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

DEC 03 2013

Kadlec Regional Medical Center
Julie L. Meek
Vice President Finance/CFO
888 Swift Boulevard
Richland, WA 99352

Re: Kadlec Medical Center, Provider No. 50-0058, FYE 12/31/2008
PRRB Case No. 13-2358

Dear Ms. Meek:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal in response to your October 30, 2013 request to withdrawal all issues that were also included in group appeals, with the exception of the SSI realignment issue. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The Provider filed an appeal for FYE 2008 which was received by the Board on June 14, 2013 from a Notice of Program Reimbursement (NPR) dated May 29, 2013. The Board acknowledged the case and assigned it case number 13-2358.

One of the issues included in the initial appeal was the DSH SSI Percentage (Provider Specific) issue (also referred to as SSI Realignment). In its description of the issue, the Provider states that it "... preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."

Board Determination:

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

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

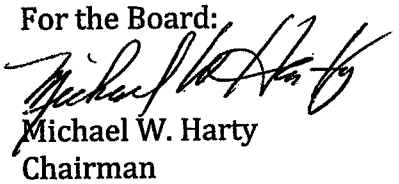
> "The provider... has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if... [a]n intermediary determination has been made with respect to the provider."

In this case, the Provider has not yet submitted a request for recalculation so there has been no final determination made by the Intermediary. Therefore, the Board dismisses the SSI realignment issue. As there are no other issues in dispute, the Board hereby closes case number 13-2358.

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
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:



Michael W. Harty
Chairman

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

cc: Noridian Administrative Services
Lee Crooks, Appeals Coordinator
WA/AK Part A Audit Appeals
P.O. Box 6722
Fargo, ND 58108-6720

Kevin D. Shanklin, Executive Director, BCBSA

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PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

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

Refer to: 06-0077GC

DEC 03 2013

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Noridian Administrative Services
c/o First Coast Service Options
Darwin San Luis
Audit Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

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

RE: San Gabriel Valley Medical Center, Provider No.: 05-0132, FYE 09/30/2000
as a participant in CHW 2000 DSH SSI Ratio Group
PRRB Case No.: 06-0077GC

Dear Mr. San Luis and Mr. Knight,

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

Pertinent Facts

On December 30, 2008, the Provider was issued a revised Notice of Program Reimbursement ("NPR") for FYE 09/30/2000. The Provider appealed from the revised NPR on March 11, 2009, appealing the DSH SSI ratio. The Provider transferred this issue to a Common Issue Related Party ("CIRP") group appeal, Case No. 06-0077GC. The issue for this CIRP group appeal is DSH SSI ratio.

The Intermediary did not identify any jurisdictional impediments in this CIRP group appeal.

Board's Decision

The Board finds that it does not have jurisdiction over San Gabriel Valley Medical Center because it is appealing from a revised NPR which does not adjust DSH SSI ratio.

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

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

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

In accordance with 42 C.F.R. § 405.1889 (2007), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[1] This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case, the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Board finds that it does not have jurisdiction over San Gabriel Valley Medical Center because the revised NPR does not adjust DSH SSI ratio. This Provider is hereby dismissed from the group. The remaining participants in the group will be remanded pursuant to CMS Ruling 1498-R.

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

Board Members
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin Shanklin, BCBSA
Darwin San Luis, Noridian Administrative Services
Thomas Knight, Toyon Associates

[1] 42 C.F.R. § 405.1889 (2007) stated "[w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable."

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Refer to: 08-2605G

DEC 03 2013

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Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburg, PA 19219

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

RE: Little Company of Mary Hospital, Provider No.: 14-0179, FYE: 06/30/1998
as a participant in QRS 1998 Medicare DSH Labor Room Day Group II
PRRB Case No.: 08-2605G

Dear Mr. LeJeune and Mr. Ravindran,

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

Pertinent Facts

On October 12, 2000, the Provider was issued an original Notice of Program Reimbursement ("NPR"). The Provider requested a reopening to correct certain adjustment issues from the original NPR on September 5, 2003. The issues to be adjusted were: Medicare DSH days and SSI ratio. The Intermediary acknowledged receipt of the request on November 10, 2004 and issued a revised NPR on November 17, 2004. The Provider appealed from the revised NPR on January 26, 2005, raising the following issues: DSH SSI proxy and DSH Medicaid percentage eligible days. The Board assigned Case No. 05-0599.

On September 11, 2006, the Provider requested to transfer the labor and delivery issue from Case No. 05-0599 to a group appeal, Case No. 05-3160G. The Board approved the transfer but subsequently moved this Provider to Case No. 06-2330G due to Common Issue Related Party ("CIRP") requirements. The Provider finally requested a transfer of this issue from Case No. 06-2330G to Case No. 08-2605G on September 11, 2009. The Provider is the only participant in this group. The issue for this group appeal is Medicare DSH labor room days.

The Intermediary did not identify any jurisdictional impediments in this group appeal.

Board's Decision

The Board finds that it does not have jurisdiction over Little Company of Mary Hospital because it is appealing from a revised NPR which does not adjust the DSH labor room days issue.

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

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

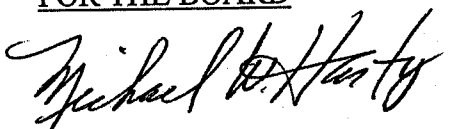
In accordance with 42 C.F.R. § 405.1889 (2007), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[1] This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case, the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Board finds that the Intermediary's notice of reopening specifically stated that the revision was to include Medicaid additional eligible days and baby additional eligible days for the DSH computation. The Intermediary's review did not include DSH labor room days in its revised DSH computation. Therefore, the Intermediary has not made a determination with respect to the issue appealed. The Board does not have jurisdiction over Little Company of Mary Hospital because the revised NPR does not adjust the DSH labor room days issue. The group is hereby dismissed since there is only one participant in the group appeal.

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

Board Members
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD



Michael W. Harty
Chairman

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[1] 42 C.F.R. § 405.1889 (2007) stated "[w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable."

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

cc: Kevin Shanklin, BCBSA
Timothy LeJeune, Novitas Solutions
J.C. Ravindran, Quality Reimbursement Services

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2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670

FAX: 410-786-5298
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Refer to: 12-0331GC

DEC 03 2013

CERTIFIED MAIL

First Coast Service Options
Geoff Pike
532 Riverside Avenue
Jacksonville, FL 32231

Hall, Render, Killian, Heath & Lyman
Maureen O'Brien Griffin
One American Square
Suite 2000, Box 82064
Indianapolis, IN 46282

RE: Wuesthoff Medical Center, Provider No.: 10-0092, FYE 09/30/1995 and 09/30/1996
as a participant in Wuesthoff Health 1995-1996, 2004-2006 DSH SSI Days Proxy CIRP
PRRB Case No.: 12-0331GC

Dear Mr. Pike and Ms. Griffin

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

Pertinent Facts

On January 26, 2006, the Provider was issued a revised Notice of Program Reimbursement ("NPR") for FYE 09/30/1996. Subsequently, on February 1, 2006, the Provider was issued a revised NPR for FYE 09/30/1995. The Provider appealed from both revised NPRs on July 6, 2006 directly into a newly formed group, the Florida Medicare DSH SSI Days Proxy (Case No. 06-2063G). This Provider subsequently transferred its appeal of the SSI issue for 1995 and 1996 to this Common Issue Related Party ("CIRP") group appeal, Case No. 12-0331GC on May 4, 2012. All remaining participants in this group appealed from original NPRs.

The Intermediary did not identify any jurisdictional impediments in this CIRP group appeal.

Board's Decision

The Board finds that it does not have jurisdiction over Wuesthoff Medical Center for FYEs 09/30/1995 and 09/30/1996 because it is appealing from revised NPRs which do not adjust the DSH-SSI Days.

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

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a) of this subpart) may be reopened,

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

In accordance with 42 C.F.R. § 405.1889 (2007), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[1] This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case, the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

The Board finds that it does not have jurisdiction over Wuesthoff Medical Center because the revised NPRs for FYEs 09/30/1995 and 09/30/1996 do not adjust the DSH-SSI Days issue. This Provider is hereby dismissed from the group. The remaining participants in the group will be remanded pursuant to CMS Ruling 1498-R.

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

Board Members
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin Shanklin, BCBSA
Geoff Pike, First Coast Service Options
Maureen O'Brien Griffin, Hall, Render, Killian, Heath & Lyman

[1] 42 C.F.R. § 405.1889 (2007) stated "[w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable."

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DEC 06 2013

Gong Nashed Pascoe, LLP
Lilian L. Gong
17216 Parthenia Street
Northridge, CA 91325 3220

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

RE: GNP Non-CIRP 2000-2006 DSH Dual Eligible Days Group, Case No. 07-2749G
Specifically Alhambra Hospital Medical Center, 05-0281, FYE 6/30/2005

Dear Ms. Gong and Mr. Lowe:

The Provider Reimbursement Review Board (the Board) previously issued a standard remand of the Dual Eligible Days issue pursuant to CMS Ruling 1498-R on March 12, 2013. It has come to the Board's attention that one of the participants on the Schedule of Providers was incorrectly removed from the group based on the FYE displayed on the Schedule. The pertinent facts with regard to this Provider, as well as the facts regarding the addition of another Provider omitted from the Schedule, and the Board's determination are set forth below.

Pertinent Facts:

The Representative filed a Schedule of Providers on August 12, 2009. One of the participants, Alhambra Hospital Medical Center (participant #13) listed its FYE as 12/31/2005 on the Schedule of Providers. The jurisdictional documentation submitted (NPR, Adjustment pages, transfer request) however, indicate the Provider's FYE is 6/30/2005. Therefore, the period from 7/1/2004 through 9/30/2004 for this Provider is actually subject to the Ruling.[1]

The Board issued a remand for the Dual Eligible Days issue in this group on March 12, 2013. The remand was footnoted to indicate that Alhambra had been removed from the Schedule of Providers because the period at issue (12/31/2005) was not covered under the Ruling.

