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Refer to: 07-0916

FEB 05 2014

CERTIFIED MAIL

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RE: Jurisdictional Challenge – St. Luke's Hospital
Provider No.: 05-0055
FYE: 12/31/2003
PRRB Case No.: 07-0916

Dear Mr. Jaeger 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

St. Luke's Hospital was issued an original Notice of Program Reimbursement (NPR) for FYE 12/31/2003 on August 18, 2006. On February 7, 2007, the Provider filed an appeal request with the Board appealing two issues: DSH Calculation – Medicare SSI Percentage, which was transferred to case number 09-1528GC on December 28, 2009; and DSH Calculation, Medicare/Medicaid Dual Eligible Patient Days, which was transferred to case number 10-0424GC on April 5, 2010.

On August 15, 2008, the Provider requested to add the Rural Floor Budget Neutrality Adjustment Factor issue to its appeal and on October 28, 2011, the Provider requested to transfer this issue to case number 09-0568GC. The Provider requested to add the Intern and Resident IME and GME FTEs and the Medicare SSI Realignment Component, both of which are pending in this appeal, on August 21, 2008 and October 15, 2008, respectively. Finally, on October 14, 2008, the Provider requested to add the Medicare Unbilled Crossover Bad Debts issue to this appeal. On March 26, 2009, the Provider requested to transfer the Inpatient bad debts to case number 02-2168G and the outpatient bad debts to case number 99-3524G.

The Intermediary filed a jurisdictional challenge with the Board on July 18, 2013, to which the Provider responded on October 17, 2013.

Intermediary's Position:

The Intermediary is challenging jurisdiction over the Provider's Intern and Resident IME and GME FTE issue. The Intermediary argues that this issue is an unclaimed cost over which the Board does not have jurisdiction. The Intermediary asserts that the Provider did not preserve its right to claim dissatisfaction with the amount of Medicare payment for the specific items as required by 42 C.F.R. § 405.1835(a)(1), therefore the Board does not have jurisdiction over the issue. The Intermediary argues that the FTEs being requested were omitted from the as-filed cost report, and that they were not identified at the time of the audit, therefore they are unclaimed costs over which the Board does not have jurisdiction.

Provider's Position

The Provider states that it inadvertently omitted the IME and GME FTEs in its cost report for fiscal year end 2003, and that it is seeking to remedy the error through the appeals process. The Provider argues that the Intermediary has not put forth any substantive arguments about why the error should not be corrected, but rather is relying on a "procedural technicality." The Provider explains that its fiscal year (FY) 2004 and 2005 resident FTEs were carried forward and allowed in the Intermediary's final determination of the FY 2006 cost report, therefore it is just asking that the validated IME and GME FTEs be carried backwards to FY 2003. The Provider contends that the Intermediary is acting as an agent of the Secretary, and that it is acting in bad faith by taking advantage of the known error that the Provider has pointed out.[1]

The Provider responds to the Intermediary's reliance on 42 C.F.R. § 405.1835 by arguing that the Intermediary ignored other applicable statutes that support the Provider's position that the Board should have jurisdiction over this issue. The Provider cites to 42 U.S.C. § 1395oo and emphasizes the phrase that the Board has jurisdiction over issues "even though such matters were not considered by the intermediary in making such a final determination." The Provider also notes that the Intermediary is relying on regulations that only apply to fiscal year ends on or after December 31, 2008; the Provider notes that the fiscal year end at issue here is 2003. The Provider also cites to *Loma Linda University Medical Center v. Leavitt* which the Provider argues stands for the proposition that "the Board acquires jurisdiction under Title 42 of the United States Code (42 U.S.C.) §139500(a) and §139500(d) '*over a dissatisfied Provider's cost report on appeal from the intermediary's final determination...even though that particular expense was not expressly claimed or explicitly considered by the Intermediary.*'"[2]

The Provider concludes that the Board should find it has jurisdiction in this case because the Provider is "merely requesting" that the IME and GME FTE costs be included and the Intermediary has been made aware of the Provider's error in not claiming the costs on its submitted cost reports.

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[1] The Provider references the *Mendenhall* doctrine, which it states stands for the proposition that once a governmental agency is aware of correct facts after an error has been made, the government entity acts in bad faith if it refuses to respond appropriately to those facts. *Mendenhall v. Nat'l Transp. Safety Bd.*, 92 F.3d 871 (9th Cir. 1996).

[2] Provider's Opposition to Intermediary Challenge, at 13 (emphasis added by Provider).

Board's Decision

Issue No. 4: Intern and Resident IME and GME FTEs

Pursuant to 42 U.S.C. § 1395oo(a) (2005) and 42 C.F.R. §§ 405.1835-405.1840 (2005), a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider. The Board has *discretionary power* under 42 U.S.C § 1395oo(d) after jurisdiction is established under 42 U.S.C. § 1395oo(a) to make a determination over all matters covered by the cost report. The Board can affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and make any other revisions on matters covered by the cost report even though such matters were not considered by the Intermediary in making its final determination.

The operation of the jurisdictional gateway established by 42 U.S.C § 1395oo(a) was addressed by the Supreme Court in the case of *Bethesda Hospital Association v. Bowen,* 485 U.S. 399 (1988). The narrow facts of *Bethesda* dealt with the self-disallowed apportionment of malpractice insurance costs.[3] The provider failed to claim the cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court stated:

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

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

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

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[3] 485 U.S. at 401-402.
[4] *Id.* at 404.
[5] *Id.* at 404-405 (emphasis added).

While the Supreme Court has not had an opportunity to squarely address whether the Board *must* take jurisdiction of an appeal of a cost that was unclaimed through inadvertence rather than futility (e.g., a law, regulation, CMS Ruling, or manual provision actually precludes reimbursement), other appellate courts have. However, there is a split among the circuit courts that have addressed the issue of unclaimed or self-disallowed costs since the *Bethesda* decision was issued.[6]

The Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile.[7] In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[8]

The Ninth Circuit addressed this issue in the case of *Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007). In this case, the provider had inadvertently zeroed out reimbursable interest expense in the cost report and filed it without any claim for reimbursement. The intermediary issued its NPR without any adjustments for interest expense. The provider then appealed to the Board and identified six aspects of the Intermediary's final determination with which it was dissatisfied (not including the zeroed out interest expense). When it later discovered its interest error, the provider added the interest expense issue to its pending appeal. The Ninth Circuit found:

> We conclude that once the Board acquires jurisdiction pursuant to 42 U.S.C. § 1395oo(a) over a dissatisfied provider's cost report on appeal from the intermediary's final determination of total reimbursement due for a covered year, it has discretion under § 1395oo(d) to decide whether to order reimbursement of a cost or expense . . . even though that particular expense was not expressly claimed or explicitly considered by the intermediary.[9]

The holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[10] The Ninth Circuit stated that it was joining the First Circuit's view as expressed in *Maine General Med. Ctr. v. Shalala*, 205 F.3d

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[6] *Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d 1065 (9th Cir. 2007); *MaineGeneral Med. Ctr. v. Shalala* 205 F.3d 493 (1st Cir. 2000); *UMDNJ-Univ. Hosp. v. Leavitt,* 539 F. Supp. 2d 70 (D.D.C. 2008), *appeal dismissed sub nom, UMDNJ-Univ. Hosp. v. Johnson,* 2009 WL 412888 (Feb. 5, 2009); *Little Company of Mary Hosp. v. Shalala,* 24 F.3d 984 (7th Cir. 1994).

[7] *See Little Company of Mary Hosp. v. Shalala,* 24 F.3d 984 (7th Cir. 1994); *See also Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999) (Little Co. II).

[8] *See MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000); *Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007).

[9] *Loma Linda,* 492 F.3d at 1068.

[10] *See* 73 Fed. Reg. 30190, 30197 (May 23, 2008).

493 (1st Cir. 2000) and *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).[11] Similarly to the Ninth Circuit, the D.C. District Court interpreted § 1395oo(a) as requiring only general dissatisfaction with the amount of total reimbursement on the NPR in order to establish Board jurisdiction under § 1395oo(a).[12]

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

Historically, the Board's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*,[13] requiring that dissatisfaction be expressed with respect to the total reimbursement for "each claim" (as opposed to a general dissatisfaction to the total reimbursement on the NPR) because the Board has viewed the NPR as being comprised of many individual determinations on various items for which the provider has sought payment in the as-filed cost report.[14]

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. 01-0320 (November 7, 2002) at 3, (finding the Board lacked jurisdiction where the provider failed to claim bad debts on a cost report); *Mercy Hospital Miami FL v. BlueCross BlueShield Ass'n,* PRRB Decision No. 2010-D4 (March 11, 2010) at 10, (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"); and *St. Vincent Hospital & Health Center vs. BlueCross BlueShield Ass'n*, PRRB Decision No. 2013-D39 (September, 13 2013) at 8, (finding the Board lacked jurisdiction over unclaimed Ambulatory Surgery Costs and Organ Acquisition Costs not claimed on the cost report). 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 reiterated that only when the provider has established jurisdiction

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[11] *Loma Linda*, 492 F.3d at 1068.
[12] *See UMDNJ Univ. Hosp. v. Leavitt*, 539 F. Supp. 2d 70, 77 (D.D.C. 2008).
[13] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F. Supp. 2d 70, 77 (D.D.C. 2008)
[14] *See, e.g., Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* PRRB Rule Rule 7; 73 Fed. Reg. at 30197.

