CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Illinois Masonic Medical Center **Provider**	**Medicare Reimbursement** **Cost Year Ending: FFY 1997**
vs.	
Blue Cross and Blue Shield Association **Intermediary**	**PRRB Dec. No. 2010-D47** **Dated: September 17, 2010**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the 60-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo (f) (1)], as amended. The Administrator notified the parties of the intent to review the jurisdictional decision. The Provider and the CMS' Office of Financial Management (OFM) submitted comments. Accordingly, the Board's jurisdictional decision is now before the Administrator for final administrative review.

Issue and Board Decision

The issue is whether the Board has jurisdiction over Medicaid eligible days that were not specifically considered within the implementation of a revised Notice of Program Reimbursement (NPR).

The Provider appealed Medicaid eligible days for purposes of the disproportionate share hospital (DSH) calculation and joined a group appeal which resulted in a full Administrative Resolution. The Provider and Intermediary jointly agreed that the Provider would provide documentation to support the days being claimed. The Intermediary reviewed the documentation and issued a revised NPR, in which it made an adjustment to add 24 allowable Medicaid eligible days, out of 230 days submitted by the Provider, for purposes of the DSH calculation. The Provider

appealed the revised NPR, requesting the inclusion of 2,244 additional unpaid, and previously unclaimed, Medicaid eligible days for purposes of the DSH calculation.

The Majority of the Board found that it lacked jurisdiction under Section 1878 of the Social Security Act [42. U.S.C. 1395oo(a)] over the additional Medicaid eligible days, because the Provider failed to meet the requirement that it be "dissatisfied" with the Intermediary's final determination in the revised NPR. The Board stated that, because the Provider did not seek inclusion of the additional days under the terms of the administrative resolution, that the days were not considered by the Intermediary in the revised cost report and, therefore, the Provider did not meet the requirement of "dissatisfaction." The Majority noted that, once jurisdiction is obtained, the Board has discretionary power to review additional matters not reviewed by the Intermediary. In this case, there is no mention of dissatisfaction with disallowances of any costs on the revised cost report and, consequently, there is no jurisdictionally valid appeal on which discretionary review could be based. The Majority further stated that, even if it had jurisdiction over the Medicaid eligible days, it would still decline to express its discretionary power to avoid undermining principles of finality in the cost reporting process.

One Board Member dissented finding that the Provider has met all of the jurisdictional requirements. The dissenter concluded that, since the Intermediary adjusted other Medicaid eligible days as part of the reopening process, that the Provider demonstrated "dissatisfaction" when it filed its request for the hearing. Thus, since the issue or matter was adjusted/corrected in the revised NPR, the days had been properly appealed.

Comments

The Provider requested that the Administrator review and reverse the Board's jurisdictional decision in this case. The Provider argued that the Board incorrectly determined that it did not have jurisdiction over the Medicaid eligible days. The Providers requested that the Administrator review and rule consistent with the Board dissent.[1]

[1] The Administrator notes that the Provider submitted additional comments on November 2, 2010, alleging that OFM's comments were not received timely and, therefore, should not be considered by the Administrator as part of the record. As cited in the Administrator's Notice of Review, the regulation at 42 C.F.R. 405.1801(a)(1)(iii) provides that the date of receipt is "presumed to be 5 days after the date of issuance of an intermediary notice or a reviewing entity document." OFM's comments were received on November 1, 2010. In this case, the Administrator's Notice of Review was dated on October 12, 2010 and

The OFM requested that the Administrator uphold the PRRB decision. The OFM noted that the Provider did not meet the provisions of 42 CFR §405.1889(b) and the PRRB was correct in dismissing the case for lack of jurisdiction.

Discussion

The record furnished by the Board has been examined, including all correspondence, position papers and exhibits submitted by the parties. The Board's decision has been reviewed by the Administrator. All comments received after entry of the Board's decision have been made a part of the record and have been considered.

