the inclusion of these type of days. Therefore, these Providers would stand on "separate" ground than those in *Bethesda*, as it was not futile (i.e., the provider was barred by neither statute nor regulation) to make the claim. Under the 2008 regulation, the Board is not able to grant jurisdiction over the days without the specific claim, but under the *Bethesda* test, the Providers still fail.

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

Internet: www.cms.gov/PRRBReview

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

Refer to: 14-3340G

OCT 24 2016

CERTIFIED MAIL

King & Spalding, LLP
Mark Polston
1700 Pennsylvania Avenue, NW
Suite 200
Washington, DC 20006-4706

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

RE: King & Spalding 2010 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group Jurisdictional Challenge
PRRB Case Number: 14-3340G

Dear Mr. Polston and Mr. Pike,

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 FACTS

The Board established a group appeal on April 28, 2014 for the King & Spalding 2010 Low Income Pool Sec. 1115 Rehab DSH Waiver Days issue. The group issue statement reads, in part, as follows:

> The Providers are appealing the Intermediary's exclusion of days associated with the Section 1115 Rehab Medicare Florida Low-Income Pool ("LIP") waiver from the numerator of the Medicaid fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRF").

ARGUMENTS

Medicare Contractor's Arguments in Jurisdictional Challenge

The Medicare Contractor contends that 42 U.S.C. § 1395ww(j)(8)(B) prohibits and precludes administrative and judicial review of prospective payment rates established under 42 U.S.C. § 1395ww(j)(3).[1] The Medicare Contractor argues that the LIP adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3), which is why

[1] *See* Medicare Administrative Contractor's Jurisdictional Challenge at 2 (May 17, 2016).

administrative review of the LIP adjustment is statutorily precluded.[2] 42 U.S.C. § 1395ww(j)(3)(A) directs the Secretary to determine prospective payment rates for IRFs, and the prospective payment rate is based on the average payment per payment unit for inpatient operating and capital costs of rehabilitation facilities.[3] Further, the Medicare Contractor contends that the Secretary must adjust these rates by specific designated factors and "such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities."[4]

The Medicare Contractor contends that one of these adjustments to the rate is the LIP adjustment.[5] The Medicare Contractor states that when the Secretary responded to comments made in response to the Secretary's final rule in the Federal Register regarding IRF LIP adjustments, the Secretary noted that the LIP adjustment was an adjustment under 42 U.S.C. § 1395ww(j)(3)(A)(v).[6] Further, 42 C.F.R. § 412.624(e)(2) provides that "[w]e adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us."[7] Therefore, because the Medicare Contractor contends that the LIP adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3), the Medicare Contractor argues that administrative and judicial review of the LIP adjustment is statutorily precluded by 42 U.S.C. § 1395ww(j)(8)(B).

The Medicare Contractor adds that the Administrator's recent decision to vacate the Board's decision in *Mercy Hosp. v. First Coast Service Options*, PRRB Dec. 2015-D7 (April 3, 2015) adds further weight to its position that the LIP adjustment is not an appealable issue before the Board.[8]

In addition, the Medicare Contractor argues that the Providers are claiming additional days that were not part of any adjustments. Also, according to 42 CFR § 405.1835(a)(1)(ii), for cost reports ending on or after December 31, 2008, a provider must file an item under protest to preserve appeal rights if the issue is being self-disallowed. The Medicare Contractor contends that if the Providers are claiming LIP Section 1115 waiver days, they should have filed these days under protest when they filed their cost reports.[9]

Providers' Response to Jurisdictional Challenge

The Providers argue that the Board has jurisdiction over the IRF 1115 waiver days issue for three principle reasons. First, the IRF statue does not preclude review of the IRF DSH adjustment at issue here. Second, any post-hoc statements by CMS to preclude review are contrary to the

---

[2] *Id.*
[3] *Id.*
[4] *Id.* (quoting 42 U.S.C. § 1395ww(j)(3)(A)(v)).
[5] *Id.* at 2.
[6] *Id.* (citing 66 Fed. Reg. 41316, 41361 (Aug. 7, 2001).
[7] *Id.* at 2.
[8] *Id.*
[9] *Id.* at 3.

statute. Third, the Providers satisfy the requirements for a Board hearing under section 1878(a) of the Social Security Act.[10]

The Providers contend that the IRF PPS statute only precludes review of "the prospective payment rates under paragraph (3)" of the section 1395ww(j). Paragraph (3) of the section sets forth only the unadjusted IRF PPS payment rates. The Providers cite a recent Board decision in *Mercy Hosp. v. First Coast Service Options*, PRRB Dec. 2015-D7 (April 3, 2015). In *Mercy* the Board:

> " "that the phrase "the prospective payment rates under paragraph (3)" in § 1395(j)(7) does not encompass all of paragraph (3). Rather, that reference is limited to the general 'rates" prior to being "adjusted" by the items enumerated in Clauses (i) to (v) of Paragraph (3). The adjustments enumerated in these clauses include the LIP adjustment that the Secretary established pursuant to the discretionary authority granted under Clause (v)."[11]

Next, the Providers asserts that they have meet the statutory requirements for a Board hearing. The Intermediary's challenge relates to the first prong of Board jurisdiction "the Providers are dissatisfied with the Intermediary's final determination as to the amount of program reimbursement due to the Providers for the period covered by such cost report." The Intermediary believes that the Board lacks jurisdiction because the Providers did not include or protest the exclusion of Section 1115 Medicaid days on their as-filed cost reports.[12] The Providers argue that the Supreme Court, and several other lower courts, have already rejected this interpretation of the provisions of the Medicare statute that set forth a provider's right to seek Board review for its 'dissatisfaction" with its overall Medicare reimbursement.[13]

The Providers further argue that jurisdiction over the section 1115 DSH LIP days issue exists – regardless of any protested amounts included by the Providers or specific adjustments to such days by the Intermediary – on the bases of section 1395oo(d), which extends Board jurisdiction to the entire cost report if jurisdiction is proper for one issue.[14]

BOARD DECISION

Pursuant to 42 C.F.R. § 405.1835(a)(i) –(ii) (2009), "[a] provider . . . has a right to a Board hearing . . . only if— (1) [t]he 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 . . . ." Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2009). Thus, when a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the

---

[10] Providers' response to Jurisdictional Challenge at 16 (June 15, 2016).
[11] Id. at 17.
[12] Id. at 19.
[13] *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988). *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).
[14] Providers' response to Jurisdictional Challenge at 22 (June 15, 2016). Providers' Supplemental Jurisdictional Brief at 1-3 (September 26, 2016)

items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."[15]

The Board finds that it does not have jurisdiction over the 1115 Waiver days issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i)–(ii) (2009). Because the Providers' cost reports were for Fiscal Year End (FYE) 04/30/2010 and 09/30/2010, the Providers were required to either claim the days, ie. make a specific claim on their cost report, or file a cost report with a protested amount for items the provider deemed to be self-disallowed costs.

There is no evidence in the record that the Providers claimed the LIP 1115 Waiver days now under appeal, and the Providers admitted as much by stating that they were not required to claim them or report as a protested amount. In addition, the Providers failed to cite to any audit adjustments removing protested amounts for the LIP waiver days or included documentation that the Providers in fact included the LIP waiver days as a protested item. The Providers representative has attempted to persuade the Board that as Provider #1, Bethesda Memorial Hospital protested the 1115 waiver days for the acute care DSH adjustment on W/S E Part A for the DSH adjustment, that is sufficient to put the MAC on notice that it would also be protesting the exclusion of such days from the LIP payment as well. The Board finds that there is no specific protest on W/S E-3 of the LIP waiver days, which is the appropriate location to protest items related to the Rehabilitation units payments, nor did the protest documentation reference for the W/S E Part A protested amount reference any waiver days associated days for the Rehab unit or LIP adjustment (only referenced # of days for acute care patients and corresponding DSH adjustment). The Provider is post-hoc asking the Board to expand its original issue statement and accept jurisdiction over the LIP waiver days absent specific evidence that LIP waiver days were protested for the IRF. The Board concludes that the Providers (including #1) failed to file the LIP 1115 Waiver days issue under protest and that the Providers failed to preserve their rights to claim dissatisfaction under 42 C.F.R. § 405.1835(a)(1)(i)–(ii) (2009).[16]

The Board does not need to address the issue of jurisdiction specific to IRF providers for the 1115 waiver days since this issue is now moot.

---

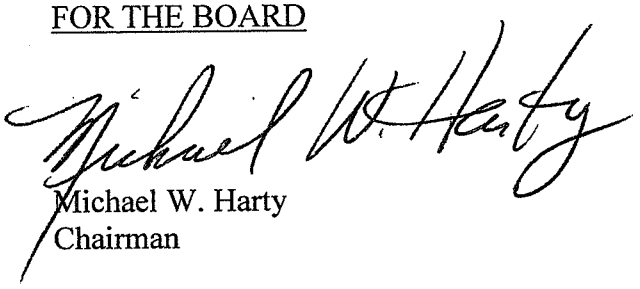
[15] 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

[16] *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*" *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges. Here, the Providers have not documented that it would have been futile to claim these days, as the Provider itself argues that the regulations and CMS guidance allow for the inclusion of these type of days. Therefore, these Providers would stand on "separate" ground than those in *Bethesda*, as it was not futile (i.e., the provider was barred by neither statute nor regulation) to make the claim. Under the 2008 regulation, the Board is not able to grant jurisdiction over the days without the specific claim, but under the *Bethesda* test, the Providers still fail.