In addition, the Board notes that Alhambra Hospital Medical Center for FYE 6/30/2006 was added to the group appeal, but was not included on the Schedule of Providers, which the Representative purported to be final in an email dated July 30, 2012. In that email, which was sent in response to the Board's request for a final Schedule of Providers, the Representative advised that a Schedule of Providers had already been filed with the Board

[1] The Representative subsequently filed a new Schedule of Providers on October 1, 2013. Alhambra Hospital Medical Center is now listed as participant 12 and still incorrectly references the FYE 12/31/2005.

on August 12, 2009. The Provider in question was added to the case after this submission on September 29, 2010.[2]

Board Determination:

Based on a review of the documentation in file, the Board is re-issuing a Standard Remand of the Dual Eligible Days issue. Please see the revised Schedule of Providers which includes Alhambra Medical Center (participant #12) for the partial period from 7/1/2004 through 9/30/2004. With regard to Alhambra for FYE 6/30/2006, the Board finds that this period is not subject to the Ruling, and therefore, this participant has been crossed off the Schedule of Providers.

Because participants with periods that are not subject to the remand remain in the group, which is scheduled for a hearing on February 27, 2014, the Board hereby requests that the Group Representative submit an updated Schedule of Providers for the remaining participants in group to the Board, with a copy to the Medicare Administrative Contractor within 30 days of the date of this letter.

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

For the Board:
Michael W. Harty
Chairman

Enclosures: Standard Remand of Dual Eligible Days
Schedule of Providers

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

[2] The Representative also requested the transfer of St. Rose Hospital for FYE 9/30/2005 to the group. This request, however, was denied by the Board on February 19, 2013 because the Provider did not timely appeal the Dual Eligible Days issue in its individual appeal prior to its request to be transferred to the subject group.

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DEC 09 2013

H. Anne Browne
HCA, Inc.
One Park Plaza
Building II-2W
Nashville, TN 37203

RE: Jurisdictional Challenge
Provider: Bringham City Community Hospital
Provider No.: 46-0017
FYE: 08/31/2008
PRRB Case No.: 13-0036

Dear Ms. Browne:

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

Background

The Provider, Brigham City Community Hospital (Brigham), is located in a rural area. For the fiscal year ending (FYE) August 31, 2008, it operated with 40 beds. Brigham is not a sole community hospital or an essential access community hospital. The Provider asserts that it meets qualifications of receiving transitional corridor payments (also known as transitional outpatient payments [TOPS]) designed for rural hospitals with less than 100 beds.

On January 29, 2009, Brigham filed its Medicare cost report without claiming TOPS. The Provider responded "NO" to question 21.06 on worksheet S-2 of the filed cost report which asks if the Provider qualifies for TOPS during the transition period prior to becoming 100 percent prospectively reimbursed for outpatient services. No revision was made on the notice of program reimbursement (NPR) dated June 22, 2012, and the TOPS was not included in the final settlement amount. Brigham requested a reopening of the NPR to include TOPS on August 2, 2012. There is no information from either party as to whether there was a formal denial of the reopening request.

The Provider filed an individual appeal on October 25, 2012. The sole issue appealed is whether the transitional corridor payments (TOPS) were properly excluded from the reimbursement amount computed for Medicare outpatient services. The Intermediary filed a Jurisdictional Challenge on April 26, 2013, regarding the TOPS issue asserting that no final determination was made. The Provider filed a response to the Intermediary's jurisdictional challenge on May 17, 2013.

Intermediary's Position

The Intermediary asserts that no adjustment was made to the cost report and the disputed item was not included in the filed cost report as required by 42 C.F.R. § 405.1835(a)(1)(i). Therefore, the Intermediary has not made a determination with respect to the Provider for the issue appealed. The Intermediary requests that the Board dismiss the appeal.[1]

Provider's Position

The Provider argues that it meets the requisite criteria for a proper appeal in that the Provider has appealed from a final determination within the 180 day deadline, filed a written request for a hearing, and the amount in controversy for the appeal issue in question exceeds the $10,000 minimum threshold. The Provider disputes the Intermediary's assertion proffering that "an omission to make an adjustment when, arguably, an adjustment should have been made is a final determination."[2]

The Provider further maintains that it has preserved its right to claim dissatisfaction with the amount of Medicare payments by self-disallowance. The Provider contends that as the cost report under appeal is for August 31, 2008, the rules requiring filing a cost report under protest are not applicable. As such, the Provider believes the Board has jurisdiction over the final determination regarding outpatient transitional corridor payments whether or not the issue was included in the protested amounts or adjusted on the NPR.[3]

In addition, the Provider argues that the Intermediary was obliged to determine a correct settlement of the cost report and notes in the Medicare Intermediary Manual § 4112.9 the Intermediary is advised: "If your audit uncovers circumstances in which a provider has inadvertently disadvantaged itself, advise the provider accordingly." The Provider admits when its FYE 2008 cost report was filed, it inadvertently disadvantaged itself by not claiming the Medicare outpatient transitional corridor payment available to qualifying hospitals with less than 100 beds. Nevertheless, the Provider argues CMS places the responsibility of arriving at a correct settlement of the cost report on fiscal intermediaries.[4]

Decision of the Board

A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group) and the request for a hearing is filed within 180 days of the NPR.[5]

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[1] Intermediary's Jurisdictional Challenge at 1.
[2] Response to Intermediary's Jurisdictional Challenge at 1, 3.
[3] Response to Intermediary's Jurisdictional Challenge at 4.
[4] Response to Intermediary's Jurisdictional Challenge at 5.
[5] 42 U.S.C. § 1395oo(a)(2012) and 42 C.F.R. §§ 405.1835-1841(2012).

The Board has previously held that it lacks jurisdiction where a Provider fails to claim an issue on its cost report. See, *Maple Crest Care Center v. Mutual of Omaha Ins. Co.*, PRRB Decision No. 2003-D4, Case no. 01-320 (November 7, 2002) at 3 (finding the Board lacked jurisdiction where the provider failed to claim bad debts on a cost report). In *Mercy Hospital Miami*, the Board majority concluded that in order for a provider to have a right to a hearing on a cost issue, "the expense must be in the cost report unless a predetermination has been made that the cost would be disallowed." *Mercy Hospital Miami, FL v. BlueCross BlueShield Ass'n,* PRRB Decision No. 2010-D4 (March 11, 2010) at 10. Exceptions to prior inclusion in a cost report are limited to where the Secretary has advised that inclusion is not required, other circumstances make inclusion impossible or unnecessary, and in the circumstances noted in *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399 (1988).

In the instant case, the Provider avers that this is an issue of self-disallowance. However, there was no statutory, regulatory, or manual provision that precluded the provider from claiming TOPS. The Provider admits it "inadvertently disadvantaged itself by not claiming the Medicare outpatient transitional corridor payment available to qualifying hospitals with less than 100 beds." The Provider's response of "no" to question 21.06 of Worksheet S-2 of the cost report signaled to the Intermediary that a "correct" settlement would not include TOPS. Consequently, the settlement did not include TOPS. Intermediaries are not charged with evaluating whether the Provider intended the contrary of what they report on the cost report. Here, the Provider failed to properly claim the cost in its cost report even though there was no legal impediment to doing such.

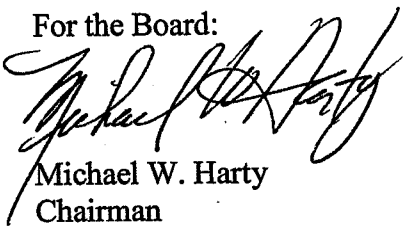
The Court in *Bethesda* distinguished providers who fail to request from the intermediary all costs to which they are entitled from providers who may properly self-disallow because a statute, regulation, or manual provision precludes them from claiming the cost. *See, Bethesda*, 485 U.S. at 405. In *St. Vincent Hospital & Health Center vs. BlueCross BlueShield Ass'n*, PRRB Decision No. 2013-D39 (September, 13 2013), the Board distinguished jurisdiction for unclaimed costs due to inadvertence from unclaimed costs due to legal impediment. Specifically, the Board looked at whether an appeal containing solely unclaimed cost due to inadvertence maintains any right to appeal under statute. The Board in *St. Vincent* noted it has "consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeal of other issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs." The Board also reiterated that only when the provider has established jurisdiction under 42 U.S.C. § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other claims not considered by the intermediary (e.g. unclaimed costs).

In this case, the provider, through its own admission, inadvertently failed to claim the disputed issue on its cost report. The cost issue is not a self-disallowed cost to which *Bethesda* applies. The cost is an unclaimed cost due to inadvertence rather than legal as outlined in *St. Vincent.* Therefore, the Board finds that it lacks jurisdiction over the transitional corridor payments (TOPS) issue and dismisses the appeal.

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

Board Members Participating
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Anderson, 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: Byron Lamprecht
Cost Report Apppeals
Wisconsin Physicians Service
P.O. Box 1604
Omaha, NE 68101

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

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: 08-0992GC

DEC 12 2013

CERTIFIED MAIL

Toyon Associates, Inc.
Glen S. Bunting
Vice President – Appeal Services
1800 Sutter Street
Suite 600
Concord, CA 94520-2546

Noridian Healthcare Solutions, LLC
Darwin San Luis
JE Provider Audit Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

RE: Toyon Sutter 1994 SSI Ratio Group Appeal, *specifically* Alta Bates Summit Medical Center
Provider No.: 05-0305
FYE: 12/31/1994
PRRB Case No.: 08-0992GC

Dear Mr. Bunting and Mr. San Luis,

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 January 4, 2008, Alta Bates Summit Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/1994. The revised NPR specifically stated that the cost report was reopened due to "MANDAMUS ACTION: Settlement Agreement Regarding Disproportionate Share Hospital Payments – Directive from CMS." The Provider filed its individual appeal request with the Board on June 6, 2008, in which it appealed six issues, including the SSI ratio issue.

The Providers filed a group appeal request with the Board on February 2, 2008, to which the Board assigned case number 08-0992GC. Alta Bates requested to transfer the SSI% issue from its individual appeal to this group appeal on December 19, 2008. On December 14, 2012, the Providers notified the Board that CMS Ruling 1498-R was applicable to the CIRP group.

