CENTERS FOR MEDICARE AND MEDICAID SERVICES

# *Decision of the Administrator*

| In the case of: | Claim for: |
|---|---|
| Salt Lake Regional Medical Center | Reimbursement Determination for Cost Reporting Period Ending: August 31, 2004 |
| **Provider** | |
| vs. | |
| Blue Cross Blue Shield Association/ Noridian Administrative Services | Review of: PRRB Dec. No. 2010-D39 Dated: June 30, 2010 |
| **Intermediary** | |

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review, on own motion, of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act (Act), as amended (42 USC 1395oo(f)). The parties were notified of the Administrator's intention to review the Board's jurisdictional decision. The Provider and the CMS' Center for Medicare (CM) submitted comments. All comments were timely received. Accordingly, this case is now before the Administrator for final agency review.

## ISSUE AND BOARD DECISION

The issue is whether the Board had jurisdiction to grant the Provider's request for expedited judicial review or EJR over the validity of the provisions of the CMS Ruling (Ruling) CMS-1498-R.

The Board held that it had jurisdiction over the Provider's appeal, but found that it did not have authority to make a determination whether the Ruling deprived it of continuing jurisdiction. Accordingly, the Board granted expedited judicial review.

## COMMENTS

The CM submitted comments, requesting review of the Board's decision. The CM argued that the Board did not have jurisdiction to grant EJR. The CM argued that the Board is bound by the Ruling and the Ruling clearly states, that the Board and the other Medicare administrative appeals tribunals lack jurisdiction over the three DSH issues discussed in the Ruling. The CM argued that the only action the Ruling permits the Board to take is to identify all appeals raising any of these three issues that are properly pending and to remand those appeals to the Medicare contractor with jurisdiction over the provider.

The Provider submitted comments stating that the Board had jurisdiction to grant its request for EJR. The Provider incorporated by reference its submission to the Board in response to the Intermediary's jurisdictional objection to the Provider's request for EJR. In its response to the Intermediary's jurisdiction objection, the Provider argued that, for the cost reporting period in dispute, the days at issue were adjusted by the Intermediary. Therefore, the Board had jurisdiction over the Provider's appeal from a revised notice of program reimbursement (NPR).

## DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's jurisdiction decision. All comments received timely are included in the record and have been considered.[1]

The regulations at 42 C.F.R. §401.108 state that CMS Rulings are binding on all CMS components. With respect to the scope of the Board's legal authority, the regulation at 42 C.F.R. §405.1867 states that, "[i]n exercising its authority to conduct proceedings… the Board must comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108...."

The underlying issue in dispute involves the treatment of inpatient days for patients who were "enrolled in both Medicare Part A when they were treated by the hospital," but did not have Medicare Part A payment made on their behalf for the particular patient days at issue, either because the patient had exhausted his or hers Medicare Part A benefits for the inpatient hospital stays, or another payer had primary obligation to pay and, thus, Medicare was the secondary payer (MSP). By request dated October 26, 2009, the Provider filed a request for a Board hearing on

[1] The Board incorporated parts of the record from PRRB Dec. No. 2010-D36.

"DSH Dual Eligible Medicare Secondary Payer and Part A Exhausted Days, Audit Adjustment Nos. 1, 2."[2] The Provider asserted jurisdiction by the Board for the DSH dual eligible days issue for several reasons including that the "days were identified in a revised claim that was presented to the intermediary prior to the issuance of the NPR, That NPR settled the provider's revised claim."