Generally, a Provider dissatisfied with the Intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) provided, inter alia, the amount in controversy for a single provider must exceed $10,000 for an individual appeal (or $50,000 for groups); and the appeal must be filed with the Board within 180 days of receipt of the final determination.[2]

The regulation at 42 CFR 405.1885 allows for a cost report to be reopened under certain circumstances. The effect of a revised NPR on a provider's right to a Board hearing is addressed in 42 C.F.R. §405.1889 (2007), which provides that:

> 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[right to intermediary hearing], 405.1835 [right to Board hearing], 405.1875 [CMS Administrator's Review] and 405.1877 [judicial review] are applicable.[3]

The regulation was further clarified in 2008, without substantial change, to state:

> (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

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comments were received by November 1, 2010. Thus the Administrator finds that OFM's comments were received timely.

[2] Section 1878 of the Social Security Act; 42 C.F.R. §§405.1835-405.1837

[3] *See also* HCFA Pub. 15-1, Transmittal No. 372, App. A § B.2.

> 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.

Thus, the appeal rights for a revised NPR are authorized and defined pursuant to the regulation. Notably, the regulations provide that a revised NPR resulting from a reopening is a separate and distinct determination from the original NPR. Thus, a provider will have a right to a hearing only for issues which were addressed in the revised NPR as provided by the regulation.[4]

The Provider originally appealed its cost reporting period ending June 30, 1997, by letter dated March 24, 2001. The Provider was specifically appealing that: "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, as part of the "Medicaid Eligible Days Group Appeal: 98-2694G." Subsequently, the Provider entered into a "Full Administrative Resolution," dated October 29, 2007, along with other members of the group, by which the Provider (14-0132), agreed to resolve all issues including the Medicaid-eligible issue. The Full Administrative Resolution provided that:

> The Intermediary and the Provider …in the above captioned appeal are entered into this administrative resolution for purposes of settling forth the basis for resolving the issues pending before the [PRRB]. Based on a mutual review of the respective parties position papers, other available documentation and authorities, and further discussions, the parties agrees to resolve the cases as follows:
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[4] *See*, e.g., *Good Samaritan Hospital v. Shalala*, 508 U.S. 402 (1993); *HCA Health Services v. Shalala*, 27 F.3d 614, 615-619 (1994) ("HCA"); *Albert Einstein Medical Center v. Sullivan*, 830 F.Supp. 846 (E.D. Pa. 1992), aff'd 6 F.3d 778 (3d Cir. 1993); *French Hospital Medical Center v. Shalala*, 841 F. Supp. 1468, 1473-74 (N.D. Cal. 1993); *Delaware County Memorial Hospital v. Sullivan*, 836 F. Supp. 238, 245 (E.D. Pa. 1991); *Rutland Regional Medical Center v. Sullivan*, 835 F. Supp. 754, 761 (D. Vt. 1993.

> C) 14-0132, FY June 30, 1997—No later than October 31, 2007, QRS, the provider representative will provide documents to support the day claimed are not exempt unit days. If the documentation is not provided, the Provider will withdraw this appeal with no further action. If the documentation is provided, the FI will complete review and issue their findings by November 30, 1997. A revised NPR will be issue(d) by December 31, 2007, if appropriate….
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> The Provider will transfer the General Assistance/Charity Care days for each of the providers and fiscal years in Exhibit B to … specific group appeals….[5]
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> The provider reserves its right to reinstate the appeal consistent with the PRRB rules regarding reinstatement and withdraw of appeals, should the intermediary not meet the dates specified above. PRRB procdrue ana dintrcutions for case reinstamten ca be accessed at http://www.cms.hhs.gov/providers/prrb/inst2002.pdf
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> The Intermediary will issue a revised Notice of Program Reimbursement to implement this administrative resolution according to the agreed dates specified for this full administrative resolution. The provider reserves the right to reinstate this appeal, consistent with the PRRB rules regarding reinstatement and withdrawal of appeals, should the intermediaries not meet the dates specified above.