The Board hereby closes Case No. 14-3340G 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, 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: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

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

CERTIFIED MAIL

OCT 27 2016

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

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

RE: Queen of the Valley Medical Center
Provider No.: 05-0009
FYE: 6/30/06
PRRB Case No.: 08-1116

Dear Mr. Knight and Ms. Alcantara,

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 February 11 2008, based on a Notice of Program Reimbursement ("NPR") dated September 4, 2007. On January 22, 2010, the Board closed Case No. 08-1116 as all issues had been transferred to group appeals or administratively resolved. On August 12, 2015, the Board reinstated the case. The Board transferred the Provider's LIP Dual Eligible Days issue from Group Case No. 08-1742GC back to this individual appeal. The only issue remaining in this case is the Medicare Rehab Low Income Patient (LIP) Payments – Dual Eligible Unpaid Part A Days – Medicaid Ratio issue. The Medicare Contractor submitted a jurisdictional challenge on September 7, 2016. The Provider filed a responsive brief on October 4, 2016.

Medicare Contractor's Position

The Medicare Contractor contends that the language of 42 U.S.C. § 1395ww(j)(8)(B)[1] unambiguously precludes administrative and judicial review of the IRF-PPS rates established under 42 U.S.C. § 1395ww(j)(3)(A). The Medicare Contractor maintains that, because the IRF-PPS rate is comprised of both the general federal rate based on historical costs and adjustments to that federal rate (including but not limited to the LIP adjustment at issue), the statute prohibits administrative and judicial review of the LIP adjustment.[2] Accordingly, the Medicare Contractor argues that the Board is divested of jurisdiction to hear the Provider's appeal because it must comply with all of the provisions of the Medicare Act and

[1] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 1886(j)(7) of the Act [42 U.S.C. § 1395ww(j)(7)] to section 1886(j)(8) [42 U.S.C. § 1395ww(j)(8)] and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs.
[2] Medicare Contractor's jurisdictional challenge at 2-3.

the regulations issued thereunder.[3]

The Medicare Contractor cites to the Administrator's decisions in several appeals in support of its position.[4] In each of the cases cited, the Administrator found that 1886(j)(8) of the Act prohibits the administrative and judicial review of LIP. Additionally, the Medicare Contractor states that the United States District Court for the District of Columbia in *Mercy Hosp., Inc. vs. Sylvia M. Burwell, Sec'y, United States Dep't of Health and Human Services, (D.D.C, 2016),* concluded that the 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[5]

Provider's Position

The Provider contends that the NPR issued on February 26, 2013 constitutes a final determination by the Medicare Contractor with respect to the Provider's cost report. In 42 C.F.R. § 405.1801(a)(2), it defines a final determination as follows: "An intermediary determination is defined as a "determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period…".[6]

The Provider explains that within the NPR the Medicare Contractor adjusted the IRF Medicaid Eligible Days, a component of the LIP calculation, in audit adjustment number 26 wherein the Provider had reported 329 days and the Medicare Contractor revised days to 357. The resulting change to the Provider's reported IRF LIP entitlement in the Medicare cost report allows the Provider an avenue to pursue a correction to their LIP entitlement via the PRRB appeal process.[7]

The Provider contends that the LIP adjustment is not a component of the IRF-PPS rate described in § 1395ww(j)(3)(A) (*i.e.*, the unadjusted federal rates) because LIP is calculated as a current cost reporting period add-on payment to the IRF-PPS federal payment and it is reported on a separate line within the Medicare cost report.[8] The Provider argues that it is only disputing the accuracy of the provider-specific data elements used by the Medicare Contractor, not the establishment or methodology for development of the federal IRF prospective payments.[9] The Provider contends that § 1395ww(j)(8) does not prohibit its challenge as to whether CMS and its agents utilized the proper data elements in executing that formula. The Provider maintains that, while § 1395ww(j)(8) prohibits administrative or judicial review for certain aspects of the establishment of the IRF payments, there is no specific