On April 28, 2010, CMS issued CMS Ruling CMS-1498-R. On May 28, 2010 the Provider filed a request for expedited judicial review challenging the validity of the ruling. The Ruling provided notice that the Board and the other Medicare administrative appeals tribunals lacked jurisdiction over three specific types of provider appeals regarding the calculation of the Medicare disproportionate share hospital (DSH) adjustment. The CMS-1498-R titled "Medicare Program Hospital Insurance (Part A)—Jurisdiction over appeals of disproportionate share hospital (DSH) payments and recalculation of DSH payments following remands from Administrative Tribunals" provides the following:

> The Ruling provides notice of the determination of the Centers for Medicare & Medicaid Services (CMS) that the Provider Reimbursement Review Board (PRRB) and the other Medicare administrative appeals tribunals lack jurisdiction over provider appeals of any of three issues described [therein] regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment. The Ruling also requires the pertinent administrative appeals tribunal (that is, the PRRB, the Administrator of CMS, the Medicare fiscal intermediary hearing officer, or the CMS reviewing official) to remand each qualifying appeal to the appropriate Medicare contractor.

Specifically, CMS Ruling CMS-1498-R prohibits the Board and the Administrator from review and removes jurisdiction to review provider appeals regarding three issues: 1) the calculation of the SSI fraction; 2) inpatient days where the patient was entitled to Part A benefits, but the inpatient hospital day was not covered under Part A or the patient part A benefits were exhausted. (MSP days and exhausted benefit days for dual-eligible patients) for cost reporting periods with discharges before October 1, 2004; and 3) labor and delivery room days for cost reporting periods with discharges before October 1, 2009.

---

[2] The Provider also appealed "Issue No 2: Inclusion of Days attributable to patients who were eligible under the state plan for medical assistance covering non-inpatient services" but apparently subsequently withdrew that issue in its filing of a preliminary position paper with the Intermediary at n.1 and its letter dated May 27, 2010 to the Board.

The Administrator finds that the issue appealed by the Provider involved Part A exhausted benefit days and MSP days for discharges occurring before October 1, 2004. While the CMS-1498-R is applicable to this issue, the CMS Ruling also requires a finding that an appeal is properly pending for the Ruling to be applicable. In particular, the Ruling states that:

> In accordance with the foregoing history and determination, CMS and the Medicare contractors will resolve each *properly* pending DSH appeal for cost reports with patient discharges before October 1, 2004, in which the hospitals seeks inclusion in the DPP of inpatient days where the patient was entitled to Part A benefits but the inpatient hospital stay was not covered under Part A or the patient's Part A hospital benefits were exhausted. CMS Ruling 1498-R at 11.

The regulation at 42 C.F.R. §405.1835 sets forth the right to a hearing before the Board. A provider may obtain a hearing before the Board with respect to its fiscal intermediary's determination of the final amount program reimbursement or payment, inter alia, only if: the provider has preserved it right to claim dissatisfaction with the amount of Medicare payments for the specific item(s) at issue; there is $10,000 or more in controversy; and the provider filed a request for a hearing within 180 days after the notice of program reimbursement or NPR. The regulation at 42 CFR 405.1840 more fully sets out the criteria and procedures regarding jurisdiction stating generally that:

> 405.1840 Board jurisdiction.
> (a) *General rules.* (1) After a request for a Board hearing is filed under § 405.1835 or § 405.1837 of this part, the Board must determine in accordance with paragraph (b) of this section, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request.
> (2) The Board must make a preliminary determination of the scope of its jurisdiction (that is, whether the request for hearing was timely, and whether the amount in controversy requirement has been met)

Finally, in order to grant expedited judicial review, the Board (or the Administrator) must first determine, pursuant to 42 CFR 405.1842(b), that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question. Specifically, the regulation at 42 C.F.R. §405.1842 entitled "Expedited judicial review", explains that:

> (a) Basis and scope. (1) This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal *if there is Board jurisdiction to conduct a hearing on*

> *the matter (as described in Sec. 405.1840 of this subpart),* and the Board determines it lacks the authority to decide the legal question (as described in Sec. 405.1867 of this subpart, which explains the scope of the Board's legal authority).
> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
> (3) The Administrator may review the Board's jurisdictional finding, but not the Board's authority determination.
> (4) The provider has a right to seek EJR of the legal question under section 1878(f)(1) of the Act only if--
> (i) The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue and a determination by the Board that it has no authority to decide the relevant legal question; or
> ….
> (b) General--(1) Prerequisite of Board jurisdiction. The Board (or the Administrator) must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question.[3]