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).[15]

In the instant case, it is undisputed that the Provider did not include the IME and GME FTEs in its cost report for FY 2003, because the Provider states in its Opposition to Intermediary Challenge that it inadvertently omitted those costs. Part of the Provider's argument is that it forgot to include these costs on its cost report, and that this appeals process is its way of remedying that mistake. The Provider does not argue that there was a statutory, regulatory, or manual provision that prevented it from claiming the IME and GME FTEs on its cost report, but rather focuses on jurisdictional arguments. Since the Provider did not claim the IME and GME FTEs on its cost report, the Intermediary has not made a determination with respect to those costs. Thus, the Board finds that it lacks jurisdiction over the IME and GME FTEs issue pursuant to 42 U.S.C. § 1395oo(a).

Because the Provider has a jurisdictionally proper appeal pending on other matters in the appeal, under 42 U.S.C. § 1395oo(d) the Board has the discretion to make any revision to matters covered by the cost report even though such matters were not considered in the Intermediary's final determination. The Board chooses not to exercise its discretion under 42 U.S.C. § 1395oo(d) over the IME and GME FTEs issue since reimbursement of the cost was not precluded by statute, regulation, or a manual provision but was a result of the Provider neglecting to include the issue on the cost report. The Board therefore dismisses the Intern and Resident IME and GME FTE issue from the appeal.

Issue No. 5: Medicare SSI Percentage Realignment

Although the Intermediary did not challenge jurisdiction over the SSI realignment issue, the Board nonetheless finds that it does not have jurisdiction over this issue. 42 C.F.R. § 405.1835 (2007) 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 . . . .

The Provider stated in its issue statement, "the Provider is requesting the MEDPAR data underlying its SSI Percentage and after reviewing this data **will decide whether to request a realignment** of its SSI Percentage" (emphasis added). The Intermediary has not made a final determination with respect to the realignment of the SSI percentage; therefore, the Board finds that it does not have jurisdiction over the SSI realignment issue pursuant to 42 C.F.R. § 405.1835 and hereby dismisses it from this appeal.

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[15] *Id.* at 15.

Conclusion

The Board hereby dismisses the Intern and Resident IME and GME FTEs and the SSI Realignment issues from case number 07-0916. As these were the last two remaining issues in case number 07-0916, the case is hereby closed.

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 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

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RE: Jurisdiction Determination for:
Methodist Hospital of Sacramento (05-0590), FYE 12/31/1996, participant #6 and
Mercy Medical Center Redding (05-0280), FYE 6/30/1996, participant #11
As participants in the CHW 1996 SSI Ratio Group, PRRB Case No.: 06-0028GC

Dear Mr. Knight & Ms. Kalafut:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and on its own motion noted jurisdictional impediments. The jurisdictional determination of the Board is set forth below.

Background

The Providers filed an initial request for a group appeal on October 11, 2005. The sole issue in the group is the SSI Percentage which is covered under CMS Ruling 1498-R. The Group Representative initially requested a remand pursuant to the Ruling under the alternative procedure, which the Board denied on April 1, 2013 because the request did not contain the associated jurisdictional documentation required. Subsequently on October 17, 2013 the Group Representative filed the Schedule of Providers with supporting jurisdictional documentation.

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 Methodist Hospital of Sacramento (participant #6) and Mercy Medical Center Redding (participant #11) because these Providers are appealing from revised NPRs which did not specifically adjust the SSI percentage issue.

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).

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:

> 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 42 C.F.R. §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

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.

With regard to Methodist Hospital of Sacramento, the Board finds that there was no adjustment on Worksheet E, Part A, Line 4, which is the distinct line for the SSI Ratio for FYEs 9/30/1996 and 12/31/1996. Further, the Board finds that the Provider's request to transfer into the subject group appeal was filed on November 11, 2005. The individual appeal from which the transfer was being requested (case no. 05-1478), however, was dismissed by the Board on September 19, 2005. Therefore, the Board hereby dismisses this participant from the group appeal.

With regard to Mercy Medical Center Redding, (participant #11) the Board finds that the Provider's revised NPR was issued

> "To Reopen the Disproportionate Share Hospital payment in accordance with the Mandamus Action settlement agreement issued by the Office of General Counsel."

Since the Mandamus Act was limited to unpaid Medicaid eligible days pursuant to HCFAR 97-2, it is unlikely the SSI Percentage was adjusted. Further, the Group Representative did not supply workpapers as required in the Board's Rules issued on March 1, 2013, so it cannot be determined that the SSI Percentage was adjusted. Because appeals from revised NPRs are limited to the specific matters revised in the revised determination, the Board

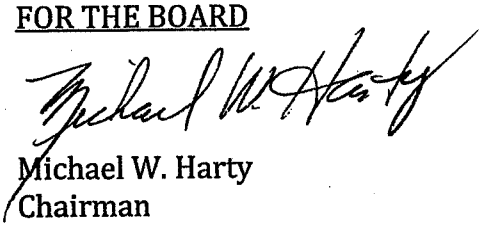
finds that it does not have jurisdiction over Mercy Medical Center Redding because there was no evidence that SSI percentage was actually adjusted.

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.

The remaining participants in the group appeal are subject to remand pursuant to CMS Ruling 1498-R. Enclosed, please find the Board's remand under the standard procedure.

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: Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R
Schedule of Providers
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BC BS Association (w/enclosures)

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RE: Request for Case Bifurcation – Toyon 1998 DSH Dual Eligible Days Group #2
Provider No.: Various
FYE: Various
PRRB Case No.: 07-1426G

Dear Mr. Bunting and Ms. Kalafut,

The Provider Reimbursement Review Board (Board) has reviewed the above-referenced appeal in response to the Providers' Request for Case Bifurcation. The decision of the Board with regard to jurisdiction and the bifurcation request is set forth below.

Background

FORMATION OF GROUP

On March 19, 2007, the Board received the Providers' initial request for the establishment of a group appeal for the Toyon 1998 DSH Dual Eligible Days #2 Group. The same Providers that were part of the original appeal request for this case remain the only two Providers in the appeal. The Providers identified the following issue statement:

> *Whether the Medicaid Ratio used to calculate Medicare Disproportionate Share Payments. (DSH) accurately reflects the number of patient days furnished to patients eligible for Medicaid in situations where the patient is also enrolled in the Medicare Part A Program but is not entitled to Medicare Part A benefits?*[1]

In the same correspondence, the Providers went on to explain:

> We contend that the number of Medicaid eligible patient days used in the DSH calculation are understated due to exclusion of various categories of Medicaid eligible patients who enrolled in Medicare Part A but are not

[1] *See* Providers' Establishment of Group Appeal, received by the Board on March 19, 2007.

entitled to Medicare Part A benefits.[2]

Alta Bates Medical Center included the Dual Eligible Days issue in its appeal request dated October 10, 2006. The Provider used the following language:

> The Provider contends that certain dual eligible Medicare/Medicaid patient days should have been included in the disproportionate share entitlement calculation. The patient days pertaining to Medicaid eligible patients whose Part A benefits were exhausted or had no Medicare Part A paid claim should be included in the Medicaid eligible days used to calculate the disproportionate share amount. These days should be included because they are excluded from the calculation of the Medicare SSI ratio.

Alta Bates was part of the original appeal request for case number 07-1426G, for which the language is quoted above. Stanford University Hospital did not include the Dual Eligible Days issue in its individual appeal request and did not include a letter requesting that this issue be added to its appeal. Stanford University Hospital was also included in the original appeal request for this group appeal, and because that request was submitted prior to the new Board rules that went into effect on August 21, 2008, limiting the ability to add issues, the Board deems the letter as the "add" and transfer letter.[3]

JURISDICTION

Alta Bates Medical Center filed its appeal from a revised Notice of Program Reimbursement (NPR) dated September 28, 2001. In its appeal request, the Provider included the Dual Eligible Days issue, quoted above, referencing adjustment numbers R4-003 and R4-006. The audit adjustment pages submitted at tab 1D reflect that adjustment R4-003 is for Hospital Adults & Peds – "To adjust the Medicaid Eligible and Total Patient Days as per audit findings." Adjustment R4-006 is for Allowable DSH "To revise the Allowable Disproportionate Share Percentage as per audit findings." It includes a memo adjustment which indicates "The Capital DSH payment will be revised on W/S L Part 1 of the cost report as flow through."

Providers' Position

On December 21, 2012, the Providers' Representative, Toyon Associates, Inc., submitted a request that the Board bifurcate a number of dual eligible day group appeals that were pending before the Board. Toyon argues that the dual eligible day group appeals in fact cover two issues: Part C days[4] and other Part A dual-eligible non-covered patient days. Toyon explains that in light of CMS Ruling 1498-R, the Part C days at issue need to be in separate appeals from the

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[2] *Id.*

[3] *See* 73 Fed. Reg. 30,236 (May 23, 2008).

[4] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

other Part A dual eligible non-covered patient days at issue, because the Part C days are not subject to the remand.

Intermediary's Position

The Intermediary did not file a response to Toyon's request to bifurcate the dual eligible day appeals.

Board's Decision

JURISDICTION

The Board finds that it does not have jurisdiction over Alta Bates because it appealed from a revised NPR that did not specifically adjust either dual eligible or HMO days.

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).[5]

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).

Pursuant to 42 C.F.R. § 405.1885(c), jurisdiction to reopen an intermediary determination rests exclusively with the intermediary. Further, 42 C.F.R. § 405.1885(a) (6) states that a determination or decision to reopen or not to reopen a determination is not a final determination within the meaning of Subpart R of Title 42 and is not subject to further administrative or judicial review.[6]

Additionally, for revised Notices of Program Reimbursement, the regulation that was in effect when the revised NPR was 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 §§

[5] 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1841.
[6] *See also Your Home Visiting Nurse Services, Inc. v. Shalala,* 119 S.Ct. 930 (1999).