---

[3] 42 C.F.R. § 405.1867; *Id.*
[4] *Mercy Hospital vs. First Coast Service Options, Inc./Blue Cross and Blue Shield Association,* Review of Decision No. 2015-D7, Administrator Decision 6/4/2015; *Sutter Auburn Faith Hospital vs. Cahaba Safeguard Administrators, LLC,* Review of Decision No. 2015-D16, Administrator Decision 10/16, 2015; *Sutter Auburn Faith Hospital vs. Cahaba Safeguard Administrators, LLC,* Review of Decision No. 2015-D28, Administrator Decision 11/18/2015; *BMHCC 2004-2006 LIP SSI% CIRP Group vs. National Government Services,* Review of Decision No. 2015-D30, Administrator Decision 11/6/2015.
[5] Medicare Contractor's jurisdictional challenge at 4-5 (Emphasis included).
[6] Provider's responsive brief at 2.
[7] *Id.* at 3.
[8] *Id.* at 4.
[9] *Id.* at 4-5.

language within § 1395ww(j)(8) prohibiting administrative or judicial review as it pertains to the establishment of LIP.[10]

The Provider points to several recent Board decisions in support of its position.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2009), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

In reviewing this matter, the Board first looked to the statutory provision prohibiting certain judicial and administrative review. 42 U.S.C. § 1395ww(j)(8) specifies:

> There shall be no administrative or judicial review . . . of the *establishment* of—
>
> (A) case mix groups, of the methodology for the classification of patients within such groups, and the appropriate weighting factors thereof under paragraph (2),
>
> (B) the prospective payment rates under paragraph (3),
>
> (C) outlier and special payments under paragraph (4), and
>
> (D) area wage adjustments under paragraph (6).[11]

The United States District Court for the District of Columbia in *Mercy Hosp., Inc. v. Burwell ("Mercy")*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016), recently concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board in *Mercy* had previously held that it had jurisdiction to review the Medicare Contractor's determination of the LIP adjustment.[12] The Administrator of CMS vacated the Board's decision concluding that the Board had lacked authority to hear the hospital's appeal in light of 42 U.S.C. § 1395ww(j)(8).[13] *Mercy* appealed to the United States District Court for the District of Columbia who affirmed the Administrator's decision.

The Board notes the text of § 1395ww(j)(8) prohibits administrative or judicial review of "*the establishment* of" the items listed in Subparagraphs (A) to (D). The Board finds the use of the word

---

[10] *Id.* at 5.
[11] (emphasis added)
[12] *Mercy Hospital v. First Coast Service Options, Inc.*, PRRB Dec. No. 2015-D7, 2013 WL 10381780, at *1 (Apr. 3, 2015).
[13] *Mercy Hospital v. First Coast Service Options, Inc.*, Review of PRRB Dec. 2015-D7, 2015 WL 3760091, at *11 (June 1, 2015).

"establishment" in the statute significant.[14] Queen of the Valley Medical Center is not challenging "the *establishment* of" either the federal rates or "the *establishment* of" the LIP adjustment to those rates, since this appeal challenges no part of the August 2001 Final Rule in which the Secretary established the LIP adjustment itself (*i.e.*, the formula used to calculate the adjustment). Rather, Queen of the Valley Medical Center is challenging whether the Medicare Contractor properly executed the LIP adjustment, specifically whether the Medicare Contractor's calculation of the LIP adjustment used the proper provider-specific data elements in that calculation.[15] The Board finds no prohibition in 1395ww(j)(8) to administrative or judicial review of *"the calculation of"* the LIP adjustment where the focus is on the accuracy of the provider-specific data elements being used in the LIP adjustment calculation.

The LIP issue in this case is similar to the issue raised in Mercy, as the Provider is challenging that an entire category of days is missing from the LIP SSI Ratio due to CMS' matching policy.

The Board notes however, that it respectfully disagrees with the U.S. District Court for the District of Columbia's decision in *Mercy* which found that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the contractor's interpretation of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates. The Board has been clear on its decision in regards to this issue.[16] The Board continues to stand by its conclusion that it has jurisdiction to review the Medicare Contractor's determination of the LIP adjustment including the understatement of the LIP SSI ratio.

As noted above, the Administrator in *Mercy* and the U.S. District Court for the District of Columbia affirming the Administrator, reversed the Board's decision that it had jurisdiction over the LIP payment factors. The Administrator and the U.S. District Court restated the Medicare Contractor's assertion that administrative and judicial review of the LIP adjustment is precluded because § 1395ww(j)(8) precludes review of the prospective payment rate under paragraph (3) as well as *all* adjustments articulated in subsequent paragraphs. The Board, however, remains unconvinced, and continues to disagree with the Administrator and the U.S. District Court for the District of Columbia's overly broad interpretation.