Board's Decision

A provider has a right to a hearing before the Board, with respect to costs claimed on a timely filed cost report, if: (a) it is dissatisfied with the final determination of the intermediary, (b) the amount in controversy is $10,000 or more ($50,000 for a group), and (c) the request for a hearing

is filed within 180 days of the date of the Notice of Program Reimbursement (NPR).[1]

Additionally, for Revised Notices of Program Reimbursement, the regulation that was in effect when the RNPRs were issued states:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in § 405.1885, such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.[2]

Furthermore, the PRRB Instructions[3] for Revised NPRs state that:

> The Board accepts jurisdiction over appeals from a revised Notice of Program Reimbursement (NPR) where the issues(s) in dispute were *specifically adjusted* by that revised NPR. The Board typically follows the courts by limiting the scope of such an appeal to only the revised issue(s). *See Anaheim Memorial Hospital v. Shalala*, 130 F.3d 845 (9th Cir. 1997).[4]

***Monmouth*: Notice of Reopening**

The Intermediary issued a Notice of Reopening (NOR) to **Alta Bates Summit Medical Center** on November 28, 2006, in response to the court's finding in *Monmouth Medical Center v. Thompson*, 257 F.3d 807 (D.C. Cir. 2001)), that the Provider was entitled to mandamus relief. The *Monmouth* case involved the agency's application of HCFAR 97-2 (February 27, 1997). The court's decision in *Monmouth* and the subsequent settlement agreements that followed the litigation, instructed the Intermediary to issue a NOR to applicable Providers for the purpose of applying HCFAR 97-2 retrospectively. The NORs indicate that the basis of the reopening was a Settlement Agreement with CMS, which allowed a NOR to be issued well after the three year reopening period set forth in 42 C.F.R. § 405.1885.

The settlement agreement afforded the hospitals the right to submit to the Intermediary "one listing of *Medicaid eligible unpaid days* that it believes should be included in the determination of its DSH payment under HCFAR 97-2." HCFAR 97-2 dealt solely with days related to unpaid Title XIX Medicaid Days that were not entitled to Medicare Part A. Any other type of day not referenced in HCFAR 97-2 would not have been the subject of this reopening, nor would the SSI% and therefore, would not be appealable to the Board from the RNPR.

Per the Monmouth decision and settlement agreement, the Intermediary issued a NOR on November 28, 2006, and a RNPR on January 4, 2008, to Alta Bates Summit Medical Center (PN 05-0305) in order to apply HCFAR 97-2. Neither the Provider's list of claimed days nor the work papers were included in the case file, but the list is not necessary for the resolution of this

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[1] 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1841.
[2] 42 C.F.R. § 405.1889 (1998) (amended 2008).
[3] PRRB Instructions in effect as of March 1, 2002.
[4] Provider Reimbursement Review Board Instructions (2002), at 3.

appeal.

Since this appeal was filed from a revised NPR specific to the Monmouth reopening and there is no evidence the SSI % was adjusted in the revised NPR since that issue does not fall under HCFAR 97-2, the Board finds that it does not have jurisdiction over this Provider pursuant to 42 C.F.R. § 405.1889(b)(1).

The Board finds that it lacks jurisdiction over this Provider, Alta Bates Summit Medical Center because it appealed from a revised NPR that did not specifically adjust the SSI% issue. The case will remain open because the appeal is still pending for the other Providers in the group.

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

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

FOR THE BOARD

Michael Harty AJN

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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: 11-0049

DEC 12 2013

CERTIFIED MAIL

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

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

RE: Jurisdiction Challenge – Highland Hospital of Rochester
Provider No.: 33-0164
FYE: 12/31/1994
PRRB Case No.: 11-0049

Dear Mr. McKay and Mr. Browning,

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 January 29, 2004, Defendant, Secretary of Health and Human Services (the Secretary), and Plaintiff/Provider, Highland Hospital of Rochester, signed a settlement agreement to act as a partial settlement and dismissal of a complaint filed in United States District Court for the District of Columbia. The agreement included consideration from the Plaintiff entering into a Stipulation of Partial Settlement and Dismissal in exchange for the agreement that the Secretary then instruct the Medicare fiscal intermediary to reopen the Hospital's Medicare cost report for FYE 12/31/94 and apply Health Care Financing Administration Ruling No. 97-2 (Feb. 27, 1997) (Ruling 97-2).[1] This reopening would determine whether the Plaintiff is entitled to a DSH adjustment.[2]

On March 5, 2004, CMS Office of the Attorney Advisor sent a letter instructing Regional Administrators of an intent to settle cases where providers "filed suit seeking the Medicare disproportionate share hospital (DSH) reopening for applicable fiscal periods pursuant to Monmouth Med. Ctr. V. Thompson, 257 F.3d 807 (D.C. Cir. 2001)."[3] This Memorandum also included applicable settlement agreements, including the settlement mentioned above, and directed Intermediaries to follow the specific instructions in the settlement agreement.

[1] See MAC's Jurisdictional Challenge Tab I-2, Settlement Agreement at 10.
[2] *Id.* at 1-2.
[3] *See* MAC's Jurisdictional Challenge Tab I-2, March 5, 2004 Memorandum from the Office of the Attorney Advisor at 6.

On March 18, 2004, Intermediary, National Government Services (formerly Empire Medicare Services), sent a letter informing Provider of their intention to reopen the cost report for Fiscal Year End 12/31/94. Within this letter, the Intermediary asked the Provider to submit "one separate listing of Medicaid Eligible, But Unpaid Patient Days" for the re-opened fiscal year.[4]

On June 11, 2009, the Provider submitted the requested listing of Medicaid eligible but unpaid days that involved three categories of days that totaled 2,048 days. The Provider requested 1,213 Medicaid unpaid days, 682 Medicare/Medicaid dual eligible unpaid days, and 153 baby days.[5]

On April 23, 2010, Provider received a Revised Notice of Program Reimbursement (NPR) for its fiscal year ending 12/31/1994 cost report that did not include the 682 dual eligible days. On October 19, 2010, the Provider filed an appeal stemming from the revised NPR in order to challenge whether the Medicare/Medicaid dual eligible days should be included in the disproportionate share calculation used for reimbursement. The Provider appeal outlined the categories of dual eligible days which it believed should be included in the calculation of its Medicaid percentage.

On January 29, 2013, Intermediary filed a jurisdictional challenge to this appeal. On February 27, 2013, Provider filed a jurisdictional response to the challenge.

Intermediary's Position

The Intermediary frames its challenge by maintaining that Health Care Financing Administration Ruling No. 97-2 (Feb. 27, 1997) is the impetus behind reopening of this cost report. The Ruling specifically includes the number of days of inpatient hospital services for patients eligible for Medicaid on that day, irrespective of the hospital ultimately receiving payment for those services. Importantly, to guide Intermediaries on this reversal, CMS sent out a letter of HCFA Ruling 97-2 Instructions. Enclosed within those instructions CMS reiterated that "42 CFR 412.106(b)(4) precludes the counting of any patient days furnished to patients entitled to both Medicare Part A and Medicaid."

The Intermediary argues that it is within this framework that the Settlement Agreement with the Provider was drafted. The resulting Settlement Agreement allows in Paragraph 4, "After the Hospital receives a Notice of Reopening, the Hospital shall be entitled to submit to the Intermediary one listing of Medicaid eligible unpaid days that it believes should be included in the determination of its DSH payment under HCFAR 97-2."[6]

The Intermediary argues that the Provider submitted three listings: Medicaid eligible unpaid, Babies to Medicaid eligible Mothers, and Medicaid eligible unpaid with Medicare Part A Eligibility but not paid. Because of the specific instructions in both the Settlement Agreement and from Ruling 97-2, the Intermediary considered only the first two of these submissions.[7]

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[4] *See* MAC's Jurisdictional Challenge Tab I-2, March 18, 2004 Letter to the Provider, Mr. Michael J. Weidner, Executive Director, Highland Hospital at 2.
[5] Provider's Response to the MAC's Jurisdictional Challenge, Tab 5.
[6] MAC's Jurisdictional Challenge Tab I2, Settlement Agreement at 11.
[7] MAC's Jurisdictional Challenge, Tab I-4, at 1.

The Intermediary concludes that the Settlement Agreement was negotiated as a full accord and satisfaction for the Provider's claim in court against the specific fiscal year. The Intermediary argues that when the Provider claimed dual eligible days, it was an unbargained expansion to the Settlement Agreement, and further, since dual eligible revisions were not specifically made in the revised NPR determination, those days are not within the scope of appeal by 42 C.F.R. § 405.1889. The Intermediary requests dismissal of the case.

Provider's Position

The Provider argues three points to show that the dual eligible days presented to and considered by the MAC as part of the reopening and therefore were part of the matter at issue in the revised NPR. The Provider asserts that the reopening was mandatory through 42 C.F.R. § 405.1885(b). The Provider further contends that because the dual-eligible days were part of the matter submitted at issue, the MAC decision not to include the dual-eligible days amounts to an appealable determination on the issue. The Provider concludes that this determination is properly before the Board on appeal, and the regulations confirm "that providers have the right to appeal from a revised NPR with respect to the matters at issue in a reopening pursuant to section 405.1885."[8]

Second, the Provider argues that the language in the Settlement Agreement only precludes it from asking for further relief from the court under the specific cause of action. The Provider distinguishes this appeal as a request for administrative relief, which it contends, is not restricted by the Settlement Agreement. The Provider mentions the language providing that the Agreement is a full accord and satisfaction of all claims in the mandamus complaint for FY 1994. The Provider interprets this language to be a limitation on requesting a new reopening, and not, as they are doing here, limiting an appeal for administrative review of the MAC's revised DSH payment determination under 42 C.F.R. § 405.1889.[9]

Third, the Provider contends the Intermediary erroneously interpreted Ruling 97-2 as restricting the DSH calculation to exclude dual-eligible days. The Provider argues that nothing in the language of Ruling 97-2 excludes dual-eligible days, and that the Intermediary instead is improperly relying on a CMS memorandum issued after Ruling 97-2 to explain the exclusion. The Provider points to a District Court holding in *Catholic Health Initiatives-Iowa Corp. v. Sebelius* 841 F.Supp.2d 270 at 278, (Where the court held the Secretary's 2010 administrative decision, in retroactively applying the policy of not including Medicaid fraction patient days for Medicaid eligible patients who exhausted their Medicare Part A inpatient hospital services to the 1997 cost reporting period, is impermissibly retroactive and invalid). The Provider argues similarly that the Intermediary improperly retroactively applied this reimbursement policy to their appeal. The Provider further parallels their appeal with previous decisions from 1996 of the CMS Administrator in which dual eligible patient days were counted.