In addition, an intermediary's determination may be reopened pursuant to the regulation at 42 C.F.R. §405.1885. The regulation at 42 C.F.R §405.1885(a)(5) provides that: "If a matter is reopened and a revised determination or decision is

---

[3] The regulation at 42 C.F.R. §405.1875 specifically sets forth the Administrator's authority to review any Board determination of jurisdiction. The regulation at 42 C.F.R. § 405.1875(a)(1) provides that, "[t]he Administrator, at his or her discretion, may immediately review any decision of the Board specified in paragraph (a)(2) of this section." In addition, paragraph (a)(2)(iii) of 42 C.F.R § 405.1875 states that, the Administrator may immediately review, "[a] Board EJR decision, but only the question of whether there is Board jurisdiction over a specific matter at issue in the decision;…." Finally, paragraph (b)(5) of 42 C.F.R. § 405.1875 outlines the criteria for deciding whether to review. It states in part that in deciding whether to review a Board decision, the Administrator considers criteria such as whether it appears that: "(5) The Board has incorrectly assumed or denied jurisdiction.…"

made, a revised determination or decision is appealable to the extent provided in § 405.1889 of this subpart.." The right to appeal a revised NPR is strictly a regulatory right under 42 C.F.R. §405.1889. The regulation at 42 C.F.R. §405.1889 specifies how revisions to determinations or decisions are to be treated for purposes of appeal. Section 405.1889 provides that:

> (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, 40531834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal, of the revised determination or decision.

The Administrator, after reviewing the record and the relevant law, regulations, and governing criteria, finds that the Board incorrectly accepted jurisdiction as the days in dispute were not at issue in the revised NPR. The Administrator finds that 42 C.F.R. §405.1889 bars the Provider from using the revised NPR as the vehicle for an appeal to request inclusion of those days in the DSH calculation. The regulation at 42 C.F.R. §405.1889 states that, "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."

In this case, the record demonstrates that the original NPR for the fiscal year ending August 31, 2004, was issued on January 31, 2006.[4] By letter dated July 27, 2006, the Provider appealed three issues: "DSH-Medicaid Eligible Days," "DSH – Labor and Delivery Room Days", and "DSH – SSI Percentage"[5] The appeal was assigned PRRB Case No. 06-2034. On October 20, 2008, the parties executed a "Full Administrative Resolution" of PRRB Case No. 06-2034. By notice dated November 13, 2008, the Board officially withdrew and closed PRRB Case No. 06-2034 for the fiscal year ending August 31, 2004. The Board closure notice instructed the Provider as to where to reference the Board rules regarding the

[4] Intermediary Exhibit I-1.
[5] Intermediary's Exhibit I-2.

consequences of withdrawal and deadlines for reinstatement where appropriate. The record shows that the Intermediary issued a Notice of Reopening, dated December 15, 2008, advising the Provider that it would be reopening the cost report to incorporate the Administrative Resolution of PRRB Case No. 06-2034. Finally, the Intermediary issued a revised NPR, dated April 30, 2009, incorporating the Administrative Resolution of the fiscal year ending August 31, 2004 appeal, PRRB Case No. 06-2034.

The Administrator finds that the matter appealed in this case involved exhausted days and MSP days. These claims were never raised by the Provider in the original appeal and were not involved with the issuance of the revised NPR. The record shows that the days at issue in this case were not part of the separate and distinct determination which comprises the revised NPR that is basis for any Board review now.