Based on the above, the Board concludes that it has jurisdiction to hear the Medicare Rehab Low Income Patient (LIP) Payments – Dual Eligible Unpaid Part A Days – Medicaid Ratio issue in this appeal. In the instant case, the Provider filed its request for hearing timely, met the amount in controversy requirement and met the dissatisfaction requirement. Queen of the Valley Medical Center is not challenging the establishment of the prospective payment rates but instead is challenging the accuracy of the Medicare Contractor's calculation of the provider-specific data elements being used in the LIP adjustment calculation.

This case is scheduled for a live hearing on November 10, 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.

---

[14] 42 U.S.C. § 1395ww(j)(8).
[15] Provider's Response to Medicare Contractor's Jurisdictional Challenge at 4.
[16] See the Board's decision in *Mercy*; See also, the Board's latest decision in *St. Joseph Hospital of Eureka v. Noridian Healthcare Solutions*, PRRB Dec. No. 2016-D4, 2016 WL 10371515 (December 2, 2015).

Board Members Participating:
Michael W. Harty
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
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

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

Internet: www.cms.gov/PRRBReview

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

Refer to: 14-4057G

CERTIFIED MAIL

OCT 27 2016

King & Spalding, LLP
Mark Polston
1700 Pennsylvania Avenue, NW
Suite 200
Washington, DC 20006-4706

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

RE: King & Spalding 2011 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group Jurisdictional Challenge
PRRB Case Number: 14-4057G

Dear Mr. Polston and Mr. Pike,

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 FACTS

The Board established a group appeal on August 28, 2014 for the King & Spalding 2011 Low Income Pool Sec. 1115 Rehab DSH Waiver Days issue. The group issue statement reads, in part, as follows:

> The Providers are appealing the Intermediary's exclusion of days associated with the Section 1115 Rehab Medicare Florida Low-Income Pool ("LIP") waiver from the numerator of the Medicaid fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRF").

ARGUMENTS

Medicare Contractor's Arguments in Jurisdictional Challenge

The Medicare Contractor contends that 42 U.S.C. § 1395ww(j)(8)(B) prohibits and precludes administrative and judicial review of prospective payment rates established under 42 U.S.C. § 1395ww(j)(3).[1] The Medicare Contractor argues that the LIP adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3), which is why administrative review of the LIP adjustment is statutorily precluded.[2] 42 U.S.C. § 1395ww(j)(3)(A) directs the Secretary to determine prospective payment rates for IRFs, and the

[1] *See* Medicare Administrative Contractor's Jurisdictional Challenge at 2 (January 15, 2016).
[2] *Id.*

prospective payment rate is based on the average payment per payment unit for inpatient operating and capital costs of rehabilitation facilities.[3] Further, the Medicare Contractor contends that the Secretary must adjust these rates by specific designated factors and "such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities."[4]

The Medicare Contractor contends that one of these adjustments to the rate is the LIP adjustment.[5] The Medicare Contractor states that when the Secretary responded to comments made in response to the Secretary's final rule in the Federal Register regarding IRF LIP adjustments, the Secretary noted that the LIP adjustment was an adjustment under 42 U.S.C. § 1395ww(j)(3)(A)(v).[6] Further, 42 C.F.R. § 412.624(e)(2) provides that "[w]e adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us."[7] Therefore, because the Medicare Contractor contends that the LIP adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3), the Medicare Contractor argues that administrative and judicial review of the LIP adjustment is statutorily precluded by 42 U.S.C. § 1395ww(j)(8)(B).

The Medicare Contractor adds that the Administrator's recent decision to vacate the Board's decision in *Mercy Hosp. v. First Coast Service Options*, PRRB Dec. 2015-D7 (April 3, 2015) adds further weight to its position that the LIP adjustment is not an appealable issue before the Board.[8]

In addition, the Medicare Contractor argues that the Providers are claiming additional days that were not part of any adjustments. Also, according to 42 CFR § 405.1835(a)(1)(ii), for cost reports ending on or after December 31, 2008, a provider must file an item under protest to preserve appeal rights if the issue is being self-disallowed. The Medicare Contractor contends that if the Providers are claiming LIP Section 1115 waiver days, they should have filed these days under protest when they filed their cost reports.[9]

Providers' Response to Jurisdictional Challenge

The Providers argue that the Board has jurisdiction over the IRF 1115 waiver days issue for three principle reasons. First, the Providers satisfy the requirements for a Board hearing under section 1878(a) of the Social Security Act. Second, the IRF statue does not preclude review of the IRF DSH adjustment at issue here. Third, any post-hoc statements by CMS to preclude review are contrary to the statute.[10]

---

[3] *Id.*
[4] *Id.* (quoting 42 U.S.C. § 1395ww(j)(3)(A)(v)).
[5] *Id.* at 2.
[6] *Id.* (citing 66 Fed. Reg. 41316, 41361 (Aug. 7, 2001).
[7] *Id.* at 2.
[8] *Id.*
[9] *Id.* at 3.
[10] Providers' response to Jurisdictional Challenge at 13 (February 12, 2016).