Because the properly filed appeal contained Medicare/Medicaid dual eligible days upon which a determination was made, there was no proscription in the Settlement Agreement against the

[8] *See* Provider's Response to the MAC's Jurisdictional Challenge at 11.
[9] *See* Provider's Response to the MAC's Jurisdictional Challenge at 13.

appeal, and Ruling 97-2 does not strictly deny this type of appeal, the Provider believes the MAC's jurisdictional objection should be denied

Board's Decision

A provider has a right to a hearing before the Board, with respect to costs claimed on a timely filed cost report, if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is filed within 280 days of the date of the Notice of Program Reimbursement (NPR).[10] The Code of Federal Regulations also provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

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

42 C.F.R. § 405.1889 (2008) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Here, the Settlement Agreement afforded the hospital the right to submit to the Intermediary "one listing of Medicaid eligible unpaid days that it believes should be included in the determination of its DSH payment under HCFAR 97-2." HCFAR 97-2 dealt solely with days related to unpaid Title XIX Medicaid Days who were not entitled to Medicare Part A. Any other type of day not referenced in HCFAR 97-2 would not have been the subject of this reopening, and therefore, would not be appealable to the Board from the revised NPR.[11]

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[10] 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405-1835-1841

11 Paragraph 4 of the Settlement Agreement limits the review to strictly unpaid days, unless a hospital did not receive Medicare DSH payment in the initial NPR or Revised NPR prior to the date of the Settlement Agreement. Per the adjustment report filed with the appeal request the Provider had received a DSH payment prior to this

The Provider, in possible violation of the terms of the settlement agreement, submitted dual eligible unpaid days as part of their "one list of days." The FI did not review these days as evidenced at Exhibit I-4 of its jurisdictional challenge, where it explained that the Medicaid eligible with Part A days would not be tested because any days with Medicaid Part A eligibility are not allowed to be counted for DSH purposes.

The Board finds that it does not have jurisdiction over the dual eligible days issue because they were not specifically revised in the revised NPR as the regulation requires, and in fact were never considered as they were not within the scope of the reopening or revised NPR. The reopening resulted from the Settlement Agreement which instructed the Intermediary to apply 97-2. The instructions for 97-2 required the Intermediary to remove Part A exhausted days before considering paid and unpaid Medicaid days. Based on the instructions to Ruling 97-2, the Intermediary properly excluded these days, therefore there was no adjustment during the reopening and the Board finds that it does not have jurisdiction over the dual eligible days issue. As the dual eligible days issue was the only issue in the appeal, case number 11-0049 is hereby closed.

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

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

FOR THE BOARD

Michael Harty (CJN)
Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

RNPR.

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: 10-1306GC

DEC 12 2013

CERTIFIED MAIL

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

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

RE: Jurisdictional Decision – QRS BJC DSH/Medicaid Eligible Labor Room Days
Provider No.: Various
FYE: Various
PRRB Case No.: 10-1306GC

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

The initial request for a group appeal was filed with the Board on August 26, 2010. The Providers appealed one issue: that the MAC failed to include labor room days as Medicaid-eligible days.

Alton Memorial Hospital, provider number 14-0002, FYE 12/31/2003

On July 14, 2009, the Provider was issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2003. The Provider filed its individual appeal request on January 7, 2010, in which it appealed Medicaid eligible labor room days, among other issues. The Provider requested to transfer the labor room days issue from its individual appeal, case number 10-0365, to this group appeal on August 24, 2010. On August 26, 2013, the Board found that it did not have jurisdiction over the Provider's revised NPR appeal in its individual appeal, case number 10-0365. The Board denied the Provider's request to transfer the labor room days issue to this group appeal.

Parkland Health Center, provider number 26-0163, FYE 12/31/2004

On August 11, 2006, the Provider was issued an original NPR for FYE 12/31/2004. The Provider filed its individual appeal request on February 9, 2007, in which it appeal two issues: Medicaid eligible days and bad debts. On February 1, 2011, the Provider requested to transfer the labor room days issue to this group appeal.

Boone Hospital Center, provider number 26-0068, FYE 12/31/2005

On September 20, 2010, the Provider was issued a revised NPR for FYE 12/31/2005. The Provider filed its individual appeal request with the Board on March 18, 2011, in which it included the labor room days issue. The Provider requested to transfer the labor room days issue to this group appeal on May 24, 2011.

Parkland Health Center, provider number 26-0163, FYE 12/31/2005

On October 13, 2009, the Provider was issued a revised NPR for FYE 12/31/2005. The Provider filed its individual appeal request with the Board on March 29, 2010, in which it included the labor and delivery days issue. The Provider requested to transfer the labor and delivery days issue to this group appeal on November 30, 2010.

Board's Decision

There was no jurisdictional challenge filed in this appeal, however the Board finds that it does not have jurisdiction over any of the Providers that remain in case number 10-1306GC. Provider number 1, Alton Memorial Hospital, is no longer a participant in case number 10-1306GC because the Board denied the transfer request on August 26, 2013, as the Board found it lacked jurisdiction over the Provider's individual appeal.

Parkland Health Center FYE 12/31/2004

The Board finds that it does not have jurisdiction over Parkland Health Center (12/31/2004) because the Provider did not properly add the labor room days issue to its individual appeal. The issue was not included in its appeal request; the first time the issue was raised was in the Provider's February 1, 2011 transfer request. In that request, the Provider stated that its broad Medicaid eligible issue statement from its appeal request really includes three sub-issues: exhausted benefits dual eligible days, Medicare managed care Part C days, and Medicaid eligible labor and delivery days. The Provider then requested to transfer these three issues to various group appeals.

The Board finds that it does not have jurisdiction over this Provider because the room days issue was not timely added. The February 1, 2011 transfer request letter is essentially a request to add the three issues to the individual appeal. However, this request was not timely pursuant to regulations that went into effect on August 21, 2008, that limited the addition of issues to appeals. 42 C.F.R. § 1835 provides in relevant part:

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

> expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section.

For appeals already pending when this regulation was promulgated, Providers were given 60 days from the date that the new regulations took effect, August 21, 2008, to add issues to their appeals. In practice this means that issues had to be added to pending appeals by October 20, 2008. *See* 73 FR 30,236 (May 23, 2008). This Provider's request did not come until 2011, therefore the Board finds that it does not have jurisdiction over the Provider.

Boone Hospital Center & Parkland Health Center, FYE 12/31/2005

The Board finds that it does not have jurisdiction over the remaining two Providers in the appeal because both Providers appealed from revised NPRs that did not specifically adjust Medicaid eligible labor room days. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 provides in relevant part:

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

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

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

Boone Hospital Center's audit adjustment report shows an adjustment to Medicaid eligible days and DSH generally, however the Provider did not provide any documentation to establish that labor room days were specifically adjusted as part of any adjustments made.

Parkland Health Center (12/31/2005) appealed from an audit adjustment report that adjusted total patient days, but that did not adjust Medicaid eligible labor and delivery days. The Provider did not submit any documentation to establish that labor and delivery days were specifically adjusted in its revised NPR.

As neither Boone Hospital Center nor Parkland Health Center (12/31/2005) appealed from revised NPRs that specifically adjusted labor room days, the Board finds that it does not have jurisdiction over these two Providers.

Conclusion

The Board previously denied jurisdiction over Alton Memorial and denied the transfer to this group appeal, therefore it is not a participant in this group. Parkland Health Center (12/31/2004) did not properly add the labor room days issue to its individual appeal prior to requesting a transfer, therefore the Board finds that it does not have jurisdiction. The Board finds that it does not have jurisdiction over Boone Hospital Center or Parkland Health Center (12/31/2005) because both Providers appealed from revised NPRs that did not specifically adjust labor and delivery days. Case number 10-1306GC is hereby closed because no Providers remain in the appeal.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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: 08-2607G

CERTIFIED MAIL DEC 17 2013

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

Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 19219

RE: Jurisdictional Decision – QRS 2003 Medicare DSH Labor Room Day Group II
Provider No.: Various
FYE: Various
PRRB Case No.: 08-2607G

Dear Mr. Ravindran and Mr. LeJeune,

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

Background

The initial request for a group appeal was filed with the Board on August 19, 2008. The Providers appealed one issue: that the Intermediary failed to include labor room days as Medicaid-eligible days. On January 3, 2011, the Intermediary submitted jurisdictional documents and noted a jurisdictional impediment regarding Denver Health Medical Center. Subsequently, on January 31, 2011, the Providers' representative withdrew Denver Health Medical Center, rendering the Intermediary's noted jurisdictional impediment moot. Then, on April 1, 2011, the Intermediary again noted a jurisdictional impediment, this time regarding University Medical Center. On August 7, 2012, the Board sent a letter requesting additional documentation related to the appeals from revised Notices of Program Reimbursement for several Providers in the group appeal. On September 6, 2012, the Providers' representative submitted the requested documents to the Board, and also added three more Providers to the group appeal.[1]

Intermediary's Position

The Intermediary did not file a formal jurisdictional challenge with the Board, but instead noted

[1] The Providers' representative added the following Providers: The Stamford Hospital (PN 07-0006, FYE 9/30/2003); Bethesda Memorial Hospital (PN 10-0002, FYE 9/30/2003); and Mary Lanning Memorial Hospital (PN 28-0032, FYE 12/31/2003).

possible jurisdictional impediments at two different times. In response to the Intermediary's first jurisdictional statement, the challenged Provider was withdrawn from the group. The second jurisdictional impediment the Intermediary noted was in regard to University Medical Center's revised NPR appeal. The Intermediary explained that the revised NPR was issued in response to the administrative resolution in case number 07-1790, and that the adjustment did not address labor room days. Because University Medical Center is appealing from a revised NPR, the Intermediary concludes that there is an impediment to Board jurisdiction because there was no specific adjustment to labor room days.