405.1811, 405.1835, 405.1875 and 405.1877 are applicable.[7]

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.

There is nothing in the record that indicates that dual eligible or HMO days were adjusted in the revised NPR for Alta Bates. In fact, the revised NPR indicates that the reopening was for DSH Medicaid eligible days and Inpatient Part B 5.8% reduction – not dual eligible days or HMO days. As there was no specific adjustment to either issue, the Board finds that it does not have jurisdiction over Alta Bates Medical Center and dismisses the Provider from case number 07-1426G.

BIFURCATION OF THE DUAL ELIGIBLE DAYS ISSUE

Because Alta Bates Medical Center is dismissed as a Provider in case number 07-1426G as of the date of this letter, the Board declines to bifurcate the HMO days as a separate and distinct issue from the dual eligible days issue for this Provider.

The Board's jurisdictional determination related to Alta Bates leaves only one Provider remaining in case number 07-1426G, which does not meet the Board requirements for a group appeal.[8] Therefore, the Board hereby transfers Stanford University Hospital to case number 04-1729G. The Provider will **not** be a participant in the appeal bifurcated from case number 04-1729G (Toyon 1998 DSH HMO Days Group, case number 14-2046G) because it did not appeal, add, or transfer the HMO days issue. Case number 07-1426G is hereby closed as no Providers remain pending 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
Schedule of Providers dated March 10, 2010

cc: Kevin D. Shanklin, BCBSA

[7] 42 C.F.R. § 405.1889 (1998) (amended 2008).
[8] PRRB Rule 12.5.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview Phone: 410-786-2671

Refer to: 14-0662

FEB 12 2014

CERTIFIED MAIL

Community Health Systems, Inc.
Larry M. Carlton, CPA
Senior Vice President
4000 Meridian Boulevard
Franklin, TN 37067

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

RE: Jurisdictional Challenge – Northeast Regional Medical Center
Provider No.: 26-0022
FYE: 5/31/2010
PRRB Case No.: 14-0662

Dear Mr. Carlton 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

Northeast Regional Medical Center was issued an original Notice of Program Reimbursement (NPR) for FYE 5/31/2010 on May 8, 2013. On November 12, 2013, the Provider filed an appeal request with the Board appealing two issues: Inclusion of Rural Health Clinic (RHC) "per visit" limitation in the cost report for a sole community provider that does not exceed 50 beds; and Indirect Medical Education (IME) calculation for a Sole Community Hospital (SCH) whose Hospital Specific Rate (HSR) exceeds the federal rate.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

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

42 C.F.R. § 405.1835(a)(3)(i) states,

> (3) Unless the provider qualifies for a good cause extension[...], the date of the receipt by the Board of the provider's hearing request is-
>
> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of a NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

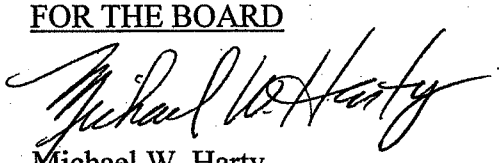
Northeast Regional Medical Center was issued its NPR on May 8, 2013 and presumed to have received it on May 13, 2013. The Provider did not present evidence that the NPR was received later than the five day presumption. An appeal request from this original NPR was delivered by FedEx and received by the Board on November 12, 2013. Thus, the date of filing was 183 days after the presumed date of receipt of the determination from the Intermediary.

Because the appeal request was not received by the Board within 180 days as required by 42 C.F.R. § 405.1835, the Board finds that it was not timely filed. The Board hereby dismisses the appeal and case number 14-0662 is closed.

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 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

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Refer to: 14-0663

CERTIFIED MAIL

FEB 12 2014

Community Health Systems, Inc.
Larry M. Carlton, CPA
Senior Vice President
4000 Meridian Boulevard
Franklin, TN 37067

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

RE: Jurisdictional Challenge – Porter Memorial Hospital
Provider No.: 15-0035
FYE: 12/31/2009
PRRB Case No.: 14-0663

Dear Mr. Carlton 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

Porter Memorial Hospital was issued an original Notice of Program Reimbursement (NPR) for FYE 12/31/2009 on May 10, 2013. On November 12, 2013, the Provider filed an appeal request with the Board appealing the following issue: Failure to include paramedical education costs in the cost report.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

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

42 C.F.R. § 405.1835(a)(3)(i) states,

> (3) Unless the provider qualifies for a good cause extension[...], the date of the receipt by the Board of the provider's hearing request is-
>
> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of a NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

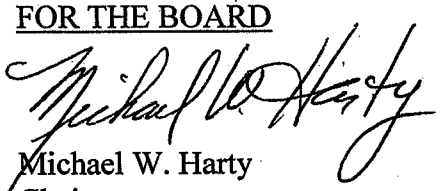
Porter Memorial Hospital was issued its NPR on May 10, 2013 and presumed to have received it on May 15, 2013. The Provider did not present evidence that the NPR was received later than the five day presumption. An appeal request from this original NPR was delivered by FedEx and received by the Board on November 12, 2013. Thus, the date of filing was 181 days after the presumed date of receipt of the determination from the Intermediary.

Because the appeal request was not received by the Board within 180 days as required by 42 C.F.R. § 405.1835, the Board finds that it was not timely filed. The Board hereby dismisses the appeal and case number 14-0663 is closed.

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 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

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Refer to: 13-0103GC

CERTIFIED MAIL **FEB 19 2014**

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

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

RE: Jurisdiction Decision – Adventist Health System/Sunbelt 1987-2000 SSI CIRP Group
Provider No.: Various (*Specifically* Metroplex Hospital, Provider no. 45-0152, FYE 9/30/1996)
FYE: Various
PRRB Case No.: 13-0103GC

Dear Ms. Erde and Mr. Pike,

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

Background

Case number 13-0103GC was broken out from case number 96-1699G, which was established on March 25, 1996. On April 27, 2012, the Providers' representative notified the Board that case number 96-1699G included Common Issue Related Party (CIRP) and non-CIRP Providers, and requested that a new appeal be established for the CIRP Providers. As a result, the Board established this group appeal on November 28, 2012.

Provider number 65 on the Schedule of Providers, Metroplex Hospital for FYE 9/30/1996, requested to be added directly to case number 96-1699G on January 25, 2000. This letter indicates that the Notice of Program Reimbursement (NPR) was issued on June 20, 1997. The Providers' representative indicated in a letter dated May 6, 2013, that it was not able to locate this NPR. Through its own research the Board has not been able to confirm this date. The Board has determined that the original NPR for Metroplex Hospital was issued on September 29, 2005 and revised NPRs were issued on September 15, 2006 and November 29, 2006.

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.**[1]

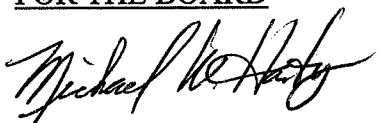
The Board finds that it does not have jurisdiction over Metroplex Hospital for FYE 9/30/1996 because the Provider did not submit documentation to establish that it timely filed its appeal. If the NPR was issued on June 20, 1997, as indicated in the Provider's request to be directly added to case number 96-1699G, the appeal would have been filed 949 days after the NPR was issued. If the NPR was issued on September 29, 2005, then the appeal request would have been premature as it would have been filed prior to the issuance of the Provider's NPR.

The Board finds that it does not have jurisdiction over Metroplex Hospital for FYE 9/30/1996 because the Provider failed to submit documentation to establish that its appeal was timely filed and hereby dismisses the Provider as a participant in case number 13-0103GC.

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

[1] Emphasis added.

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Refer to:

FEB 19 2014

14-1913GC
Certified Mail

Christopher L. Keough, Esq.
Akin, Gump, Strauss, Hauer & Feld
Robert S. Strauss Building
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: Shands HealthCare 2014 PPS Rate Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-1913GC

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 23, 2014 request for hearing appealing the August 19, 2013 Federal Register[1] and January 24, 2014 request for expedited judicial review (EJR) (both documents were received on January 24, 2014). The Board's determination with respect to the request for EJR is set forth below.

Issues

The Providers are seeking a correction of their Medicare payment rates per discharge for operating and capital related costs of inpatient services furnished during FFY 2014. In the final inpatient prospective payment system (IPPS) rule for FFY 2014 the Secretary effected a 0.2% reduction to the standardized amount[2] paid for operating costs under IPPS, the hospital specific rates for some sole community hospitals and Medicare dependent hospitals[3] and the Federal rate

[1] *See District of Columbia Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare and Medicaid Guide (CCH)* ¶ 41,025 (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

[2] The standardized amount is the sum of: (1) a labor component which represents labor cost variations among different areas of the country and (2) a non-labor component which represents a geographic calculation based on whether the hospital is located in a large urban or other area. The labor component is then adjusted by the wage index. *See* "Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated" (CMS Office of the Inspector General Report OEI-09-00-00200, August 2001) on the internet at http://oig.hhs.gov/oei/reports/oei-09-00-00200.pdf.

[3] Although payments to most hospitals under IPPS are made on the basis of the standardized amounts, some categories of hospitals are paid in whole or in part based on their hospital specific rate, which is determined from their costs in a base year. Sole community hospitals (SCHs) receive payment on the higher of the hospital specific rate based on their updated costs in a base year (the highest of FY 1982, FYE 1987, FY1996, or FY 2006) or the IPPS Federal rate based on their standardized amount whichever yields the greatest payment. Medicare dependent hospitals (MDHs) received the higher of the Federal rate or the Federal rate plus 50% of the amount by which the Federal rate is exceeded by the higher of its FY 1982 or FY 1987 hospital-specific rate. For discharges occurring on or after October 1, 2007, but before October 1, 2013, a MDH would receive the higher of the Federal rate or the Federal rate plus 75% of the amount by which the Federal rate is exceeded by the highest of its FY 1982, FY 1987

for capital costs.[4,5] The Secretary applied this reduction to the payment rates in connection with CMS' adoption of a policy known as the "2-midnight rule." The Providers believe that the payment rate reduction should be set aside because it exceeds the Secretary's statutory authority under the prospective payment statute, 42 U.S.C. §§ 1395ww(d) and 1395ww(g), is contrary to the plain language and intent of the statute, and is arbitrary, capricious, not based upon substantial evidence, and otherwise contrary to the law. *See* 5 U.S.C. § 706.