The Providers contend that the IRF PPS statute only precludes review of "the prospective payment rates under paragraph (3)" of the section 1395ww(j). Paragraph (3) of the section sets forth only the unadjusted IRF PPS payment rates. The Providers cite a recent Board decision in *Mercy Hosp. v. First Coast Service Options*, PRRB Dec. 2015-D7 (April 3, 2015). In *Mercy* the Board states:

> " that the phrase "the prospective payment rates under paragraph (3)" in § 1395(j)(7) does not encompass all of paragraph (3). Rather, that reference is limited to the general 'rates" prior to being "adjusted" by the items enumerated in Clauses (i) to (v) of Paragraph (3). The adjustments enumerated in these clauses include the LIP adjustment that the Secretary established pursuant to the discretionary authority granted under Clause (v)."[11]

Next, the Providers asserts that they have meet the statutory requirements for a Board hearing. The Intermediary's challenge relates to the first prong of Board jurisdiction "the Providers are dissatisfied with the Intermediary's final determination as to the amount of program reimbursement due to the Providers for the period covered by such cost report." The Intermediary believes that the Board lacks jurisdiction because the Providers did not include or protest the exclusion of Section 1115 Medicaid days on their as-filed cost reports.[12] The Providers argue that the Supreme Court, and several other lower courts, have already rejected this interpretation of the provisions of the Medicare statute that set forth a provider's right to seek Board review for its 'dissatisfaction" with its overall Medicare reimbursement.[13]

The Providers further argue that the Board should follow the district Court's holding in *Banner* to not require self-disallowance in order to establish jurisdiction over the section 1115 DSH LIP days issue.[14]

BOARD DECISION

Pursuant to 42 C.F.R. § 405.1835(a)(i) –(ii) (2009), "[a] provider . . . has a right to a Board hearing . . . only if— (1) [t]he 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 . . . ." Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2009). Thus, when a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."[15]

The Board finds that it does not have jurisdiction over the 1115 Rehab DSH Waiver days issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i)–(ii)

---

[11] Id. at 14.
[12] Id. at 13.
[13] *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988). *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).
[14] Providers' Supplemental Jurisdictional Brief at 1-3 (September 26, 2016)
[15] 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

(2009). Because the Providers' cost reports were for Fiscal Year End (FYE) 04/30/2011 and 09/30/2011, the Providers were required to either claim the days, ie. make a specific claim on their cost report, or file a cost report with a protested amount for items the provider deemed to be self-disallowed costs.

There is no evidence in the record that the Providers claimed LIP 1115 Rehab DSH Waiver days on their as-filed Medicare cost reports or that they were reported as a protested amount. In addition, the Providers failed to cite to any audit adjustments removing protested amounts for the 1115 Rehab DSH waiver days or included documentation that the Providers in fact included the 1115 Rehab DSH waiver days as a protested item.

The Board finds that although participants #1, 2, and 3 included protested amounts on W/S E Part A for LIP 1115 waivers, the providers failed to file the 1115 Rehab DSH Waiver days issue under protest. The Board finds that there is no specific protest on W/S E-3 of the LIP waiver days, which is the appropriate location to protest items related to the Rehabilitation units payments, nor did the protest documentation reference for the W/S E Part A protested amount reference any waiver days associated days for the Rehab unit or LIP adjustment (only referenced # of days for acute care patients and corresponding DSH adjustment). Protesting the 1115 waiver days for the acute care DSH adjustment on W/S E Part A for the DSH adjustment, is not sufficient to put the MAC on notice that it would also be protesting the exclusion of such days from the LIP payment as well. The Provider is post-hoc asking the Board to expand its original issue statement and accept jurisdiction over the LIP waiver days absent specific evidence that LIP waiver days were protested for the IRF. Therefore, all four Providers failed to document that they filed their as-filed cost reports under protest as required under 42 C.F.R. § 405.1835(a)(i) –(ii) (2009) and are dismissed from the appeal.[16]

The Board does not need to address the issue of jurisdiction specific to IRF providers for the 1115 Rehab DSH Waiver days since this issue is now moot. The Board does not have jurisdiction under the protest requirement for all providers in this appeal, and hereby, closes case no. 14-4057G.

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.