Providers' Position

The Providers did not submit a response to the Intermediary's statements regarding jurisdiction.

Board's Decision

University Medical Center, PN 45-0686, FYE 12/31/2003

The Board finds that it does not have jurisdiction over University Medical Center because it is appealing from a revised NPR that did not specifically adjust labor and delivery room days. The Code of Federal Regulations provides for an opportunity for a revised NPR. At the time of the reopening, 42 C.F.R. § 1885 (2006) provided, in relevant part:

> (a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board, or Secretary, as the case may be . . .

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

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[2]

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

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[2] 42 C.F.R. § 405.1889 (2006).

The Provider submitted an audit adjustment report that adjusted DSH generally, which does not satisfy the specificity requirements for an appeal from a revised NPR. The Provider submitted its Final Position Paper for its individual appeal, case number 07-1790 in response to the Board's request for additional documentation. However, the Final Position Paper did not brief the labor and delivery room days issue. As the Provider appealed from a revised NPR that did not specifically adjust labor and delivery room days, the Board finds that it does not have jurisdiction over this Provider.

Bethesda Memorial Hospital, PN 10-0002, FYE 9/30/2003

The Board finds, that it does not have jurisdiction over this Provider because it is appealing from a revised NPR that did not specifically adjust the labor room days as required by 42 C.F.R. § 405.1889. The Provider's audit adjustment report did adjust Medicaid days, however the Provider did not submit any documentation to establish that labor room days were adjusted as part of the Medicaid days adjustment, therefore the Board finds that it does not have jurisdiction over Bethesda Memorial Hospital.

Mary Lanning Memorial, PN 28-0032, FYE 12/31/2003

The Board finds that it does not have jurisdiction over this Provider because the labor room days issue was not timely added to the Provider's appeal request. The Provider's original appeal request, dated February 21, 2006, did not include the labor and delivery day issue. The appeal request stated:

> The Provider contends that the fiscal intermediary did not determine Medicare reimbursement for disproportionate share hospitals (DSH) in accordance with the statutory instructions . . . . The Intermediary, contrary to the regulation, failed to include as Medicaid-eligible days services to patients eligible for Medicaid, as well as patients eligible for general assistance and charity care.

The Provider also appealed the SSI percentage issue in its original appeal request. However, on the Provider's Model Form D request to transfer the labor and delivery days issue to case number 08-2607G, the Provider indicated that it included the issue in its original appeal request, which it did not. Effective August 21, 2008, new Board regulations went into effect that limited the addition of issues to appeals. 42 C.F.R. § 405.1835 provides in relevant part:

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

For appeals already pending when this regulation was promulgated, Providers were given 60 days from the date that the new regulations took effect, August 21, 2008, to add issues to their appeals. In practice this means that issues had to be added to pending appeals by October 20, 2008. *See* 73 FR 30,236 (May 23, 2008). The Provider did not add the labor room days issue to its appeal prior to October 20, 2008, therefore the issue was not timely added, and the Board finds that it does not have jurisdiction over this Provider.

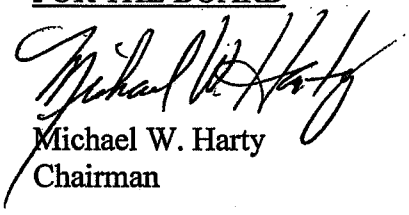
Conclusion:

The Board finds that it does not have jurisdiction over University Medical Center and Bethesda Memorial Hospital, because these Providers are appealing from revised NPRs that did not specifically adjust labor room days. The Board also finds that it does not have jurisdiction over Mary Lanning Memorial Hospital because it did not timely add the labor room days issue to its individual appeal before transferring it to this group appeal. Case number 08-2607G will remain open as there are Providers that remain pending in the group appeal.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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: 08-0530

DEC 19 2013

CERTIFIED MAIL

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

Noridian Healthcare Solutions, LLC
Darwin San Luis
JE Provider Audit Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

RE: Jurisdictional Decision – Community Hospital of the Monterey Peninsula
Provider No.: 05-0145
FYE: 12/31/2002
PRRB Case No.: 08-0530

Dear Mr. Knight and Mr. San Luis,

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

Background

The Provider was issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2002 on November 27, 2007. On January 4, 2008, the Provider filed an appeal request with the Board appealing the following issues:

- DSH – SSI Ratio
- DSH – Dual Eligible Days
- DSH – General Assistance Days
- DSH – Code 2 & 3 Eligible Days
- DSH – Labor Room Days
- DSH – Labor/Delivery/Recovery/Post-partum Unit
- DSH – Operating DSH Entitlement.

The Board assigned case number 08-0530 to this individual appeal.

On April 11, 2008, the Provider submitted a letter to the Board requesting to transfer several issues to group appeals. The Provider requested to transfer the SSI ratio issue to case number 07-2097G, which was remanded pursuant to CMS Ruling 1498-R and closed on March 18, 2013. It requested to transfer the dual eligible days issue to case number 07-2238G, which remains open. The Provider also requested to transfer the labor room days issue to case number 07-2694G, which was withdrawn on September 10, 2010, due to an Administrative Resolution. Last, the Provider requested to transfer the labor/delivery/recovery/post-partum unit issue to case number 07-2717G which was also withdrawn on September 10, 2010, due to an Administrative

Resolution. In the same letter, the Provider requested to withdraw the General Assistance Days issue.

On October 17, 2012, the Board sent a letter to the Provider requesting additional documentation related to its revised NPR appeal. The Provider responded to this request on November 12, 2012.

Provider's Position

In its November 12, 2012 response to the Board's request for additional documentation, the Provider argues that the Board has jurisdiction pursuant to 42 C.F.R. § 405.1835(a). The Provider contends that it has met all of the jurisdictional requirements set forth in the regulation that was in effect on January 4, 2008 when the Provider filed its appeal request. The Provider submitted a copy of its September 26, 2006 reopening request in which it requested additional eligible days, as well as claiming that dual eligible days should be included in the Medicaid ratio.[1] The Provider was unable to provide a copy of the Intermediary's Notice of Reopening or any information applicable to the original NPR or previous revised NPR dated April 20, 2006. The Provider was also unable to locate a copy of the Intermediary's DSH workpaper to support the eligible day adjustment.[2]

Board's Decision

There was no jurisdictional challenge filed in this individual appeal, which is scheduled for a hearing on November 4, 2014. The issues that currently remain pending in the appeal are the Code 2 & 3 Eligible days and the Operating DSH Entitlement issues. The Provider has requested to transfer the Dual Eligible Days issue to a group appeal that remains open, case number 07-2238G. The Board hereby denies the transfer request because the revised NPR did not specifically adjust dual eligible days.

The Board finds that it does not have jurisdiction over the remaining three issues in the appeal because none of the issues were specifically adjusted in the revised NPR. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

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

In accordance with 42 C.F.R. § 405.1889 (2007), a revised NPR is considered a separate and

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[1] Provider's Response to Board's request for Additional Jurisdictional Documentation dated November 12, 2012 at Ex. 3.
[2] *Id.* at 1; *see also* Provider's Request for Hearing dated January 4, 2008, Audit Adjustment Report.

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

Here, the Provider's revised NPR states that the cost report for FYE 12/31/2002 was reopened in order to "reimburse Capital DSH."[4] Inpatient prospective payment system (IPPS) hospitals are eligible for an add-on to their capital payments related to the DSH adjustment. While the components of the traditional operating DSH payment (calculated on Worksheet E, Part A of the Medicare cost report) are the same as the components of the capital DSH payment (calculated on Worksheet L), the qualifications and calculations of the two DSH payments are distinct.[5]

The audit adjustment report shows adjustments to various DSH components including:

- Worksheet S-2 to reflect the Provider's request for Capital DSH reimbursement;
- Worksheet S-3 to adjust Medicaid (col. 5) and total (col. 6) patient days net of labor and delivery days;
- Worksheet L to show the ratio of Medicaid patient days to total days; and
- Worksheet L to report the SSI ratio.

The audit adjustment report does not show an adjustment to dual eligible days, Code 2 & 3 eligible days, or the operating DSH entitlements. In addition, the Provider did not submit any workpapers or documentation to support a conclusion that the adjustments that were made included specific adjustments to those three issues.

Because the dual eligible days, Code 2 & 3 days, and the operating DSH components were not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over the three remaining issues in case number 08-0530. The case is hereby closed as there are no remaining issues pending.

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

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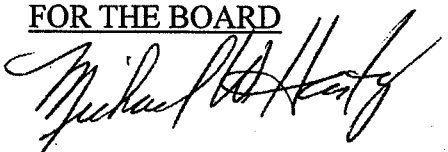
[3] 42 C.F.R. § 405.1889 (2007) stated "[w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable."

[4] Provider's Response to Board's request for Additional Jurisdictional Documentation dated November 12, 2012, Ex. 3.

[5] *See* 42 C.F.R §§ 412.106 and 412.312.

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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: 14-0483

CERTIFIED MAIL DEC 19 2013

David Collins, CPA
L.H. & Associates, LLC
P.O. Box 0511
Lafayette, CA 94549-0611

Re: St. Rose Hospital
Provider No. 05-0002
FYE 9/30/2008
PRRB Case No. 14-0483

Dear Mr. Collins:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's November 25, 2013 request for expedited judicial review (EJR) (received November 29, 2013). This request is unopposed. The issue under dispute involves whether the Centers for Medicare & Medicaid Services (CMS) erred in calculating a budget neutrality adjustment to the prospective payment system (PPS) standardized amount to account for the effects of the rural floor on the wage index. The Board's jurisdictional determination over the rural floor budget neutrality issue and determination with respect to the request for EJR are set forth below.

Medicare Statutory and Regulatory Background

This is a dispute over the amount of Medicare reimbursement due to a provider of medical services.