A review of the administrative resolution, dated October 20, 2008, shows that it was entered into as a "Full Administrative Resolution" for the fiscal year ending August 31, 2004. The resolution required the following specific actions. The parties agreed that the Provider would transfer two issues to group appeals involving SSI percentage and labor & delivery room days. The third issue, involving Title XIX eligible days, was administratively resolved as follows:

> The provider and contractor have agreed to resolve this issue. The provider has supplied the contractor with a revised listing of title XIX days. After reviewing this data, the contractor agrees to add back 172 Title XIX days and 431 Total days to the cost report. As a result of this change the cost report will now reflect Title XIX days of 4087 and total days of 18,148. After this adjustment the providers Title XIX percentage will be 22.52%. This amount will be added to the SSI % of 4.34% to arrive at a disproportionate payment adjustment percentage of 26.86%. The allowable DSH payment adjustment percentage will be adjusted to 11.37% as a result of this change. A revised adjustment report is attached.

The agreement states that: "This is a **Full Administrative Resolution** and the Provider's signature serves as the Provider's request to withdraw this case from appeal." (Emphasis in original.) The computer generated attached adjustment shows the addition of the 172 days and 431 days, respectively, to Title XIX eligible days.

The Intermediary's Notice of Reopening, issued December 15, 2008, states that:

> The cost report is being reopened for the following reasons. To incorporate the adjustments associated with the administrative resolution of PRRB Case No. 06-2034 that was signed on 10/20/2008. This includes as following:
>
> 1) To include an additional 172 Title XIX days and add 431 total days to w/s S-3. As a result of these changes your allowable disproportionate share adjustment percentage will be 11.37 percent.

The corrected (revised) Notice of Program Reimbursement, dated April 30, 2009, includes a revised Adjustment Report. The Adjustment No. 1 is "to amend the Title XIX and total days based on the additional documentation supplied during the administrative resolution of PRRB Case No. 06-2034", again showing the inclusion of the 172 days and 431 days on Worksheet S-3 Part 1. Adjustment No. 2 shows the increase of the allowable DSH percentage based on the administrative resolution of PRRB Case No. 06-023 by 0.34 from 11.03 to 11.37. The Provider appealed Adjustment Nos. 1 and 2 in this case.

The Provider and the Board relied on Provider Exhibit P-1 to support a finding that there was a "redetermination" of the exhausted and MSP days in the revised NPR. The Provider describes the worksheet as follows in order to justify the appeal of the issues pursuant to the revised NPR:

> As shown in the workpaper, excerpted above the starting point for the *Intermediary's reopening determination* of 4449 "revised title XIX days" From there, the intermediary determined to exclude certain types of Medicaid–eligible days including 39 "Dual Eligible Days," 102 "non-inpatient services days," and 202 Title XIX L&D." There remained a total of 4087 "revised Title XIX days." This number compared to 3915 "title XIX days originally allowed" in the cost report to yield an adjustment necessary of 172 days, which is the number that appears in the audit adjustment report. *See* Ex. P-2. In summary, the audit adjustment made by the Intermediary in reopening encompassed the days now being appealed by the provider. (Emphasis added.)

The Provider does not specify the source or date of the Provider Exhibit P-1 other than as a work paper "relating to the reopening."[6] However, the document was not

---

[6] The Provider acknowledges that: "It is true, as the Intermediary states in its challenge that the "MSP/Part A Exhausted days and days associated with patients

submitted as an attachment to the revised NPR in the Provider's Request for Hearing or in the Intermediary's Exhibits but only appears as a "stand alone" document. The Administrator finds that a review of the Intermediary's "reopening determination," which is the revised NPR, including the Audit Adjustment Report, dated April 30, 2009, only shows the addition of days, consistent with the administrative resolution, and does not show the exclusion of the days at issue as portrayed by the Provider. Thus, the Administrator finds that the record does not show that the "starting point" of the "intermediary reopening determination" was to exclude certain days. The exclusion of the days, instead, seems to have been the starting point in reaching a negotiated administrative resolution of the case.