---

[16] *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*" *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges. Here, the Providers have not documented that it would have been futile to claim these days, as the Provider itself argues that the regulations and CMS guidance allow for the inclusion of these type of days. Therefore, these Providers would stand on "separate" ground than those in *Bethesda*, as it was not futile (i.e., the provider was barred by neither statute nor regulation) to make the claim. Under the 2008 regulation, the Board is not able to grant jurisdiction over the days without the specific claim, but under the *Bethesda* test, the Providers still fail.

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

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

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

Internet: www.cms.gov/PRRBReview

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

Refer to: 14-2151G

OCT 27 2016

CERTIFIED MAIL

King & Spalding, LLP
Mark Polston
1700 Pennsylvania Avenue, NW
Suite 200
Washington, DC 20006-4706

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

RE: King & Spalding 2009 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group Jurisdictional Challenge
PRRB Case Number: 14-2151G

Dear Mr. Polston and Mr. Pike,

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 FACTS

The Board established a group appeal on April 28, 2014 for the King & Spalding 2009 Low Income Pool Sec. 1115 Rehab DSH Waiver Days issue. The group issue statement reads, in part, as follows:

> The Providers are appealing the Intermediary's exclusion of days associated with the Section 1115 Rehab Medicare Florida Low-Income Pool ("LIP") waiver from the numerator of the Medicaid fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRF").

ARGUMENTS

Medicare Contractor's Arguments in Jurisdictional Challenge

The Medicare Contractor contends that 42 U.S.C. § 1395ww(j)(8)(B) prohibits and precludes administrative and judicial review of prospective payment rates established under 42 U.S.C. § 1395ww(j)(3).[1] The Medicare Contractor argues that the LIP adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3), which is why

[1] *See* Medicare Administrative Contractor's Jurisdictional Challenge at 2 (July 31, 2015).

administrative review of the LIP adjustment is statutorily precluded.[2] 42 U.S.C. § 1395ww(j)(3)(A) directs the Secretary to determine prospective payment rates for IRFs, and the prospective payment rate is based on the average payment per payment unit for inpatient operating and capital costs of rehabilitation facilities.[3] Further, the Medicare Contractor contends that the Secretary must adjust these rates by specific designated factors and "such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities."[4]

The Medicare Contractor contends that one of these adjustments to the rate is the LIP adjustment.[5] The Medicare Contractor states that when the Secretary responded to comments made in response to the Secretary's final rule in the Federal Register regarding IRF LIP adjustments, the Secretary noted that the LIP adjustment was an adjustment under 42 U.S.C. § 1395ww(j)(3)(A)(v).[6] Further, 42 C.F.R. § 412.624(e)(2) provides that "[w]e adjust the Federal prospective payment, on a facility basis, for the proportion of low-income patients that receive inpatient rehabilitation services as determined by us."[7] Therefore, because the Medicare Contractor contends that the LIP adjustment is a component of the IRF prospective payment rate established under 42 U.S.C. § 1395ww(j)(3), the Medicare Contractor argues that administrative and judicial review of the LIP adjustment is statutorily precluded by 42 U.S.C. § 1395ww(j)(8)(B).

The Medicare Contractor adds that the Administrator's recent decision to vacate the Board's decision in *Mercy Hosp. v. First Coast Service Options*, PRRB Dec. 2015-D7 (April 3, 2015) adds further weight to its position that the LIP adjustment is not an appealable issue before the Board.[8]

In addition, the Medicare Contractor argues that the Providers are claiming additional days that were not part of any adjustments. Also, according to 42 CFR § 405.1835(a)(1)(ii), for cost reports ending on or after December 31, 2008, a provider must file an item under protest to preserve appeal rights if the issue is being self-disallowed. The Medicare Contractor contends that if the Providers are claiming LIP Section 1115 waiver days, they should have filed these days under protest when they filed their cost reports.[9]

Providers' Response to Jurisdictional Challenge

The Providers argue that the Board has jurisdiction over the IRF 1115 waiver days issue for three principle reasons. First, the Providers satisfy the requirements for a Board hearing under section 1878(a) of the Social Security Act. Second, the IRF statue does not preclude review of the IRF

---

[2] *Id.*
[3] *Id.*
[4] *Id.* (quoting 42 U.S.C. § 1395ww(j)(3)(A)(v)).
[5] *Id.* at 2.
[6] *Id.* (citing 66 Fed. Reg. 41316, 41361 (Aug. 7, 2001).
[7] *Id.* at 2.
[8] *Id* at 3.
[9] *Id.* at 3.

DSH adjustment at issue here. Third, any post-hoc statements by CMS to preclude review are contrary to the statute.[10]

The Providers contend that the IRF PPS statute only precludes review of "the prospective payment rates under paragraph (3)" of the section 1395ww(j). Paragraph (3) of the section sets forth only the unadjusted IRF PPS payment rates. The Providers cite a recent Board decision in *Mercy Hosp. v. First Coast Service Options*, PRRB Dec. 2015-D7 (April 3, 2015). In *Mercy* the Board states:

> " that the phrase "the prospective payment rates under paragraph (3)" in § 1395(j)(7) does not encompass all of paragraph (3). Rather, that reference is limited to the general 'rates" prior to being "adjusted" by the items enumerated in Clauses (i) to (v) of Paragraph (3). The adjustments enumerated in these clauses include the LIP adjustment that the Secretary established pursuant to the discretionary authority granted under Clause (v)."[11]

Next, the Providers asserts that they have meet the statutory requirements for a Board hearing. The Intermediary's challenge relates to the first prong of Board jurisdiction "the Providers are dissatisfied with the Intermediary's final determination as to the amount of program reimbursement due to the Providers for the period covered by such cost report." The Intermediary believes that the Board lacks jurisdiction because the Providers did not include or protest the exclusion of Section 1115 Medicaid days on their as-filed cost reports.[12] The Providers argue that the Supreme Court, and several other lower courts, have already rejected this interpretation of the provisions of the Medicare statute that set forth a provider's right to seek Board review for its 'dissatisfaction" with its overall Medicare reimbursement.[13]

The Providers further argue that the Board should follow the district Court's holding in *Banner* to not require self-disallowance in order to establish jurisdiction over the section 1115 DSH LIP days issue.[14]

BOARD DECISION

Pursuant to 42 C.F.R. § 405.1835(a)(i) –(ii) (2009), "[a] provider . . . has a right to a Board hearing . . . only if— (1) [t]he 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 . . . ." Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2009). Thus, when a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the

---

[10] Providers' response to Jurisdictional Challenge at 13 (August 31, 2015).
[11] Id. at 14.
[12] Id. at 13.
[13] *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988). *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).
[14] Providers' Supplemental Jurisdictional Brief at 1-3 (September 26, 2016)

items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."[15]

The Board finds that it does not have jurisdiction over the 1115 Rehab DSH Waiver days issue because the appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(i)–(ii) (2009). Because the Providers' cost reports were for Fiscal Year End (FYE) 04/30/2009 and 09/30/2009, the Providers were required to either claim the days, ie. make a specific claim on their cost report, or file a cost report with a protested amount for items the provider deemed to be self-disallowed costs.

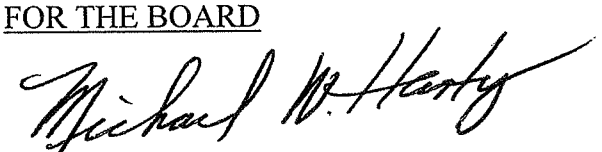
There is no evidence in the record that the Providers claimed the LIP 1115 Rehab DSH Waiver days on their as-filed Medicare cost reports or that they were reported as a protested amount. In addition, the Providers failed to cite to any audit adjustments removing protested amounts for the 1115 Rehab DSH waiver days or included documentation that the Providers in fact included the 1115 Rehab DSH waiver days as a protested item. Absent specific evidence that LIP waiver days were protested for the IRF, the Board concludes that the Providers failed to file the 1115 Waiver days issue under protest and that the Providers failed to preserve their rights to claim dissatisfaction under 42 C.F.R. § 405.1835(a)(i) –(ii) (2009).[16]

The Board does not need to address the issue of jurisdiction specific to IRF providers for the 1115 waiver days since this issue is now moot. The Board lacks jurisdiction as the provider have failed to meet the protest requirement, and hereby closes case no. 14-2151G.

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, 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

---

[15] 42 C.F.R. § 405.1835(a)(1)(ii) (2009).

[16] *Banner Heart Hosp. v. Burwell* (DDC August 19, 2016).The District Court in *Banner* concluded that the Board "violates the administrative appeal provision of the Medicare statute and the key Supreme Court precedent interpreting it, *Bethesda*" *Bethesda* emphasizes the futility of presenting a legal challenge to an intermediary when the intermediary has no authority to entertain or decide such challenges. Here, the Providers have not documented that it would have been futile to claim these days, as the Provider itself argues that the regulations and CMS guidance allow for the inclusion of these type of days. Therefore, these Providers would stand on "separate" ground than those in *Bethesda*, as it was not futile (i.e., the provider was barred by neither statute nor regulation) to make the claim. Under the 2008 regulation, the Board is not able to grant jurisdiction over the days without the specific claim, but under the *Bethesda* test, the Providers still fail.

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