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS rule[6] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[7]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because a Medicare review contractor determines that the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). Centers for Medicare & Medicaid Services (CMS) has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[8]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise Part B inpatient payment policy to allow payment under Part B for all hospital services that furnished and were reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within 1 year from the date of service).[9]

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or FY 2002 hospital-specific rate. *See* 78 Fed. Reg. 50496, 50509 and 50987 (August 19, 2013). The MDH provision was to expire on 9/30/2013; however, the Bipartisan Budget Act of 2013, P.L. 113-67, § 1106 amended 42 U.S.C. § 1395ww(d)(5)(G), extended the deadline to April 1, 2014.

[4] *See* 78 Fed. Reg. 50496, 50746-54 (August 19, 2013).

[5] More specifically see 78 Fed. Reg. at 50949 (The Secretary believes that *all* hospitals, LTCHs and CAHs, with the exception of IRFs, would appropriately be included in our final polices regarding the 2-midnight admission guidance and medical review criteria for determining the general appropriateness of inpatient admission and Part A payment. (emphasis added)).

[6] 77 Fed. Reg. 45061, 45155-45157 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68,210, 68426-68433 (November 15, 2012).

[7] *78 Fed. Reg.* at 50907.

[8] *Id.*

[9] *Id.*

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[10] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., they should order admission for patients who are expected to need care for 24 hours or overnight. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, whether or not there is a later transfer or discharge and the patient is not present overnight. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the basis for payment and it is the physician responsible for patient care who decides if the patient should be admitted.[11]

In the Federal fiscal year (FFY) 2014 IPPS proposed rule[12] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[13]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of cases in which hospitals had appealed Part A inpatient claim denials in which it was determined the inpatient admission was not reasonable or necessary. These claims had received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, but the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decision effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, these payments were made whether the subsequent hospital claim for payment was made within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permit billing only for a limited list of Part B inpatient services and require the services be billed within specific timeframes.[14]

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[10] Chapter 6, §20.6 and Chapter 1, §10.
[11] 78 Fed. Reg. at 50907-08.
[12] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[13] 78 Fed. Reg. 50908.
[14] *Id.*

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[15] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "proposed rule CMS-1455-P." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[16] The one-year deadline for filing claims remains unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. § 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[17]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized that there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[18]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[19] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[20]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS [outpatient PPS] to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000

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[15] *See* 78 Fed. Reg. 16614 (March 18, 2013) and on the internet at http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[16] 78 Fed. Reg. at 50909.
[17] *Id.* at 50927.
[18] *Id.* at 50944.
[19] *Id.*
[20] *Id.* at 50945.

encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[21] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[22]

Providers' Request for EJR

The Providers request that the Board grant EJR with respect to the correction of their Medicare payment rates per discharge for operating and capital-related costs of IPPS services furnished in FFY 2014 relative to the 2-midnight rule. The Providers are not contesting the coverage change, but contend that, even if the coverage change is appropriate, the payment reduction should be set aside because it exceeds the Secretary's statutory authority under the PPS statute,[23] is contrary to the plain language and intent of the statue, and is arbitrary, capricious, not based on substantial evidence, and otherwise contrary to the law. *See* 5 U.S.C. § 706.

Background

Under both inpatient and capital PPS, Medicare pays prospectively-established rates for each patient case. In addition to a base payment rate per discharge, payment adjustments are provided for extraordinary costly "outlier" cases, indirect medical education costs and costs for treating a disproportionate share of low-income patients. 42 U.S.C. § 1395ww(d).

Under PPS for operating costs, the payment per discharge is the product of the national payment rate, called the standardized amount, a "wage index" value reflecting labor costs in each hospital's area relative to a national average, and a weighting for the diagnosis related group (DRG) assigned to the patient's illness or condition for that discharge. The statute prescribes the calculation of the base rate—the standardized amount—in precise detail, specifically detailing what the rate "is equal to" for a fiscal year based on specific, precisely defined determination that the Secretary "shall" make. 42 U.S.C. § 1395ww(d)(1) (the capital PPS amount is similarly based on a Federal payment per discharge that is established in 42 U.S.C. § 1395ww(g)).

The standard payment rate is subject to several upward payment adjustments and exceptions for special cases that are extraordinary costly (outliers) and for particular categories of hospitals that reasonably incur high than average costs per case (for example, graduate medical education and

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[21] *Id.* at 50952-53.
[22] *Id.* at 50990.
[23] 42 U.S.C. §§ 1395ww(d) (inpatient PPS),1395ww(g) (capital PPS).

disproportionate share hospitals). In addition, the statute exempts some types of hospitals (sole community and Medicare dependent hospitals) from the standard payment rate so they may receive greater payment based on their own "hospital-specific" cost per discharge. 42 U.S.C. §§ 1395ww(d)(5)(D) & (G). The statute also grants the Secretary authority to establish other appropriate adjustments and exceptions by regulations. 42 U.S.C. § 1395ww(d)(5)(I). Congress enacted that provision to permit additional adjustments and exceptions, for special cases or discrete types of hospitals with special circumstances to ensure payment equity in the IPPS payment system. *See* H.R. Rep. No 98-47, 195 (1983 (Conf. Rep.) *reprinted in* 1983 U.S.C.C.A.N. 404, 485.

The 0.2% Payment Rate Reduction

The Providers believe that the 0.2% reduction exceeds the Secretary's authority. The statute precisely prescribes the calculation of the standardized amount for operating costs, 42 U.S.C. §§ 1395ww(d)(1), (3)., the federal rate for capital costs, *id.* § 1395ww(g), and the hospital specific rates for sole community and Medicare dependent hospitals, *id.* § 1395ww(d)(5)(D) and (G), and those provisions do not provide or allow for the Secretary's 0.2% reduction. The 0.2% reduction also exceeds the Secretary's authority to adopt additional adjustments and exceptions under section 1395ww(d)(5)(I), and violates the language and intent of that provision and the IPPS statute as a whole. 42 U.S.C. §§ 1395ww(d).

The Providers believe the 0.2% reduction is also arbitrary and capricious, and is not a reasonable interpretation of the statute because it constitutes an unacknowledged and unexplained departure from the Secretary's prior, more limited application of the adjustments and exceptions authority under section 1395ww(d)(5)(I). The Secretary has never before interpreted that section to effect a global payment rate reduction that applies across the board to all cases, all types of hospitals, and to both prospective payment rates for operating and capital costs as well as the hospital-specific rate for exception hospitals

Further, the Providers do not believe the Secretary provided an adequate explanation of a justification for the across the Board reduction in the payment rate per discharge. They do not believe there is an adequate explanation for the 0.2% reduction. In particular, the Providers do not believe the Secretary has adequately explained how the agency derived the estimates that were used to calculate the 0.2% reduction.

Since the Board lacks the authority to grant the relief sought—elimination of the 0.2% reduction— the Providers request that the Board grant the request for EJR.

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the requests for hearing and expedited judicial review. The documentation shows that the estimated amount in controversy for the appeal exceeds $50,000, as required for a group appeal. The estimated amount in controversy is subject to recalculation by the Medicare Administrative Contractor for the actual final amount.

The Board finds that:

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

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount, the hospital specific rate for some SCH and MDH hospitals and Federal rate of capital cost issues, there are no findings of fact for resolution by the Board;

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

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for some SCH and MDH hospitals, and Federal rate of capital cost issues, is valid.

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

Board Members Participating

Michael W. Harty
John Gary Blowers, 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. § 405.1877 and 405.1877
Schedule of Providers

cc: Geoff Pike, First Coast Services Options (w/Schedule of Providers)
Kevin Shanklin, BCBSA (w/Schedule of Providers)

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Phone: 410-786-2671

Refer to: 14-0265GC

FEB 19 2014

CERTIFIED MAIL

WellStar Health System
Ebenezer Erzuah
Director of Reimbursement
805 Sandy Plains Road
Marietta, GA 30066

Cahaba GBA, LLC
Renee Rhone
Senior Auditor/Appeals Specialist
1206 Pointe Centre Drive, Suite 240
Chattanooga, TN 37421

RE: WellStar Health System 2008 Allina SSI
Provider No.: 11-0035, 11-0143
FYE: 06/30/2008
PRRB Case No.: 14-0265GC

Dear Ebenezer Erzuah and Renee Rhone,

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

Cobb Hospital and Medical Center was issued an original Notice of Program Reimbursement (NPR) for FYE 06/30/2008 on February 12, 2013. Likewise, Kennestone Hospital was issued an original NPR for FYE 06/30/2008 on February 19, 2013. Rather than filing individual appeal requests, the Providers both filed their initial appeals as part of the request for a mandatory group appeal. Cahaba GBA (the MAC) received the Providers' appeal request on August 9, 2013. However, the Provider's appeal request was not filed with the Board until November 6, 2013. In their request, the Providers appealed one issue: DSH – Inclusion of Medicare Advantage days in the SSI ratio.

MAC's Position

The MAC's 30 day jurisdictional review was received by the Board on November 20, 2013. In it, the MAC contended that the Providers were actually appealing two separate issues: DSH – Inclusion of Medicare Advantage days in the SSI ratio, and DSH – Exclusion of Medicare Advantage days in the Medicaid fraction.

Providers' Position

Along with their request for group appeal dated August 5, 2013, the Providers included a cover letter dated November 4, 2013 with an explanation for the late filing and a request for an exception to the 180 day rule. The Providers stated that both copies of their appeal were

accidentally mailed to the MAC rather than the Board, and enclosed a copy of the FEDEX receipt slip showing receipt by the MAC on August 9, 2013.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the receipt of the final determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary's jurisdictional challenge was limited to the question of whether the Providers were actually appealing two separate issues and did not address the issue of timeliness, the Board nonetheless finds that it does not have jurisdiction over this appeal because it was not timely filed. Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB rules, an appeal must be filed with the Board no later than 180 days after the provider has received its final determination.

42 C.F.R. § 405.1835(a)(3)(i) states,

> (3) Unless the provider qualifies for a good cause extension[...], the date of the receipt by the Board of the provider's hearing request is-
>
> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

Cobb Hospital and Medical Center was issued its NPR on February 12, 2013 and presumed to have received it on February 17, 2013. Kennestone Hospital was issued its NPR on February 19, 2013 and presumed to have received it on February 24, 2013. Neither Provider presented evidence that its NPR was received later than the five day presumption. A mandatory group appeal request from the original NPRs was delivered by FedEx and received by the Board on November 6, 2013. Thus, the dates of filing were 262 and 255 days after the presumed dates of receipt of the determinations from the Intermediary, respectively.

Because the appeal requests were not received by the Board within 180 days as required by 42 C.F.R. § 405.1835, the Board finds that neither of the appeal requests were timely filed. Pursuant to 42 C.F.R. § 405.1836, the Board must dismiss untimely hearing requests, except that it may

grant an extension of the 180 day time limit upon a showing of good cause for the late filing by the Provider.

42 C.F.R. § 405.1836(b) states, in pertinent part:

> (b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it can not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit .... .

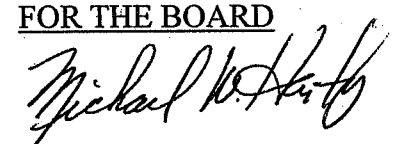
The Board finds that the Providers neither showed that their untimely filing was due to "extraordinary circumstances beyond [their] control" nor, considering the circumstances, submitted their request for an extension within a reasonable time. Administrative errors are neither extraordinary nor beyond the Providers' control, and therefore are not within the scope of circumstances contemplated by 42 C.F.R. § 405.1836(b). Furthermore, even if a mailing error were to potentially qualify as a good cause for late filing, the Providers' request for an extension was not received by the Board until November 6, 2013, at which time the 180 day time limit for the hearing requests from Cobb Hospital and Medical Center and Kennestone Hospital had expired 82 and 75 days earlier, respectively. Therefore, the Board finds that the Providers' request for an extension was not received within a reasonable time under the circumstances.

The Board finds that the Providers failed to demonstrate good cause for an extension of the 180-day time limit. The Board hereby dismisses Cobb Hospital and Medical Center and Kennestone Hospital from the group appeal. Since there are no remaining providers in the group, case number 14-0265GC is closed.

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 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

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Refer to: 14-0965

CERTIFIED MAIL

FEB 19 2014

Centura Health
Doug Lemieux
Director of Reimbursement
188 Inverness Drive West, Suite 500
Englewood, CO 80112

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

RE: Penrose/St. Francis Health Services
Provider No.: 06-0031
FYE: 06/30/2009
PRRB Case No.: 14-0965

Dear Doug Lemieux and Timothy 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

Penrose/St. Francis Health Services was issued an original Notice of Program Reimbursement (NPR) for FYE 06/30/2009 on May 20, 2013. On November 22, 2013, the Provider filed an appeal request with the Board appealing two issues: DSH Calculation – Medicaid Eligible Patient Days; and IME Resident to Bed Ratio & FTE Count, both of which remain pending in this appeal.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the receipt of the final determination. Before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

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

42 C.F.R. § 405.1835(a)(3)(i) states,

> (3) Unless the provider qualifies for a good cause extension[...], the date of the receipt by the Board of the provider's hearing request is-
>
> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination.

For mailing purposes, pursuant to 42 C.F.R. § 405.1801(a)(1)(iii) and PRRB Rule 4.3, the date of receipt of an NPR is presumed to be five days after the date of issuance, unless established by a preponderance of the evidence that it was actually received on a later date. Furthermore, 42 C.F.R. § 405.1801(a)(2) establishes that the date of receipt by the Board is the date of delivery where the document is transmitted by a nationally-recognized next-day courier or, alternatively, the date stamped "received" by the reviewing entity where a nationally-recognized next-day courier is not used.

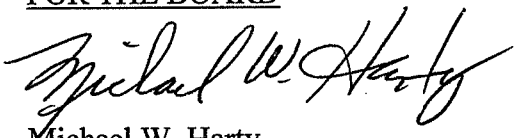
Penrose/St. Francis Health Services was issued its NPR on May 20, 2013 and presumed to have received it on May 25, 2013. The Provider did not present evidence that the NPR was received later than the five day presumption. An appeal request from this original NPR was delivered by FedEx and received by the Board on November 22, 2013. Thus, the date of filing was 181 days after the presumed date of receipt of the determination from the Intermediary.

Because the appeal request was not received by the Board within 180 days as required by 42 C.F.R. § 405.1835, the Board finds that it was not timely filed. The Board hereby dismisses the appeal and case number 14-0965 is closed.

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 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

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FEB 21 2014

Hall, Render, Killian, Heath & Lyman
Neal A. Cooper
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P.O. Box 82064
One American Square
Indianapolis, IN 46282

National Government Services, Inc.
Danene L. Hartley
Appeals Lead
MP INA101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Detroit Riverview Hospital, Provider No. 23-0119, FYEs 6/30/05 & 6/30/06
As a participant in Ascension Health 2004-2007 L&D DSH Group
PRRB Case No. 09-0195G

Dear Mr. Cooper & Ms. Hartley:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal in response to the Group Representative's January 30, 2014 request for reinstatement. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

Ascension Health filed a Labor & Deliver Room Days Group for FYEs 2004-2007 on October 20, 2008.

A remand pursuant to CMS Ruling 1498-R, under the alternative procedure, was requested on September 8, 2010. The Board issued an Alternative Remand letter on November 8, 2010.

On December 31, 2013, the Medicare Administrative Contractor (MAC) issued a remand denial notice for the subject Provider's FYE 6/30/2005. The denial indicates the Provider does not meet the requirements for the remand because the "Medicaid days were not adjusted or protested." The Provider received the same denial letter for its FYE 6/30/2006 on January 2, 2014.

By letter dated January 30, 2014, the Representative requested reinstatement of the group to allow a jurisdictional review of the subject Provider for FYEs 2005 and 2006.

Representative's Position:

The Representative argues that the Intermediary's jurisdictional determination is without merit as the Provider meets the three main jurisdictional requirements for a Provider to

obtain a hearing. Additionally, the Provider argues *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 299 (1988). This case dealt with the Board's authority to hear appeals of matters without their having been included in the cost report or having an adverse intermediary determination.

Board Determination:

The Board hereby reinstates the subject group appeal for the sole purpose of determining jurisdiction over the disputed Provider pursuant to CMS Ruling 1498-R, section 4b.[1]

Further, after reviewing the facts for Detroit Riverview Hospital for FYEs 2005 and 2006 the Board finds its jurisdiction over this Provider is established under 42 U.S.C. §1395oo(a). It provides, in relevant part:

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

DSH is an adjustment to the inpatient prospective payment system (IPPS) payment rates. See, 42 U.S.C. § 1395ww(d)(5)(F)(VI) and 42 C.F.R. § 412.106. The DSH payment is based on whether a hospital meets certain criteria (e.g. number of beds, geographical location) and whether it treats a threshold number of low income patients. Once the hospital meets the threshold eligibility for a DSH adjustment, the amount of the payment grows with the number of low income patients treated. The adjustment is the sum of two fractions, the Medicare and Medicaid fractions. The Medicare fraction (also known as the SSI fraction) utilizes the number of days of inpatient care for Medicare patients who are eligible for Supplemental Security Income (SSI). The Medicaid fraction is derived from inpatient hospital days for patients entitled to medical assistance under Title XIX of the Social Security Act, which established the Medicaid program.

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[1] CMS Ruling 1498-R, Section 4b (April 28, 2010) allows the provider to resume its original appeal of the same claim before the Board, provided the provider submits a written request to the Board requesting to resume the appeal. The Board is then to process the original appeal under the normal appeal procedures.

The Provider did not claim Labor and Delivery Room Days on the cost report because CMS policy precluded it from claiming these days. Before December 1991, an inpatient day for a labor and delivery room (LDR) patient admitted at the census-taking hour was counted for purposes of both the DSH payment adjustment and for allocating costs on a provider's cost report. *See* 74 Fed. Reg. 43754, 43899 (Aug. 27, 2009) ("FY2010 IPPS final rule"). In response to judicial precedent, CMS later revised both its DSH policy and its cost allocation policy by counting LDR inpatient days only if the patient occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. *Id.* at 43899-900. *See also* 42 C.F.R. §412.106(a)(1)(ii)(B) (2005). Therefore, during the period of time in question for this Provider (FYEs 2005 & 2006) the Provider was barred from including patient days for LDR patients that occupied an ancillary LDR bed at the census-taking hour, but had not yet occupied a routine care bed.

Bethesda, dealt with the Board's authority to hear appeals of matters without their having been included in the cost report or having an adverse intermediary determination. In *Bethesda*, the provider failed to claim a cost because a regulation dictated that it would be disallowed. In those circumstances, the Court found the plain meaning of section 1395oo(a) to resolve the question of whether the Board had jurisdiction. It stated:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.* No statute or regulation expressly mandates that *a challenge to the validity of a regulation* be submitted first to the fiscal intermediary. Providers know that, under the statutory scheme, the fiscal intermediary is confined to the mere application of the Secretary's regulations, that the intermediary is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the intermediary to do otherwise would be futile. (emphasis added; footnotes omitted).

Id. at 404.

As in *Bethesda*, the Provider in question in this group was barred by regulation from including specific LDR days in Medicaid days or total days. Because the Provider had no discretion in excluding these days from the DSH computation, the Board finds the appeal of the LDR days from original NPRs to be permissible under 42 U.S.C. § 1395oo(a).

In addition, the Provider meets the other requirements for a standard remand (i.e. it filed a timely request to be directly added to the LDR Days group appeal, included the issue, did not transfer to any other group, meets the amount in controversy, etc.). Therefore, the Board hereby reinstates the group appeal for the purpose of remanding the subject Provider under the standard procedure. Since the other participants have already been

remanded to the MAC under the alternative procedure and Detroit Riverview Hospital for FYEs 2005 and 2006 is subject to CMS Ruling 1498 and is being remanded under the standard procedure, there are no remaining issues to be resolved and the group case is hereby closed.

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

Enclosure: Standard Remand for Detroit Riverview Hospital

cc: Kevin D. Shanklin, Executive Director, BC BS Association (w/enclosure)

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FEB 21 2014

King & Spalding, LLP
Daniel Hettich
1700 Pennsylvania Avenue, NW
Suite 200
Washington DC 20006 2706

RE: The Medical Center, Provider No. 18-0013, FYE 9/30/2008, Case No. 13-1767

Dear Mr. Hettich:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal which was dismissed on January 16, 2014 for the Provider's failure to timely file a preliminary position paper by the January 1, 2014 due date. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Provider filed an appeal on April 30, 2013 from a revised NPR dated November 1, 2012, which included the following issues:

- Medicare Advantage Days in the SSI & Medicaid Ratios
- Dual Eligible Exhausted Days in the SSI & Medicaid Ratio
- SSI Percentage Data Match (Baystate)
- Kentucky Medicaid State DSH Plan Days in the Medicaid Fraction
- Labor Delivery Room Days in the Medicaid Fraction
- DSH Percentage Error/Employee Discount Days

On November 19, 2013, the Provider appointed King & Spalding, LLP to handle the appeal. This authorization letter was included with multiple Transfer Requests (Model Form D's) received by the Board on December 2, 2013. The Representative requested the SSI Data Match issue be transferred to case no. 14-1133G, the Dual Eligible Exhausted Days issue be transferred to case no. 14-1134G, the SSI Medicare Advantage Days issue be transferred to case no. 14-1135G & the Medicaid Fraction Medicare Advantage Days issue be transferred to case no. 14-1136G.

By letter dated December 23, 2013, the Representative requested an alternative remand of the Labor Delivery Room Days issue, the withdrawal of the Employee Discount Days issue and the closure of the individual appeal. This letter was not timely associated with the case, resulting in the Board's dismissal of the appeal on January 16, 2014 for the Provider's failure to file preliminary position papers on the remaining issues.

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 the subject case should not have been dismissed for failure to file a preliminary position paper. Therefore, the Board is reinstating the subject appeal for the purpose of issuing a jurisdictional determination regarding the issues raised from a revised NPR.

According to the Notice of Reopening, the revised NPR was issued

> To revise the Medicare SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS.[1]

This is consistent with the audit adjustment report which states:

> To adjust SSI% and LIP %, if applicable, to agree to updated CMS amounts and to update DSH allowable % accordingly.[2]

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.

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[1] Providers appeal request dated April 29, 2013 at Tab 1.
[2] *Id.* At Tab 3.

(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.

The Board finds that the revised NPR issued in this case was specific to the SSI ratio. There is no evidence to support an adjustment to the patient days in the Medicaid fraction of the DSH calculation. Therefore, the Board does not have jurisdiction over the Medicaid Fraction Labor Room Days and Medicaid Fraction Dual Eligible Days issues. Therefore, the request for remand of the Labor Room Days issue pursuant to CMS Ruling 1498-R is denied. Also, the requests to transfer the Medicaid Fraction portion of the Medicare Advantage Days and Dual Eligible Days issues from case number 13-1767 to case numbers 14-1136G and 14-1134G are denied.

In accordance with the Representative's earlier request, the Board has transferred the SSI Data Match issue to case number 14-1133G, the SSI Fraction Dual Eligible Exhausted Days issue to case number 14-1134G and the SSI Fraction Medicare Advantage Days issue to case number 14-1135G. The Employee Discount Days issue was withdrawn. Since there are no remaining issues in the appeal, the Board hereby closes case number 13-1767.

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:
John Gary Bowers, CPA
Michael W. Harty
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: Judith Cummings, Accounting Manager, CGS Administrators
Kevin D. Shanklin, Executive Director, BC BS Association

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL

FEB 21 2014

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

Noridian Healthcare Solutions, LLC
Donna Kalafut, Sr. Consultant
Federal Specialized Services
P.O. Box 6782
Fargo, ND 58108 6782

RE: Jurisdiction Determination for:
Baptist Medical Center (10-0088), FYE 09/30/1995, participant #5 and
Monongahela Valley Hospital (39-0147), FYE 6/30/1995, participant #7
Baptist Health System (45-0058), FYE 8/31/1995, participant #9
As participants in the QRS 1995 DSH SSI Proxy Group, PRRB Case No.: 04-0760G

Dear Mr. Ravindran & Ms. Kalafut:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and on its own motion noted jurisdictional impediments. The pertinent facts and the Board's jurisdictional decision are set forth below.

Background

The Providers filed an initial request for a group appeal on February 26, 2004. The Providers did not request a remand, but the issue in dispute is subject to CMS Ruling 1498-R. There are 9 participants in the group. Participant #s 5, 7, 8 and 9 appealed from revised NPRs.[1]

Participant #5, Baptist Medical Center, supplied a copy of the revised NPR and the request to reopen which addressed 4 items. The reopening request does not, however, mention SSI. Since the Provider did not supply a workpaper, there is not enough evidence to support an adjustment to SSI.

Participant #7, Monongahela Valley Hospital, indicated the SSI issue was self-disallowed. Because the Provider filed from a revised NPR, the issue must have been adjusted.

---

[1] Participant #8, Avera McKennan Hospital, also appealed from a revised NPR. Although the reopening request supplied by the Provider does not mention SSI and is specific to Medicaid eligible days, the Provider did submit a workpaper which showed the DSH amount on line 4 as 0. Based on the workpaper, the SSI Percentage must have changed since the Provider now qualifies for DSH.

Therefore, the application of *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) does not apply in this circumstance.

Again, as noted for participant #5, the request for reopening raises 3 issues, none of which are SSI. Since the Provider did not supply a workpaper, there is not enough evidence to support an adjustment to SSI.

Participant #9, Baptist Health System, submitted a workpaper which states its purpose was "To recalculate DSH payment using revised Medicaid days." There is not, however, enough evidence to support an adjustment to SSI.

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 Baptist Medical Center (participant #5), Monongahela Valley Hospital (participant #7) and Baptist Health System (participant #9) because these Providers are appealing from revised NPRs which did not specifically adjust the SSI Percentage issue.

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).

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:

> 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 42 C.F.R. §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

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

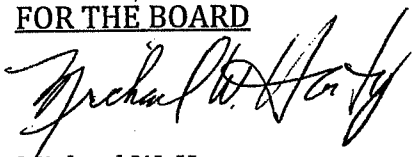
reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.

Because appeals from revised NPRs are limited to the specific matters revised in the revised determination, the Board finds that it does not have jurisdiction over the subject Providers because there is not enough evidence to support an adjustment to the SSI Percentage. Therefore, the Board hereby dismisses participant #s 5, 7 and 9 from 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.

The remaining participants in the group appeal are subject to remand pursuant to CMS Ruling 1498-R. Enclosed, please find the Board's remand under the standard procedure.

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: Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R
Schedule of Providers
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Kevin D. Shanklin, Executive Director, BC BS Association (w/enclosures)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-2076

FEB 2 4 2014

CERTIFIED MAIL

Ms. Tracy A. Jessner, Esq.
Hooper, Lundy & Bookman, P.C.
1875 Century Park East
Suite 1600
Los Angeles, CA 90067

RE: Bates County Memorial Hospital
Provider No.: 26-0034
FYE – 09/30/2014
PRRB Case No.: 14-2076

Dear Ms. Jessner:

In a letter dated January 24, 2014, received in the Board's offices on January 27, 2014, the Provider filed a Form A – Individual Appeal Request for the above-captioned Provider and Fiscal Year End ("FYE"). The Board acknowledged receipt of the appeal request by letter dated February 4, 2014 and assigned case number 14-2076.

Upon further review of the appeal request, the Board notes that on the Form A at Item #8 and the Statement of the Issue, the Provider states that the Total Amount in Controversy for all Issues is $4,769.00. Pursuant to 42 C.F.R. ¶ 405.1835(a)(2); ¶ .405.1839(a)(1) and Board Rule 6.3, any individual appeal request must have a total amount in controversy of at least $10,000 when the appeal is initially filed.

Since the amount in controversy does not meet the jurisdictional requirements necessary to proceed, the Board hereby closes the subject appeal and removes it from its docket.

The Provider may have appeal rights with the Intermediary pursuant to 42 C.F.R. ¶ 405.1839(a) which advises that the amount in controversy for an Intermediary hearing is at least $1,000 but less than $10,000. The request must meet the requirements for an Intermediary hearing as addressed in 42 C.F.R. ¶ 1809. The Board does not have the authority to transfer the subject appeal to the Intermediary; the Provider must file the appeal directly with the Intermediary.

FOR THE BOARD:

Michael W. Harty
Chairman

Board Members Participating:

Michael W. Harty
Keith E. Braganza, CPA
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

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

Kevin D. Shanklin
Executive Director
Senior Government Initiatives
BlueCross BlueShield Association
225 North Michigan Ave.
Chicago, IL 60601-7680

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Refer to: 14-0305

FEB 25 2014

CERTIFIED MAIL

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

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

RE: Jurisdictional Challenge – Durham Regional Hospital
Provider No.: 34-0155
FYE: 6/30/2005
PRRB Case No.: 14-0305

Dear Mr. Ravindran and Ms. Huggins,

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

Durham Regional Hospital was issued a revised Notice of Program Reimbursement (NPR) for FYE 6/30/2005 on May 13, 2013. On October 25, 2013, the Provider filed an appeal request with the Board appealing the following two issues: the Rural Floor Budget Neutrality adjustment (RFBNA), and the Provider's diagnostic-related groups (DRGs).

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more, and the request for hearing is received by the Board within 180 days of the date of receipt of the intermediary's final determination. However, before the Board can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over this appeal because the Provider appealed from a revised NPR in which the only issues on appeal, RFBNA and DRGs, were not adjusted. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2012) 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:

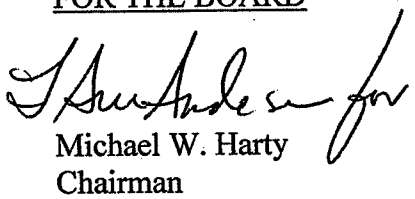
> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions 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 May 13, 2013 revised NPR shows that DSH was recalculated to include Labor & Delivery Days pursuant to the Board's remand under CMS Ruling 1498-R. Because neither the RFBNA nor DRGs were specifically adjusted in the revised NPR, the Board finds that it does not have jurisdiction over this Provider's appeal as it lacks the specificity requirements for a revised NPR. As RFBNA and DRGs were the only issues in the appeal, case number 14-0305 is hereby dismissed.

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

Board Members Participating
Michael W. Harty
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

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FEB 25 2014

CERTIFIED MAIL

Noridian Healthcare Solutions, LLC
Donna Kalafut
JE Part A Appeals Coordinator
P.O. Box 6782
Fargo, ND 58108-6782

Blumberg Ribner, Inc.
Isaac Blumberg
Chief Operating Officer
315 South Beverly Drive, Suite 505
Beverly Hill, CA 90212

RE: Blumberg Ribner Independent Hosps 2003 Dual Eligible Days 2nd Group, PRRB Case No. 09-1924G Specifically Participant Pacific Hospital of Long Beach, Provider No. 05-0277, FYE 6/30/03

Dear Donna Kalafut and Isaac Blumberg:

The Provider Reimbursement Review Board (the Board) recently began a review of the above-captioned appeal in order to process a standard remand pursuant to CMS Ruling 1498-R for the Dual Eligible Days issue.

Upon review, the Board notes that the Provider referenced above should be dismissed from this group appeal based on the following:

- The Provider appealed from a Revised Notice of Program Reimbursement that did not adjust dual eligible days.

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

Enclosed, please find a Standard Remand of the Dual Eligible Days issue for the remaining participants in the group appeal.

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

FOR THE BOARD:

Board Member

Enclosure: Standard Remand of Dual Eligible Days Issue Under CMS Ruling CMS-1498-R

cc: Kevin D. Shanklin, Executive Director, BCBSA

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Refer to:

CERTIFIED MAIL

FEB 26 2014

Blumberg Ribner, Inc.
Isaac Blumberg, Chief Operating Officer
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

Healthcare Reimbursement Services, Inc.
Corinna Goron, President
17101 Preston Road, Suite 220
Dallas, TX 75248 1372

RE: Chino Valley Medical Center, Provider No. 05-0586, FYE 12/31/2006, Case No. 13-1504

Dear Mr. Blumberg and Ms. Goron:

The Provider Reimbursement Review Board (the Board) recently reviewed the subject appeal for Case No. 13-1504 in response to various requests to transfer issues to group appeals filed by Healthcare Reimbursement Services, Inc. (HRS). In reviewing the case file, the Board also has reviewed correspondence with Blumberg Ribner, Inc. (Blumberg) for a subsequent appeal that was consolidated into Case No. 13-1504. The pertinent facts (which relate to both HRS and Blumberg) and the Board's determinations for Case No. 13-1504 with regard to representation, jurisdiction and the transfer requests are set forth below.

Pertinent Facts:

This appeal concerns the Provider's fiscal year ending December 31, 2006 (FY 2006). HRS filed an individual appeal for the subject Provider on April 9, 2013 from a revised NPR dated October 16, 2012 for FY 2006 (hereinafter referred to as the "First RNPR"). The appeal of the First RNPR included the following issues:

- SSI Systemic Errors – including Dual Eligible (Exhausted Benefit) Days, Baystate issues and M+C Days
- DSH Managed Care Part C Days – Medicaid Fraction
- Rural Floor Budget Neutrality Adjustment

The authorization letter attached to the appeal is dated February 22, 2012 and appointed HRS "as its designated representative with respect to the Rural Floor Budget Neutrality ("BNA")" for 11 Prime Healthcare providers for certain designated fiscal years. In connection with the Provider, the authorization letter pertained to the Provider's FYs 2005 to 2011.

By email dated April 15, 2013, the Board acknowledged the individual appeal filed by HRS and assigned it case number 13-1504. This email was sent to both HRS and the Intermediary and also notified the parties of certain filing deadlines. In particular, this email notified HRS that the Provider must file preliminary papers with Board by **December 1, 2013**.

On August 21, 2013, Blumberg filed a separate individual appeal for the same subject Provider and same FY but from a subsequently revised NPR dated February 19, 2013 (hereinafter referred to as the "Second RNPR"). The sole issue identified in the appeal for the Second RNPR was Extrapolation Errors for Medicaid Eligible Days. The authorization letter attached to the appeal request is dated August 15, 2013 and designated Blumberg for the entire individual appeal for FY 2006 by stating the following:

> By this letter, we hereby authorize Blumberg Ribner, Inc. to represent the Provider before the PRRB with respect to matters related to the above-referenced fiscal year [*i.e.*, FY 2006]. Additionally, this authorization extends to matters addressed in the context of either the individual PRRB appeal for the subject fiscal year or any related PRRB group appeals.

Board Rule 6.2 specifies that there may be only one appeal pending per provider per fiscal year and that, once an appeal has been established for a fiscal year, any subsequent appeal requests relating to other determinations for that fiscal year will be consolidated into the existing appeal. Accordingly, the Board incorporated the appeal of the Second RNPR into the existing case that had been established for the appeal of the First RNPR (*i.e.*, Case No. 13-1504).[1]

Based on the new authorization submitted with the appeal of the Second RNPR, the Board removed HRS as the authorized representative and entered Blumberg as the official representative for this appeal. Accordingly, on September 4, 2013, the Board sent an email to Blumberg and the Intermediary advising that the Second NPR had been incorporated into case number 13-1504, "an appeal based on an earlier determination for the same fiscal year, currently at the Board. (See Rule 6.2 regarding multiple final determinations involving the same cost reporting period.)." This email also provided Blumberg and the Intermediary with the following information on the filing of position papers:

> If you have not filed position papers in the referenced case, you must brief the issue(s) from the revised NPR in your position papers. Due dates for final position papers will be set in the Notice of Hearing and Critical Due Dates letter, which will be issued when the case is scheduled for a specific hearing date. If you have already filed final position papers in the appeal, you should contact the Board regarding the due date for a supplemental brief addressing the issue(s) from the revised NPR.

By three letters dated November 22, 2013, HRS requested that the Board make the following transfers of issues to group appeals:

- SSI Percentage issue to 14-0148GC (the HRS 2006 Prime Healthcare DSH SSI Percentage CIRP) (This issue is actually for 3 components of SSI)
- Managed Care Part C Days to 14-0155GC (the HRS 2006 Prime Healthcare DSH Medicare Managed Care CIRP)
- Rural Floor Budget Neutrality Adjustment to 13-3616GC (the HRS 2006 Prime Healthcare RFBNA CIRP)

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[1] Board Rule 6.2 "As a general rule, the Board will consolidate all appeals from final determinations for the same cost reporting period into the existing case number."

Upon transfer of these issues, HRS requested the closure of the individual appeal as there would be no remaining issues. *Note: each of these three transfer requests included a copy of the original HRS authorization dated February 22, 2012.*

Regulatory Background & Board Rules:

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 the NPR.

In this case, the Provider is appealing issues from two revised NPRs, each of which has distinct appeal rights. The initial appeal request filed by HRS pertained to the First RNPR issued on October 16, 2012 and the appeal request filed by Blumberg pertained to the Second RNPR issued on February 19, 2013.

The Code of Federal Regulations provides for an opportunity for providers to appeal 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.
>
> (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.

Further, 42 C.F.R. § 405.1868 discusses the Board's authority in establishing enforcing Board Rules:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The

> Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders . . . .

Board Rule 6.2 specifies that, once an individual appeal is established for a fiscal year and remains open, any subsequent appeals from other final determinations from the same fiscal year cost reporting period will be consolidated with the initial appeal:

> For individual appeals, an appeal may be for only one cost reporting period. If multiple final determinations were issued on different dates for the cost reporting period being appealed (e.g., NPR, revised NPRs, exception request denials, etc.), timely separate appeal requests must be filed for each subsequent final determination. When filing a subsequent appeal request for the same cost reporting period, identify the case number of the existing individual appeal.
>
> As a general rule, the Board will consolidate all appeals from final determinations for the same cost reporting period into the existing case number. The Board expects the parties to meet deadlines in the existing case for both the old and new issues although the Board will consider motions to extend such deadlines for newly added issues from subsequent determinations. The Board, upon its own motion, or upon motion of the parties, may issue separate case numbers for the new issues.[2]

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

> The Board will send an acknowledgement via e-mail indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.
>
> The acknowledgment and subsequent correspondence will establish various deadlines and due dates. Failure by a party to comply with such deadlines (including deadlines established by a JSO, See Rule 23.2) may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868.
>
> NOTE: The Board began sending electronically the Acknowledgement and Critical Due Dates Letters in May 2008, along with Notices of Hearing in July 2009. As a result, the case representative can expect to receive such notices in this manner at the e-mail address on file with the Board. If the Provider has not received an acknowledgement letter from the Board establishing critical due dates within 30 days following the filing of an appeal request, the case representative should contact the Board at 410-786-2671. Per Rule 41.2, the Board may dismiss a case for failure to comply with any of the critical due dates and, therefore, it is imperative that the Provider maintain current contact information on file with the Board (including e-mail address) per Rule 5.2.)[3]

---

[2] (Emphasis added.)
[3] (Emphasis added.)

Board Rule 5.1 details Provider Representation before the Board. The rule states:

> The case representative is the individual with whom the Board maintains contact. A case representative may include a "designated" case representative (e.g., attorney or consultant) . . . . There may be only one case representative per appeal.[4]

Finally, the Representative's responsibilities are set forth in Board Rule 5.2 which states:

> The representative is responsible . . . for meeting Board deadlines and for timely responding to correspondence or requests from the Board or opposing party. All actions by the representative are considered to be those of the Provider (But see Model Form D certification that Provider has been notified on transferring an issue to a group appeal.) Failure of the representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines.[5]

Board Determination:

Managed Care Part C Days issue:

The Board dismisses this issue from the appeal because the authorization letter attached to the appeal request for this issue did not authorize HRS to file an appeal on this particular issue for FY 2006. Rather, the authorization letter only authorized HRS to file an appeal for FY 2006 as it relates to the rural floor budget neutrality.[6]

The Board's rules are clear that there may be only one representative per individual appeal. However, the Board notes that this representative continues to file individual appeals with issue specific representation letters that **do not** cover all the issues they are filing in the individual appeal request. A representation letter for any individual appeal should cover the **entire** individual appeal, as is required by Board Rule 5.1. If HRS has not obtained a providers authorization to file an appeal of a specific issue on their behalf, then any attempt by the unauthorized representative to appeal that issue before the Board would be contrary to 42 C.F.R. 405.1835 (a) "A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period . . ."

Even if HRS had been properly authorized for this issue, the Board would have denied jurisdiction over it. As previously noted, appeals from revised NPRs are limited to the specific matters addressed in the revised (corrected) determination. Based on the adjustment report submitted with the October 16, 2012 revised NPR, adjustment #4 was made to "update the SSI % and DSH% based on the CMS update dated 3/2012." There was no adjustment made to the Medicaid fraction. Therefore, the Board lacks jurisdiction in this case over any component of the Medicaid fraction, including but not limited to the managed care Part C days issue.

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[4] (Emphasis added.)
[5] (Emphasis in original.)
[6] *See infra* note 8.

Rural Floor Budget Neutrality issue:

The Board finds that it does not have jurisdiction over this issue. The Provider indicated that it self-disallowed the issue. However, the Provider does not have any option to self-disallow on a revised NPR. Moreover, a specific revision is required for the Board to have jurisdiction over a specific issue from a revised NPR and there was no adjustment of the rural floor budget neutrality on the revised NPR that was appealed for this issue. *See* 42 C.F.R. §§ 405.1889(a), (b)(1) and (b)(2).

SSI Percentage issue:

The Board dismisses this issue from the appeal because the authorization letter attached to the appeal request for this issue did not authorize HRS to file an appeal on this particular issue for FY 2006. Rather, the authorization letter only authorized HRS to file an appeal for FY 2006 as it relates to the rural floor budget neutrality.[7]

Transfer of Issues to Groups:

Because the Board has either dismissed or denied jurisdiction over the DSH SSI Percentage, Managed Care Part C Days and Rural Floor Budget Neutrality issues, the Board hereby denies HRS' requests to transfer these issues to the respective group appeals (Case Nos. 14-0148GC, 14-0155GC, and 13-3616GCs). The Board notes that these transfer requests could not be treated as a request to add issues because the transfer requests were filed outside the period allowed for the addition of issues to an appeal.

Authorized Representation:

The Board finds that the official authorized representative on file for the subject appeal continues to be Blumberg based on the authorization letter of August 15, 2013 as the basis for the original decision has not changed.[8] Per Board Rules 5.1 and 6.2, there may only be on individual case per FY and only one representative per individual case. The documents accompanying the initial appeal request shows that the Provider only gave HRS limited authority for FY 2006 over a single issue and that this limited authority did not encompass the second appeal request. In contrast, the documents accompanying the second appeal request shows that the Provider gave Blumberg complete authority for FY 2006 that would encompass both the initial appeal request and the second appeal request. The Board further notes (as discussed more fully below) that Board Rules 5.5(A), 6.2 and 9 clearly establish that it is the responsibility of the Provider and its representative to manage its appeals.

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[7] *See infra* note 8.

[8] In reviewing the case files for the three group appeals to which HRS was requesting transfer of issues pursuant to its letters dated November 22, 2013, the Board became aware of the fact that: (1) each of requests to establish these three group cases contained an authorization from Prime Healthcare letter dated July 9, 2013; and (2) this authorization letter authorized HRS in the context of the individual or group appeals for all Prime Healthcare providers for certain designated fiscal years without issue limitation and specified with respect to the Provider that it pertained to FYs 2005 to 2013. However, the Board notes that the July 19, 2013 authorization letter was **neither** filed with **nor** is it a part of the record for this individual case (*i.e.*, Case No. 13-1504). As a result, the July 9, 2013 authorization letter has no bearing on determining the official representative for this individual case. This conclusion is further reinforced by the facts that the date of the authorization letter is well after the date of the original hearing request was filed and that the authorization letter is very broad covering individual or group appeals for multiple providers and multiple fiscal years without any issue limitation.

Remaining Issue and Due Dates:

The sole issue remaining in the individual appeal is Extrapolation Errors for Medicaid Eligible Days which was appealed from the Second RNPR by Blumberg on behalf of the Provider. The previously established due date for the submission of preliminary position papers for this case was December 1, 2013.

The Board issued new Rules effective August 21, 2008. Sections 23 through 25 of these Rules offered a new option; to file a proposed Joint Scheduling Order (JSO) or file preliminary position papers by the same due date. Upon review of the above-captioned appeal, it was noted that neither a proposed JSO nor the preliminary position paper was submitted to the Board by the due date. Therefore, the Board hereby dismisses this case and removes it from the docket. Set forth below are the Board's findings in support of this determination.

Board Rule 6.2 clearly states that, when an appeal is consolidated into an existing appeal, "the Board expects the parties to meet deadlines in the existing case for both the old and new issues." To the extent a party has any confusion regarding due dates for the preliminary papers, Board Rule 9 directs parties to contact the Board: "If the Provider has not received an acknowledgement letter from the Board establishing critical due dates within 30 days following the filing of an appeal request, the case representative should contact the Board at 410-786-2671." Finally, Board Rule 5.5(A) specifies that "the recent appointment of a new representative, generally will not be considered cause for delay of any deadlines or proceedings." Accordingly, Board Rules 5.5(A), 6.2 and 9 clearly establish that it is the responsibility of the Provider and its representative to manage its appeals, including critical due dates set by the Board.

In acknowledging its appeal, the Board notified Blumberg that its appeal had been consolidated into an existing appeal, that the Provider should refer to Board Rule 6.2, and that "[i]f you have not filed position papers in the referenced case, you must brief the issue(s) from the revised NPR in your position papers." The fact that Blumberg was not the representative on file for this case when the notice of critical due dates was issued did not obviate Blumberg's responsibilities to manage the case (or the Provider's responsibilities to manage its representatives) when it filed its appeal of the Second RNPR. Blumberg was responsible for the case and was on notice that its appeal had been consolidated with an existing case and that the due dates for the existing case were applicable. Pursuant to Board Rules 5.5(A) and 6.2, the December 1, 2013 due date for preliminary position papers applied to the appeal of the Second RNPR. In this regard, the Board notes that the appeal of the Second RNPR was filed on August 21, 2013 and acknowledged by the Board on September 4, 2013 which was well before the December 1, 2013 due date. Consistent with the instruction in Board Rule 9, Blumberg should have contacted the Board following its receipt of the Acknowledgement letter to the extent there was any confusion regarding the due dates for preliminary position papers.[9]

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[9] As explained in Board Rule 9, beginning May 2008, the Board began issuing emails to acknowledge receipt of an appeal. If there was not a pre-existing case for the fiscal year being appealed, then the Board also included in that email the due dates for preliminary position papers. The Board notes that Blumberg serves as a representative on many cases before the Board and should be aware of the Board's practice and procedure.

Conclusion:

Based upon the above findings and determinations, the Board hereby dismisses this case and removes it from the docket. Review of these determinations 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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