A closer examination shows that Provider Exhibit P-1 is consistent with, and appears to "memorialize" the negotiations leading up to the administrative resolution, rather than any "redetermination" at the time of the reopening. The Provider points to emails as further evidence to support, similar to the Provider P-1, that there was a "redetermination" in the reopening involving the exclusion of the dual eligible days. However, the emails, at Provider Exhibit P-3, capture the negotiations leading up to the administrative resolution. The Provider points to the Intermediary's statement that: "for 2004 we have excluded … 39 dual eligible days."[7] However, the Provider fails to point out that the Intermediary's email to the Provider, Provider's consultants and Provider's attorney, further states that: "However, it is my understanding <u>that you agree with the dual eligible days</u> …."[8] (Emphasis added.) The subsequent emails do not rebut the Intermediary's understanding on this point. The subsequent and last emails, dated October 7, 2009, rather shows the Provider (and/or consultants) final "OK" with the "numbers," which reflected the exclusion of the 39 dual eligible days, as discussed in the preceding emails.[9]

While the Provider argues that the adjustments reflected in Provider Exhibit P-1 and the emails encompass the days now at issue and were part of the reopening, an

---

eligible only for outpatient services were not addressed in the October 20, 2008 administrative resolution, nor were they part of the [Provider's original appeal.]"

[7] Provider's Opposition to Intermediary Jurisdictional Objection at n. 3.

[8] Provider Exhibit P-3 at 3.

[9] While the right to appeal a revised NPR does not originate from section 1878, the regulation at 42 CFR 405.1835 also includes a requirement that the Provider be able to demonstrate dissatisfaction and is incorporated at 42 CFR 405.1889. Among other bars, a Provider that challenges an agreed upon administrative resolution cannot, because of the very existence of the agreement, demonstrate "dissatisfaction."

examination shows that the days shown excluded in Provider Exhibit P-1 and discussed in the email were agreed to, by the Provider, in the negotiations to reach an administrative resolution. In contrast, the reopening and revised NPR merely effectuated the Administrative resolution by adding the agreed upon days to the DSH calculation consistent with the administrative resolution.[10] Therefore, the Administrator finds that the record demonstrates that the days now at issue were not adjusted in the revised NPR and, thus, cannot be appealed pursuant to the revised NPR. Moreover, any matter "that is not specifically revised" may not be considered in any appeal of the revised determination. That is, reliance on Edgewater Hospital v. Bowen, 857 F.2d 1123 (7th Cir. 1988), is misplaced. The days at issue were not specifically revised pursuant to the revised NPR and, thus, may not be considered in this appeal.

The Provider at this time wants to challenge the 4087 Title XIX days it agreed upon in the administrative resolution. The Provider is claiming 4120 days (33 of the 39 "dual eligible days").[11] The Administrator finds that Provider is now challenging the agreed upon "number" which encompassed the "Full Administrative Resolution" for this cost year. Accordingly, the record not only demonstrates that reopening and revised NPR did not make an adjustment relating to the days at issue or a redetermination with respect to such days, but that the Provider is challenging the administration resolution to which it had agreed and which fully resolved the fiscal year ending August 31, 2004 cost report claims raised in PRRB Case No. 06-2034. Accordingly, for all of the foregoing reasons, the Provider's claim for the days at issue is not properly pending before the Board pursuant to the appeal of the revised NPR.

[10] Even were the Provider Exhibit P-1 demonstrated to be part of the reopening audit adjustments, the record shows it but memorializes the agreement reached by the parties and does not represent a "redetermination

[11] The Provider states that, of the 39 dual eligible days discussed in the negotiation of the administrative resolution, it is not appealing six of the days. Provider's Opposition to Intermediary's Jurisdictional Objection at n. 1.

## DECISION

Accordingly, the Board's jurisdictional decision is vacated in accordance with the foregoing opinion.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES**

Date: 8/23/2010 /s/

Marilyn Tavenner
Principal Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services