The Medicare program was established to provide health insurance to the aged and disabled. *See* 42 U.S.C. §§ 1395-1395cc. CMS, formerly the Health Care Financing Administration, is the operating component of the Department of Health and Human Services charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries and Medicare Administrative Contractors (hereinafter referred to as intermediaries). Intermediaries determine the payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. *See* 42 U.S.C. § 1395h, 42 C.F.R. §§ 413.20 and 413.24.

The operating costs of inpatient hospital services are reimbursed by Medicare primarily through the PPS. The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors. *See* 42 U.S.C. § 1395ww(d)(5). This case involves the annual changes to the PPS rates for hospital inpatient operating costs (IPPS) and the methodology for determining those rates.

Standardized Amount

The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS which were then used to compute the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Section 1395ww(d)(2)(C) requires that updated base-year per discharge costs be standardized in order to adjust data which might cause variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments (for Alaska and Hawaii), indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww(d)(3)(E) requires the Secretary from time to time to adjust the proportion of the hospitals' costs that are attributable to wages and wage-related costs of the DRG prospective payment rates for area differences in hospital wage levels. The adjustment factors (wage index) should reflect the relative hospital wage level in the geographic area of the hospital being compared to the national average hospital wage level. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E)(ii) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

Budget Neutrality

Budget neutrality is determined by comparing aggregate IPPS payments before and after making changes that are required to be budget neutral (e.g., reclassifying and recalibrating the diagnostic related groups (DRGs)). Outlier payments are also included in the simulations. *Id.* at 48147. In FFYs 2007 and prior, CMS stated that: [the] budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the [prior years'] budget neutrality adjustments. *Id.* at 48147.

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. CMS believes that an adjustment to the wage index would result in substantially similar payments as an adjustment to the standardized amount, as both involve multipliers to the standardized amount and both would be based upon the same modeling parameters. 72 Fed. Reg. 47130 (August 22, 2007).

Rural Floor

Section 4410 of the Balanced Budget Act of 1997 (BBA of 1997) established the rural floor by requiring that the wage index of a hospital in any urban area cannot be less than the wage index determined for the state's rural area. Since Federal fiscal year (FFY) 1998, CMS has implemented the budget neutrality requirement of this provision by adjusting the standardized amounts. 72 Fed. Reg. 24680, 24787 (May 3, 2007). In establishing the PPS standardized

amount for FFY 2007 and for prior Federal fiscal years, CMS adjusted the standardized amount downward to account for the effects of the rural floor. *See e.g.* 71 Fed. Reg. at 48145-48148 (August 18, 2006). In FFY 2008 CMS applied the budget neutrality adjustment to the wage index, rather than the standardized amount. [1]

In responding to providers concerns regarding the change to the calculation set forth above and the cumulative effect of the budget neutrality adjustment in the final IPPS rule, CMS stated that:

> [T]he rural floor budget neutrality adjustment previously was a cumulative adjustment, similar to the adjustments we currently make for updates to the wage index and DRG [diagnostic related groups] reclassification and recalibration. Beginning in 2008, the rural floor budget neutrality adjustment will be noncumulative.
>
> ****
>
> With regard to alleged errors in FY 1999 through 2007, our calculation of the budget neutrality in past fiscal years is not within the scope of this rulemaking. Even if errors were made in prior fiscal years, we would not make an adjustment to make up for those errors when setting rates for FY 2008. It is our longstanding policy that finality is critical to a prospective payment system. Although such errors in rate setting are inevitable, we believe the need to establish final prospective rates outweighs the greater accuracy we might gain if we retroactively recomputed rates whenever an error is discovered.

72 Fed. Reg. 47130, 47330 (August 22, 2007).

Wage Index

The statute, 42 U.S.C. § 1395ww(d)(3)(E) and (d)(9)(C)(iv), requires that CMS make an adjustment to the labor-related portion of the national and Puerto Rico PPS rates to account for area differences in hospital wage levels. This adjustment is made by multiplying the labor-related portion of the adjusted standardized amounts by the appropriate wage index for the area in which the hospital is located. *Id.* at 48153. The wage index must be updated annually. *Id.* at 48005.

Procedural History

This appeal was timely filed from an original NPR. The Provider contends that the rural floor budget neutrality adjustments as implemented by CMS violate the law's requirement of budget neutrality. The Provider argues that rather than adjusting area wage indexes to achieve budget neutrality, the Secretary adjusted the standardized amount and carried that forward from year to year. The Provider continues that CMS duplicated prior adjustments by each year calculating the

[1] 72 Fed. Reg. 47130, 47329 (August 22, 2007).

full amount of the adjustment necessary to counteract the effect of the rural floor and then applying that adjustment to a figure that includes adjustments carried over from previous years. CMS then reduced the standardized amount to account for the full difference between these two figures. The Provider concludes that the cumulative effect of the improperly duplicative budget neutrality adjustments was to reduce the payment levels below what they otherwise should have been.

Basis for EJR

To establish the PPS rate for FFY 2008 and for prior years, CMS used a payment simulation model to determine each year's budget neutrality adjustment to the standardized amount to account for the effect of the rural floor. In the FFY 2007 rule, CMS described the simulation model and its calculation of the resulting budget neutrality adjustment as follows:

> [W]e used FY 2005 discharge data to simulate payments and compared aggregate payments using the FY 2006 relative weights and wage indexes to aggregate payments using the FY 2007 relative weights and wage indexes. The same methodology was used for the FY 2006 budget neutrality adjustment.
>
> . . . These budget neutrality adjustment factors are applied to the standardized amounts without removing the effects of the FY 2006 budget neutrality adjustments.

71 Fed. Reg. 47870, 48147 (August 18, 2006).

In establishing the PPS rate for FFY 2008 CMS applied the budget neutrality adjustment to the wage index rather than to the standardized amount as it had done in previous years. 72 Fed. Reg. 47130, 47330 (August 22, 2007). CMS did not rectify the cumulative impact of its methodology errors from FFY 1999 through 2007, as described above. *Id.* at 47421. Thus, for FFY 2008, the Provider is appealing the understated FFY 2008 standardized amount used in other FFYs.

The Provider is challenging an aspect of CMS' calculation of the final PPS rates published in the Federal Register for FFY 2008. The Provider contends that CMS erred in calculating a budget neutrality adjustment to the PPS standardized amount to account for the effects of the rural floor on the wage index. This alleged error results in a systematic understatement of the PPS rates, and this error has been an annual and recurring one. Each year's error is permanently incorporated into the standardized amount paid under PPS for each successive year.

Jurisdiction over the Issue

The Provider contends that the Board has jurisdiction over these appeals because the appeals were timely filed from NPRs and the amount in controversy threshold has been met. The Provider points out that review of the PPS payment determination is subject only to the exceptions set forth at 42 U.S.C. § 1395oo(g)(2). This section provides, in relevant part, that determinations described in 42 U.S.C. § 1395ww(d)(7) shall not be reviewed by the Board or any

court. Among the matters not subject to review is the determination of the requirement, or the proportional amount, of any budget neutrality adjustment. The Provider contends that this preclusion of review provision is limited to certain budget neutrality adjustments for fiscal years 1984 and 1985 to ensure that the total amounts paid under PPS, then a new system, were the same as the total amounts that would have been spent under the Medicare law (as modified by the Tax Equity & Fiscal Responsibility Act of 1982 (TEFRA)). 42 U.S.C. § 1395ww(e)(1)(A)-(B).

The Intermediary did not provide comment to the Board in this matter.

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeal because review of budget neutrality adjustments is expressly prohibited by the statute and regulations. *See* 42 U.S.C. §1395ww(d)(7); 42 U.S.C. § 1395oo(g)(2); 42 C.F.R. §§ 405.1804 and 405.1840(b)(2). Because jurisdiction over an issue is a prerequisite to granting a request for EJR, the Board finds that EJR is not appropriate.

Payment under the prospective payment system is governed by the statutory provisions of 42 U.S.C. § 1395ww. Subsection (d)(7) states that:

> There shall be no administrative or judicial review under [42 U.S.C. §1395oo] or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount of any adjustment effected pursuant to subsection (e)(1) [budget neutrality] or the determination of the applicable percentage increase under paragraph (12)(A)(ii) . . .

The Board's governing statute, 42 U.S.C. § 1395oo(g)(2), states that:

> The determinations and other decisions described in section 1395ww(d)(7) shall not be reviewed by the Board or by any court pursuant to action brought under subsection (f) or otherwise.

CMS' implementing regulation, 42 C.F.R. § 405.1804, entitled "Matters not subject to administrative and judicial review under prospective payment" provides:

> Neither administrative or judicial review is available for controversies about the following matters:
>
> (a) The determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rates. . . . (emphasis added)

CMS stated at the time the rule was adopted that the purpose of the rule is:

> to state that the determinations and decisions described in section 1886(d)(7) of the Act may not receive Board or judicial review. Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
>
> > A determination of the requirement, or the proportional amounts of, any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act . . .

48 Fed. Reg. 39752, 39785 (September 1, 1983).

In addition, section 701(a) of the Administrative Procedure Act (APA) states that the appeal provisions of the APA apply to the administrative actions except where statutes preclude judicial review. *See* 5 U.S.C. § 701(a). The statutes and the regulations both preclude administrative and judicial review of the budget neutrality adjustment.

In *Amgen, Inc. v. Smith*,[2] the D.C. Circuit Court considered whether there is jurisdiction over outpatient PPS (OPPS) payments where the statute precludes administrative or judicial review of the "other adjustments" to OPPS (the classification system, establishment of groups and relative payment weights for covered services, of wage adjustment factors). The Court explained that there is a strong presumption that Congress intends judicial review of administrative action which can only be overcome with "clear and convincing evidence" that Congress intended to preclude appeal. The Court concluded that where the statute stipulated that "there should be no administrative or judicial review," that language constituted clear and convincing evidence that the appeal was precluded. The Court further noted that payments under PPS are made on a prospective basis and, given the length of time that review of individual appeals could take, the result would be retroactive adjustments to payment rates with the potential of creating havoc with the payment system. The aggregate impact of appeal decisions would undermine the Secretary's ability to ensure budget neutrality.