As set forth above, the Provider's signature on the administrative resolution served as the request to withdraw the case from appeal. A Board notice, dated December 6, 2007, shows that the Provider was dismissed from Case No. 98-2694G pursuant to the Administrative Resolution. The Provider never requested reinstatement of the appeal in accordance with the Administrative Resolution or Board instructions.

The Intermediary issued the revised NPR for the cost reporting year ending June 30, 1997, incorporating the full Administrative Resolution on December 3, 2007.[6]

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[5] An October 5, 2007 electronic communication confirmed that no general assistance/charity care days would be transferred for the Provider.

[6] *See* Intermediary's Exhibit I-5, notes A-E. The Intermediary stated that the Provider submitted 230 days for review as Medicaid eligible days. The Intermediary stated that it concluded that 24 of the 230 days would be included. The Intermediary did not allow the 206 other days because of lack of

documentation; non PPS stays; Medicare eligible/paid days claimed as unpaid days; stays were claimed on another cost report period already included on the

The Provider subsequently appealed the December 3, 2007 revised NPR by letter dated May 28, 2008. The Provider alleged that: "The Intermediary, contrary to the regulation, failed to include as Medicaid Eligible Days services to patients for Medicaid, as well as patients eligible for general assistance." The Provider initially appealed 1175 unpaid, Medicaid eligible days, by this May 28, 2008 letter, none of which were included in the original 230 days requested in the administrative resolution. By letter dated November 25, 2009, the Provider identified inter alia, an additional 1069 "supplemental" days. The Provider conceded that there was no overlap between the original submission of 230 days that resulted in the administrative resolution and the new listing of a total of 2,244 days. The Provider explained that the new days lists included Medicaid eligible days for patients with Medicaid coverage and babies who are covered by Medicaid because their mothers had Medicaid coverage.[7] The list also included general assistance days.

The Administrator first finds that certain of the days (for example, the general assistance days, nursery days) were not matters that were the subject of the revised NPR. The matters at issue in the revised NPR were limited to days raised and addressed in the administrative resolution and included a listing of 230 Medicaid eligible days of which 24 were included in the revised DSH calculations. The Provider would have no right to a hearing, over these additional days, because the days are outside the "issue specific" limitation on the scope of Board review of a revised NPR.

Further the Provider is appealing the same issues (Medicaid eligible and general assistance days) pursuant to the revised NPR that it had originally appealed and resolved through a full Administrative Resolution. While the right to appeal a revised NPR does not originate from section 1878 of the Social Security Act, 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." In this instance, the revised NPR was only issued as a result of the full administrative resolution and as the Provider agreed to the related adjustments, it cannot demonstrate that it is now dissatisfied with the matters addressed on the revised NPR. Finally, even assuming arguendo that the Board would have jurisdiction over this appeal, for the same reasons that the Provider cannot show dissatisfaction, it cannot now dispute the Intermediary's findings on the revised NPR. The Provider agreed to a full resolution of the cost year ending

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Medicaid period listing and some patients were not Medicaid eligible for part or all of the stay submitted.

[7] "Nursery" days do not appear to have been in dispute in the prior appeal.

1997 appeal pursuant to the October 29, 2007 agreement. The plain language of the administrative resolution shows that it was intended to resolve for all time all disputes raised in the FY 1997 appeal for this Provider.[8] Accordingly, as a matter of law and in the interest of finality which settlement agreements are to provide,[9] the Provider may not now revisit the fiscal year 1997 cost year pursuant to the appeal of this revised NPR, which implemented the settlement agreed upon by the parties.[10]

[8] As noted the provider did not have any specific issues transferred to any other ongoing group appeals.

[9] The intermediaries are, however, limited in that they cannot agree to any resolutions that are outside of their contracted authority.

[10] *See*, e.g., *Hoag Memorial Hospital Presbyterian v. Sullivan*, (1993 WL 122275 (C.D. Cal.) Med & Med GD (CCH) P 41,341 (March 9, 1993)

DECISION

The decision of the Board is affirmed in accordance with the foregoing opinion.

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

Date: 11/16/10 /s

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