In an earlier decision, *Universal Health Services of McAllen, Inc. v. Sullivan*,[3] (*UHS*) the D. C. District Court distinguished between an appeal of a Medicare Geographic Classification Review Board (MGCRB) decision (over which judicial review is precluded) and a challenge to the validity of the guidelines utilized by the MGCRB and the Secretary to make reclassification decisions. The Court noted that § 701(a) of the APA precludes judicial review where a statute or regulation denies review. In *UHS*, the Court found that it had jurisdiction over the challenge to the guidelines but would not have had jurisdiction over an appeal of an MGCRB decision which was precluded by law.

The Board is not persuaded that preclusion of review of budget neutrality provisions is limited to the fiscal years 1984 and 1985. Even though the rural floor budget neutrality provision was not specifically addressed in the limits on administrative and judicial review, we find the language of the statute itself unambiguous in that there is no indication that the prohibition on administrative

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[2] 357 F.3d 103 (D.C. Cir. 2004).
[3] 770 F. Supp. 704 (D.C. Dist. 1991).

or judicial review is limited to the two fiscal periods identified by the Providers. Therefore, no further inquiry into Congressional intent is warranted. Moreover, if any ambiguity were present, it is resolved by the expansive regulatory language, binding on the Board, that prohibits review of "any controversies about [budget neutrality determinations]."

42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 permit providers to bypass the Board's hearing procedure and obtain judicial review of a specific matter at issue involving a question of law or regulation where the Board determines that it is without authority to decide the legal question. Prior to rendering a decision that it lacks the authority to decide the legal question before it, the Board must determine that it has jurisdiction over the matter at issue in the appeal under 42 U.S.C. § 1395oo. 42 C.F.R. § 405.1842(a)(2008). We conclude that both the statute and regulation preclude administrative review of the budget neutrality adjustment; therefore, the Board lacks jurisdiction over the issue.

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

Cape Cod and the Request for EJR

Ordinarily our EJR analysis would end with a determination of no jurisdiction. However, in *Cape Cod HC 2007 Wage Index/Rural Floor Group*, PRRB case number 07-0705G et al, (*Cape Cod*), the Secretary has taken a contrary position. In *Cape Cod*, the Board concluded that it lacked jurisdiction over the budget neutrality adjustment based on the authorities set forth above. The Board's decision was not reversed by the CMS Administrator. On appeal to the Federal district court, however, the Secretary moved for remand on the basis that the Board had jurisdiction over the issue. The provider plaintiffs responded that the remand was unnecessary because the case was properly before the court on EJR. It argued that implicit in the Board's finding it lacked jurisdiction was a determination that it also lacked authority to decide the question, thus, EJR was appropriate. In its remand order, the District Court explained that the two findings are distinct. "Jurisdiction to take any legal action" asks whether the Providers may obtain a hearing at all; "authority to decide the question" asks whether the Board has authority to reach the merits of Providers' claims. The Court concluded that the Secretary's position was correct: the Court lacked subject matter jurisdiction without the Board's first being afforded an opportunity to consider the merits of the Providers' claims, including whether it has authority to decide the question. Neither the D.C. District court remand[4] nor the remand from the Deputy Administrator addresses the Secretary's rationale for his position regarding jurisdiction. Assuming, however, that the Secretary will take the same position in this case with respect to the Board's having jurisdiction over the budget neutrality issue, and in the interest of judicial economy, the Board will also address the question of whether EJR is appropriate.[5]

The Provider in this appeal seeks to have its final wage index rate modified by applying a

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[4] *Cape Cod Hospital v. Leavitt*, (D.D.C. July 21, 2008) (2008 WL 2791683).

[5] After the above remand based on the Secretary's position regarding jurisdiction, the Board found the Provider was entitled to expedited judicial review. In December of 2009, the District Court for the District of Columbia granted the defendant's (government's) motion for summary judgment for the budget neutrality adjustment. *Cape Cod Hospital et al. v. Sebelius*, 2009 WL 4981330 (D.D.C. December 22, 2009) at pp. 9-16.

different calculation methodology relating to the budget neutrality and rural floor factors. Pursuant to 42 C.F.R. § 412.64, the Secretary calculates the standardized amount on an annual basis. This calculation is published annually in the Federal Register following a complex and lengthy process of data collection and analysis. The methodology for the calculation is described in general terms.

The Board is bound by the Secretary's final rules and has no authority to review the data underlying the rate published unless specifically authorized. Notably the Final Rule only provides for Board review of denials of requests by hospitals for correction of certain wage data that eventually goes into one hospital-specific component of the final rate.[6] If the provider appealing the denial is successful, the remedy is limited to the hospital bringing the successful appeal. There is no provision for the Board to adjust the rate itself (as applied to all hospitals) to account for the effect of the error. The Board concludes that the specific grant of authority and establishment of a detailed process for correcting the rate of only the hospital bringing the appeal, coupled with the failure to include the effect of that correction on other hospitals or to establish a similar correction process for other components of the wage index, are strong indications that the Board does not have authority to change the rate itself.

Even more compelling, however, is the language of the statute and the regulation quoted above that prohibits review of budget neutrality determinations which are at the heart of the question before the Board in this case. Even if the Board interpreted the statutory and regulatory prohibitions on review of budget neutrality determinations too broadly to bar jurisdiction, those prohibitions cannot be ignored altogether. We conclude that the statute and regulation evidence Congress' and the Secretary's intent that budget neutrality determinations are insulated from the Board's authority to affirm, reverse or modify a reimbursement determination. Otherwise, the specific prohibitions articulated there would be rendered meaningless.

Assuming, arguendo, that the Secretary takes the same position in these cases that the Board has jurisdiction, then the Board finds that:

1) based upon the Provider's unopposed assertions regarding the challenges to the rural floor/budget neutrality methodology, there are no findings of fact for resolution by the Board;

2) it is bound by the Final Rule in the Federal Register and the regulation; and

3) it is without authority to decide the legal question of whether the calculation methodology for the budget neutrality/rural floor adjustment is valid.

The Board finds that it does not have jurisdiction over the RFBNA issue, therefore the request for expedited judicial review is denied. If, however, the Secretary finds that the Board does have jurisdiction over the RFBNA issue, then expedited judicial review would be appropriate. As the Rural Floor Budget Neutrality Adjustment issue is the sole remaining issue in the appeal, the Board hereby closes case number 14-0483.

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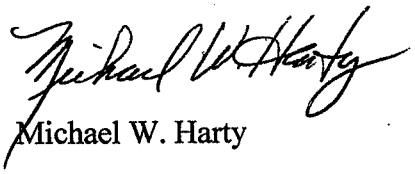
[6] 64 Fed. Reg. 41490, 41513 (July 30, 1999). This authority has never been codified in the code of Federal Regulations.

BOARD MEMBERS PARTICIPATING:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

For the Board:



Michael W. Harty

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

cc:

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

Darwin San Luis
Noridian Healthcare Solutions, LLC
JE Provider Audit Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

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: 13-1303

DEC 23 2013

CERTIFIED MAIL

Parker, Hudson, Rainer & Dobbs LLP
Jonathan L. Rue
285 Peachtree Center Avenue
Suite 1500
Atlanta, GA 30303

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

RE: Jurisdictional Decision – Lexington Medical Center
Provider No.: 42-0073
FYE: 9/30/2006
PRRB Case No.: 13-1303

Dear Mr. Rue and Ms. Huggins,

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

Background

Lexington Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 9/30/2006 on October 25, 2012. On March 29, 2013, the Board received the Provider's appeal request in which it appealed one issue: the Rural Floor Budget Neutrality Adjustment (RFBNA). The Board received a Proposed Joint Scheduling Order (PJSO) on November 27, 2013.

MAC's Position

There was no jurisdictional challenge submitted in case number 13-1303, however the MAC did raise an argument about jurisdiction in the PJSO. The MAC argues that the Board does not have jurisdiction over the RFBNA issue in this appeal because the Provider failed to timely appeal the Secretary's published GAF/DRG budget neutrality factor as published in the Federal Register on August 12, 2005. The MAC argues that appeal rights for this issue come from the Secretary's issuance of the rate rather than from an NPR.

Provider's Position

The Provider did not submit a response to the Intermediary's statements regarding jurisdiction. However, in the PJSO, the Provider stated that the RFBNA issue is governed by Cape Cod v.

Sebelius,[1] which indicates that additional reimbursement is due to the Provider. The Provider concludes that CMS has acknowledged the erroneous payments.

Board's Decision

The Board finds that it does not have jurisdiction over the Provider's appeal from a revised NPR because the only issue on appeal, the RFBNA, was not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (effective August 21, 2008) provides in relevant part:

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

In accordance with 42 C.F.R. § 405.1889 (2012), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Here, the Provider's audit adjustment report associated with the October 25, 2012 revised NPR shows that DSH was adjusted in order to adjust the SSI%. There was no adjustment made to the RFBNA, therefore the Board does not have jurisdiction because the appeal does not meet the specificity requirements for a revised NPR appeal.

Because the RFBNA was not specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over this Provider's appeal. Case number 13-1303 is hereby closed.

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

---

[1] 630 F.3d 203 (D.C. Cir. 2011).

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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: 07-2324G

DEC 23 2013

CERTIFIED MAIL

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

Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 19219

RE: Request to Reopen and Reinstate Provider – Baptist St. Anthony Health System, as a member of QRS 2004 Medicare DSH Labor Room Days Group
Provider No.: 45-0231
FYE: 12/31/2004
PRRB Case No.: 07-2324G

Dear Mr. Ravindran and Mr. LeJeune,

The Provider Reimbursement Review Board (Board) has reviewed the Provider's Request for Reinstatement of case number 07-2324G. The Board's decision is set forth below.

Background

On June 27, 2007, the Providers filed a request for a group appeal; the Board assigned case number 07-2324G.

On February 18, 2010, Baptist St. Anthony Health System was issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2004. The Provider requested to be directly added to this group appeal on July 22, 2010. On September 5, 2013, the Board issued a jurisdictional decision in which it denied jurisdiction over Mary Lanning Memorial Hospital because it did not timely add the labor room days issue to its appeal, and over Bethesda Memorial Hospital and Baptist St. Anthony as both Providers appealed from revised NPRs that did not specifically adjust labor room days. The remaining Providers in the appeal were remanded pursuant to CMS Ruling 1498-R. QRS submitted this Request to Reopen and Reinstate Provider on October 25, 2013.

Provider's Contentions

QRS requests that the Board reopen its September 5, 2013 jurisdictional determination in which it found that it lacked jurisdiction over Baptist St. Anthony. QRS argues that its revised NPR adjusted Medicaid eligible days and, more specifically, labor room days, contrary to the Board's

finding in the jurisdictional determination. QRS submitted additional documentation in which the MAC identified and adjusted labor room days in support of its request.

Board's Decision

The Board hereby grants QRS' request to reopen case number 07-2324G in order to reinstate Baptist St. Anthony, because the Provider's revised NPR did adjust labor room days.

QRS submitted the Final Schedule of Providers & Jurisdictional Documents on May 10, 2013, which is after the updated Board rules went into effect that requires Providers to submit additional jurisdictional documentation when appealing from revised NPRs.[1] QRS submitted some of the extra documentation for Baptist St. Anthony's revised NPR appeal, however it was not possible to determine that there had been an adjustment to labor room days from just those documents, therefore the Board denied jurisdiction over the Provider. When QRS submitted the October 25, 2013 request to reopen the jurisdictional determination, it submitted additional MAC workpapers that had not been previously included. From these workpapers the Board determines that the adjustment to Medicaid eligible days did include an adjustment to labor room days: 231 labor room days were removed.

The Board previously determined that it did not have jurisdiction over Baptist St. Anthony because the Provider did not submit the documentation establishing the adjustment until its reopening request. Based on the information it had, the Board determined that the Provider did not meet the specificity requirements of an appeal from a revised NPR. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 1885 provides in relevant part:

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

42 C.F.R. § 405.1889 (2004) explains the effect of a cost report revision:

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

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

[1] PRRB Rule 7.1, effective March 1, 2013.

jurisdiction is limited to the specific issues revisited on reopening.

The additional documentation that the Provider submitted with its reopening and reinstatement request show that there was an adjustment to labor room days when the cost report was revised. Therefore, the Board grants the request to reopen case number 07-2324G and reinstates Baptist St. Anthony in order to confirm jurisdiction over this Provider. The Board will address the remand issue under separate cover.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

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: 12-0289

DEC 31 2013

CERTIFIED MAIL

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

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

RE: Jurisdictional Decision – St. Francis Hospital and Medical Center
Provider No.: 07-0002
FYE: 9/30/2002
PRRB Case No.: 12-0289

Dear Mr. Ravindran and Mr. Browning,

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 September 28, 2011, the Provider was issued a revised Notice of Program Reimbursement (NPR) for FYE 9/30/2002. The Provider filed an appeal request with the Board on March 30, 2012, in which it appealed seven issues related to the Disproportionate Share Hospital (DSH) adjustment:

1. SSI% - Provider Specific
2. SSI% - Systemic Errors
3. Medicaid Eligible Days
4. Exhausted Medicare Benefits Medicaid Dual Eligible Days
5. Medicare Managed Care Part C Days
6. Medicaid Eligible Connecticut Medical Assistance/General Assistance Days
7. Medicaid Eligible Labor Room Days.

On December 31, 2012, the Board sent a letter to the Provider's representative requesting additional documentation pertaining to its appeal from the revised NPR. The MAC filed a jurisdictional challenge over all of the issues in the Provider's appeal on February 14, 2013. On March 1, 2013, the Provider submitted a response to the MAC's jurisdiction challenge and the Board's request for additional information. In this response, the Provider indicated that the labor room days issue was previously withdrawn. In addition, the Provider requested to withdraw the SSI% Provider Specific, SSI% Systemic Errors, and the Connecticut General Assistance Days issues, leaving only three issues pending in the appeal. The remaining issues are: Medicaid

Eligible Days, Dual Eligible Days, and Medicare Part C Days.

MAC's Position

The MAC argues that the Board lacks jurisdiction over all of the issues in the Provider's revised NPR appeal. The MAC explains that several issues were transferred out of the appeal or withdrawn:

Issue	Status
-SSI% - Systemic Errors	-Transferred to CN 08-2927G (open) on 10/25/2012
-Exhausted Medicare Benefits Medicaid Dual Eligible Days	-Transferred to CN 12-0130G (open) on 10/25/2012
-Medicare Managed Part C Days	-Transferred to CN 08-2939G (open) on 10/25/2012
-Medicaid Eligible Connecticut Medical Assistance/	-Transferred to CN 08-2169G (open) on 10/29/2012
-Medicaid Eligible Labor Room Days	-Withdrawn on 10/30/2012

The MAC explains that the Provider requested an adjustment for 1,328 additional Medicaid Eligible days upon reopening of the cost report, which the MAC allowed. The Provider is now requesting additional Medicaid eligible days, which the MAC argues the Board does not have jurisdiction over.

The MAC cites 42 C.F.R. § 405.1889(b):

> (1) Only those matters that are specifically revised in the revised determination or decision are within the scope f any appeal of the revised determination or decision.
> (2) Any matter that is not specifically revised (including any matter that was reopened and not revised) may not be considered in any appeal of the revised determination or decision.

The MAC concludes that the appeal rights for the revised NPR are limited to the specific Medicaid Eligible Days and Outpatient Bad Debts that were reviewed for the settlement. The MAC contends that because it included all of the Medicaid eligible days that the Provider requested, the additional days that the Provider is now requesting were not submitted for review, thus the Board does not have jurisdiction. The MAC refers to *Illinois Masonic Medical Center v. Sebelius*,[1] to support its conclusion that the Provider cannot appeal additional Medicaid eligible days.

The MAC concludes that the remaining issues were not addressed in the revised settlement, therefore they are not valid appeal issues.

[1] United States District Court, District of Columbia, No. 11-cv-00105 (BJR), Order and Memorandum Opinion on Cross Motions for Summary Judgment.

Provider's Position

In its Response to the MAC's Jurisdictional Challenge, the Provider first clarifies that it has withdrawn the SSI% - Provider specific; SSI% - Systemic Errors; Connecticut General Assistance Days; and Medicaid Eligible Labor Room Days issues, leaving only the Medicaid Eligible Days, Dual Eligible Days, and Medicare Part C days in the appeal.

The Provider does not respond to the MAC's contentions that the issues should be dismissed because the Board does not have jurisdiction over the revised NPR appeal. Instead, it makes arguments about the merits of the case – such as why the Medicare Part C days and dual eligible days should be included in the Medicaid Proxy. The Provider argues that its purpose in filing the reopening was to include all days where patients were eligible for Medicaid in the Medicaid proxy pursuant to several court decisions. The Provider concludes that its DSH calculation is understated and that because the MAC revised the cost report and adjusted the Medicaid proxy, that the Board does have jurisdiction over the remaining issues in the appeal.

Board's Decision

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

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

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

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

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

In its reopening request, the Provider requested reimbursement for crossover bad debt; 1,328 additional Medicaid eligible days; 3,006 General Assistance days; and a correction to the SSI ratio.[2] The MAC's Notice of Reopening, dated January 19, 2010, indicated that it reopened the Provider's cost report for the following items:

> To include Medicare cross over bad debts not previously reported.
> To include Medicaid Eligible Days not previously included in the final cost report.
> To update the SSI% to a recalculated amount, if approved by CMS.[3]

Medicaid Eligible Days

The Board finds that it does not have jurisdiction over the Medicaid Eligible Days issue because the Provider fails to meet the requirement that it be "dissatisfied" with the Intermediary's final determination in the revised NPR. The audit adjustment report and audit workpapers for the revised NPR demonstrate that the Provider received an additional 1,328 Medicaid days – those days that it specifically requested in its reopening.[4] Although Medicaid days were adjusted in the revised NPR, the days currently in dispute are a new universe of days that were not considered or adjusted by the by the Intermediary when the cost report was revised. Thus, pursuant to 42 C.F.R. § 405.1889(b)(1), such days are beyond the scope of any appeal of the revised determination.

Dual Eligible Days & Medicare Managed Care Part C Days

The Board finds that it does not have jurisdiction over Dual Eligible Days and Part C Days issues because they were also not considered or specifically adjusted when the cost report was reopened. The Provider did not raise these categories of days within its reopening request, nor were these issues noted in the Intermediary's Notice of Reopening. There was no documentation submitted to establish that either category of patient day was reviewed or adjusted as part of the Intermediary's review of other Medicaid eligible days. Therefore, the Dual Eligible and Part C days are also beyond the scope of an appeal of the revised determination per 42 C.F.R. § 405.1889(b)(1).

Transfers

The Board hereby denies the transfers of the Dual Eligible Days issue and Medicare Managed Care Part C Days issue to case numbers 12-0130G and 08-2939G as the Board has found it does not have jurisdiction over these issues. The Board also denies the transfer of the SSI% -

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[2] Provider's Response to MAC's Jurisdictional Challenge at Ex. 2.
[3] *Id.*
[4] MAC's Jurisdictional Challenge, Ex. I-1, Adj. No. 1 and Ex. I-7.

Systemic Errors issue and Connecticut General Assistance Days issue to case numbers 08-2927G and 08-2169G as the Provider withdrew these issues from its individual appeal pending the Board's jurisdictional determination.

Conclusion

Pursuant to 42 C.F.R. §§ 405.1835(a) and 405.1889(b), the Board finds that it does not have jurisdiction over the three remaining issues in St. Francis Hospital's appeal from its revised NPR and hereby dismisses the Medicaid Eligible Days, Dual Eligible Days and Part C Days issues from the appeal. The Board also denies the Provider's requests to transfer the Dual Eligible Days, Medicare Managed Care Part C Days, SSI% - Systemic Errors, and Connecticut General Assistance Days issues to case numbers 12-0130G, 08-2939G, 08-2927G, and 08-2169G. Since there are no issues over which the Board has jurisdiction, case number 12-0289 is closed.

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

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA