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

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Refer to: 01-3029G

CERTIFIED MAIL

OCT 03 2014

A. Carlson Associates, LLC
Barbara Meehan
Provider Rep.
2640 E. Barnett Road
Suite E-146
Medford, OR. 97504

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

Re: Reconsideration Request
Mary Greely Medical Center, Provider No. 16-5143
As a participant in Certus 1994 SNF RCL Exception Low Occupancy Adjustment Group
PRRB Case No. 01-3029G

Dear Ms. Meehan and Mr. Lamprecht:

The Provider Reimbursement Review Board (Board) has reviewed the reconsideration request submitted on August 14, 2014 (received August 15, 2014) to reverse the jurisdictional decision issued by the Board on August 1, 2014. The jurisdictional reconsideration decision of the Board is set forth below.

Background

On August 1, 2014, the Board denied the transfer of the SNF RCL Exception Low Occupancy Adjustment issue from the individual appeal to the group and dismissed the Provider from the current group, Case No. 01-3029G, since the individual appeal for Mary Greeley Medical Center, Case No. 97-1923, was in a closed status at the time the transfer was requested.

The Board found that Participant # 2, Mary Greeley Medical Center, Provider No. 16-5143, established its original appeal with the Board on March 25, 1997 from a final determination dated December 30, 1996. The Board acknowledged the appeal and assigned Case No. 97-1923. Case No. 97-1923 was closed based on a withdrawal letter received on October 20, 2000.[1] The Provider subsequently attempted to transfer the SNF RCL Exception Low Occupancy Adjustment issue from individual appeal to the newly formed Certus 1994 SNF RCL Exception Low Occupancy Adjustment Group, Case No. 01-3029G, through the December 21, 2000 request for restructuring.[2]

[1]The Board's closure date was initially identified as November 1, 2000, but the attached closure letter reflects the actual issuance date as November 3, 2000.
[2] There was no evidence submitted within the schedule of providers or supporting documentation to indicate that this participant had previously been transferred to the prior group appeal, Case No. 00-3851G.

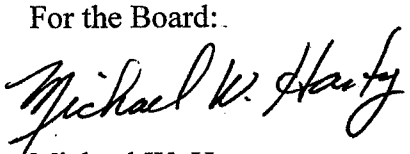
On August 14, 2014, the Provider submitted a request that the jurisdictional decision issued on August 1, 2014 be reversed. The Provider contends that they have searched all of the files maintained by A. Carlson Associates including all computer files transferred from Certus when A. Carlson Associates took responsibility for these appeals. The Provider didn't find any record of the letter withdrawing the Mary Greeley FY94 appeal of the SNF RCL Exception Low Occupancy issue prior to the transfer of the issue to group appeal. The Provider also didn't find any record of the receipt of a dismissal by the Board. In turn the Provider is requesting evidence, from the Board that supports the Provider or Provider's Representative withdrawal of the appeal, Case No. 97-1923.

Board Determination

In the reconsideration request, the Provider offers a Chronological Summary of the Case History per files maintained by A. Carlson Associates with exhibits. This timeline indicates that for Participant #2, "the letter from Susan Starr dated December 21, 2000 reflected the direct addition of [Mary Greeley Medical Center] into the new group to be established for non-commonly owned providers." However, per the attached letter addressed to Ms. Starr the Board acknowledged the withdrawal of the individual appeal for Mary Greeley Medical Center, Case No. 97-1923, and closed the appeal effective November 3, 2000. As the closure date preceded the December 21, 2000 request for transfer, the Board hereby denies the reconsideration request.

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

For the Board:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. §1395oo(f)
42 C.F.R. §§405.1875 and 405.1877
Copy of the Board letter dated November 3, 2000, closing Case No. 97-1923

cc: Kevin D. Shanklin, Executive Director, Senior Gov. Initiatives, BCBSA

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Refer to: 05-1440GC & 96-1699G

CERTIFIED MAIL OCT 10 2014

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

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

RE: Southeast Region 1989 – 1997 Part A Exhausted Days Group, case no. 05-1440GC
Southeast Region 1989 – 1993 SSI Calculation Group, case no. 96-1699G
Provider No.: Various
FYE: Various

Dear Ms. Erde and Mr. Pike,

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeals and has noted several jurisdictional impediments. The jurisdictional decision of the Board is set forth below.

Background

On March 25, 1996, Duane Morris requested an optional group appeal for the SSI percentage issue. The Board assigned case number 96-1699G to this group appeal. On May 6, 2004, the Board received a letter which indicated case number 96-1699GC should be broken up into several groups because there was more than one issue pending in the appeal. On May 10, 2005, the Board granted the Providers' representative's request and established case number 05-1440GC for Part A Exhausted Days and case number 05-1441GC for Part C Days.

On November 11, 2013, the Board issued a decision denying jurisdiction over DCH Regional Medical Center (9/30/1996) in case number 96-1699G because it did not properly transfer the SSI percentage issue into the appeal. On the same date, the Board remanded the remaining Providers to the Intermediary pursuant to CMS Ruling 1498-R and closed case number 96-1699G. The Board upheld its dismissal of this Provider on March 26, 2014, in a denial of the Provider representative's request for reconsideration.

On May 9, 2014, the Board received the final Schedule of Providers for case number 05-1440GC. The Schedule of Providers is broken into two parts: Part I includes CIRP Providers and Part II includes non-CIRP Providers and is identical to the Schedule of Providers in case number 96-1699G.

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 $50,000 or more for a group, and the request for a hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Case Number 05-1440GC

The Board finds that it does not have jurisdiction over Provider 1 on Part II of the Schedule of Providers, Bay Medical Center (provider no. 10-0026, 9/30/1989). On March 25, 1996, the Provider requested to transfer from its individual appeal, case number 92-1016, to case number 96-1699G, which was subsequently bifurcated into multiple appeals including case number 05-1440GC. However, the Provider withdrew its individual appeal on November 13, 1995, which is prior to the transfer request. As a provider cannot transfer an issue from a closed appeal, the Board finds that Bay Medical Center (9/30/1989) did not properly transfer the issue and dismisses the Provider from case number 05-1440GC.

The Board finds that it does not have jurisdiction over Provider 10 on Part II of the Schedule of Providers, DCH Regional Medical Center (provider no. 01-0092, FYE 9/30/1996) because it did not properly transfer the dual eligible days issue from its individual appeal to case number 96-1699G. Consistent with the Board's decisions in case number 96-1699GC issued on November 11, 2013 and March 26, 2014, the Board finds that the Providers' representative consistently used the wrong case number on the various documents submitted for Provider 10. The add request and transfer letters both reference the correct provider number and fiscal year end, however the case number listed is incorrect for that Provider and FYE. The Board determined that the representative made too many mistakes such that the Provider failed to establish that the SSI percentage issue was added for Provider number 10 to the correct case. As there is no documentation establishing that DCH Regional Medical Center (9/30/1996) was transferred to group number 96-1699G, the Board hereby dismisses the Provider from case number 05-1440GC.

The Board finds that it does not have jurisdiction over Provider 16 on Part II of the Schedule of Providers, Memorial Hospital of Hollywood (provider no. 10-0038, FYE 4/30/1990). On October 30, 1997, Memorial Hospital of Hollywood requested to transfer from its individual appeal, case number 93-1909, to case number 90-1499G. The Provider sent a letter on December 16, 1997 indicating that the transfer to case number 90-1499G was in error and that it intended to transfer to case number 96-1699G, which was subsequently bifurcated into multiple appeals including case number 05-1440GC. However, the Board dismissed case number 93-1909 on June 17, 1997 because the Provider did not timely filed its final position paper. As a provider cannot transfer an issue from a closed appeal, the Board finds that Memorial Hospital of Hollywood (4/30/1990) did not properly transfer the issue and dismisses the Provider from case number 05-1440GC.

The Board finds that it does not have jurisdiction over Provider 20 on Part II of the Schedule of Providers, Memorial Hospital of Hollywood (provider no. 10-0038, FYE 4/30/1994). On October 30, 1997, the Provider requested to transfer the issue from its individual appeal, case number 97-

0379, to case number 90-1499G. However, case number 90-1499G was closed on April 8, 1996, so the Provider could not have transferred an issue into that group appeal. Several other Memorial Hospital of Hollywood fiscal year ends were transferred into case number 90-1499G, but the Board received letters correcting case number 90-1499G to case number 96-1699G. The Board did not receive such a correction letter for FYE 4/30/1994. Because case number 90-1499G was already closed at the time of the transfer request, the Board denies the request. The Provider did not submit a request to transfer the issue to case number 96-1699G and its individual appeal was closed on April 21, 1998. Because the issue was not properly transferred to case number 96-1699G, which was subsequently bifurcated into multiple appeals including case number 05-1440GC, Memorial Hospital of Hollywood (4/30/1994) is hereby dismissed from case number 05-1440GC.

Case Number 96-1966G

The Schedule of Providers and supporting documentation in case number 96-1699G is identical to the Schedule of Providers and supporting documentation for Part II of case number 05-1440GC. Because case number 05-1440GC was bifurcated from case number 96-1699G, the jurisdictional problems that exist in case number 05-1440GC also exist in case number 96-1699G. The Board noted three additional jurisdictional deficiencies in its review of case number 05-1440GC that are also applicable in case number 96-1699G. Therefore, the Board hereby reopens case number 96-1699G and rescinds the remand as issued on November 11, 2013 in order to further address jurisdiction.

The Board has already dismissed Provider 10, DCH Regional Medical Center (9/30/1996) from case number 96-1699G, and is also dismissing the Provider from case number 05-1440GC. For the reasons noted above, the Board hereby dismisses Providers 1, 16, and 20 from case number 96-1699G, consistent with the dismissals in case number 05-1440GC.

The remands of case numbers 05-1440GC and 96-1699G pursuant to CMS Ruling 1498-R will be addressed under separate cover.

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

Board Members:
Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson 1

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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CERTIFIED MAIL

OCT 16 2014

Anita Lee
Office of the County Counsel
648 Kenneth Hahn Hall of Administration
Health Services Division
500 West Temple Street, Room 602
Los Angeles, CA 90012

RE: Jurisdictional Challenge
Provider: Martin Luther King Jr./Drew Medical Center
Provider No: 05-0578
FYE: 06/30/04
PRRB Case No.: 08-1658

Dear Ms. Lee:

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

Background

On September 26, 2007, a Notice of Program Reimbursement (NPR) was issued to the Provider, Martin Luther King Jr./Drew Medical Center, for the cost reporting period ending June 30, 2004. On March 21, 2008, the Provider filed an appeal of the NPR challenging eight issues. The Board assigned case number 08-1658 to the case. On October 20, 2008, the Provider requested to add the following issues to the appeal: indirect medical education (IME)/ graduate medical education (GME) incorrect full-time equivalent (FTE) resident cap for base year, IME/GME incorrect FTE resident counts for prior and penultimate years, transitional corridor payments and relative value units (RVU).

On October 05, 2012, the Intermediary filed a jurisdictional challenge regarding the IME and GME historical FTE resident cap issues alleging no intermediary determination/no adjustment was made. On December 07, 2012, the Provider filed an opposition to the Intermediary's jurisdictional challenge. On June 24, 2014, the parties reached a partial administrative resolution for all but the IME/GME historical FTE resident cap issues.

Intermediary's Position

The Intermediary contends that it made audit adjustments 32, 34, and 36 related to IME and GME. Audit adjustment 32 was made to the current year FTE counts for IME and GME. Audit adjustment 34 adjusted the prior and penultimate year FTE counts for IME and GME. Audit adjustment 36 adjusted the IME prior year resident to bed ratio. The Intermediary argues that it

made no adjustments to the historical resident cap for either IME or GME. The Intermediary maintains the Provider is attempting to appeal amounts that were not adjusted. The Provider was not precluded from claiming the additional payment for which it asserts the hospital is qualified based on their records. The Intermediary requests that the Board dismiss the IME and GME historical resident cap issues from the appeal.[1]

Provider's Position

The Provider contends that it filed its cost report listing 241.27 FTEs as the historical cap for GME purposes and 222.86 FTEs as the historical cap for IME purposes. These figures are consistent with the numbers identified on audit by the Intermediary in FYE June 30, 1999, but are lower than the numbers that the Provider believes to be correct. The Provider maintains it believes the actual unweighted number of residents to be used is 250.39 FTEs for GME purposes and 232.97 FTEs for IME purposes. The Provider concedes that the Intermediary made no modification to the historical caps reported by the Provider. However, the Provider contends the historical resident caps were applied to the revised number of residents for fiscal year end (FYE) June 30, 2004, and used to calculate allowable reimbursement.[2]

The Provider argues that although the Intermediary did not make an audit adjustment to the historical resident caps reported, the statute at 42 U.S.C § 1395oo(a),[3] confers jurisdiction irrespective of whether there was an audit adjustment. Further, the Board should exercise its discretion to consider the evidence on this point because the Intermediary had previously considered and made a decision on the amounts of the historical caps.[4] Moreover, the Provider contends consistent with the law in the Ninth Circuit (the circuit in which the Provider is located) it has also met the dissatisfaction requirement even though it did not specifically report the higher historical caps that it now believes should have been used. The Provider cites to the cases of *Loma Linda University Medical Center v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007) and *UMDNJ-University Hospital v. Leavitt*, 539 F.Supp.2d 70 (D.D.C. 2008), in support of its contention.[5]

The Provider maintains in *Loma Linda*, the Ninth Circuit Court of Appeals considered the question of whether a provider can meet the "dissatisfaction" requirement in the statute when it had not included the disputed amount in the cost report. The court found that the statute itself clearly conferred jurisdiction over all matters covered by the cost report even though that particular expense was not expressly claimed or explicitly considered by the Intermediary.[6] The court noted that Section 1395oo(d) allows the PRRB to make revisions on costs that were not expressly claimed.[7]

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[1] Intermediary's Jurisdictional Challenge at 2-3.
[2] Provider's Opposition to Jurisdictional Challenge at 1.
[3] 42 U.S.C. § 1395oo(a)(1)(A)(1) states that a provider has a right to a hearing before the PRRB if it: "is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1816 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 title for the period covered by such report."
[4] Provider's Opposition to Jurisdictional Challenge at 2.
[5] *Id.* at 3.
[6] *Loma Linda*, 492 F.3d at 1068.
[7] *Id.* at 1071.

The Provider contends that the *UMDNJ* case reached the same result in a case involving accidently omitted clinical medical education costs. Thus, the Provider concludes the fact that it did not use the correct historical caps in filing its FYE June 30, 2004 cost report does not deprive the Board of jurisdiction to hear its challenge to the historical caps, so long as the disputed items are "covered by the cost report." [8]

The Provider contends that the regulation at 42 C.F.R. § 405.1835(a)(1)(ii) permits providers to meet the dissatisfaction requirement, even though they have not directly claimed disputed amounts in the body of the cost report. The Provider maintains that the regulatory requirement to file a cost report under protest only applies to cost reporting periods ending on or after December 31, 2008, and does not apply to cost reporting periods ending before that date, like this one. The Provider contends that it did not have to use a protested item in this fiscal year to preserve its right to appeal, as it was challenging a Medicare policy, or was claiming costs that may not be allowable.

The Provider maintains that it had previously reported higher historical caps on its cost report for FYE June 30, 1999, and the Intermediary reduced the number to the figures used by the Provider on its FYE June 30, 2004 cost report. Thus, at the time the Provider filed its FYE June 30, 2004 cost report, the Intermediary had found that a lower historical cap was proper under the Medicare rule. The Provider argues given this finding, the Intermediary would have found a claim for a higher amount not allowable.[9] The Provider differentiates the circumstances in this case from those in which providers fail completely to include a particular expense. The Provider maintains both the filed and the audited cost reports include specific information regarding the historical caps.[10] It reported a historical cap on residents, but instead of using the accurate number, it used the number determined by the Intermediary in a prior period audit adjustment. The Provider argues Providers should be encouraged, not discouraged, from conforming to prior period audit adjustments.[11]

The Provider maintains this is not a case where there is a need to present the issue to the Intermediary first, in order to allow it to issue a determination for the PRRB to review. There would be no value in this case in having the Intermediary first review the amounts of the historical caps for this fiscal year, because it already made its decision on what those numbers should be in the context of the FYE June 30, 1999 audit. The historical limit is based on information from FYE June 30, 1996; the relevant number is the same for each year and does not have to be re-determined annually. The Provider argues by not adjusting the number during the FYE June 30, 2004 audit, the Intermediary tacitly affirmed that its prior determination of the historical caps were correct.[12]

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[8] Provider's Opposition to Jurisdictional Challenge at 3-4.
[9] *Id.* at 5-6.
[10] *Id.* at 4.
[11] *Id.* at 7.
[12] *Id.* at 7-8.

Decision of the Board

Pursuant to 42 U.S.C. §1395oo(a) (2007) and 42 C.F.R. §§ 405.1835-405.1840 (2007), 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. After jurisdiction is established under 42 U.S.C. § 1395oo(a) the Board has the discretionary power under 42 U.S.C § 1395oo(d) 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.[13] 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.[14]

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.[15]

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

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[13] 485 U.S. at 401-402.
[14] *Id.* at 404.
[15] *Id.* at 404-405 (emphasis added).

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.

The Ninth Circuit has 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." 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 stated:

> 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.[16]

The holding[17] suggested 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).[18] Further, the Ninth Circuit stated it was joining the First Circuit's similar view as expressed in *Maine General Med. Ctr. v. Shalala*, 205 F.3d 493 (1st Cir. 2000) and *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).[19]

Maine General involved hospitals that listed zero for reimbursable bad debts on their cost reports. The Providers did not discover mistakes in their as-filed cost reports until after the

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

[17] The court held "that the Board had jurisdiction pursuant to § 1395oo(a) for a hearing with respect to Loma Linda's 1985 cost report because the provider was dissatisfied with a final determination by Blue Cross as to the amount of total reimbursement due and other jurisdictional prerequisites were met. As a hearing had not yet been held when Loma Linda sought relief on an additional aspect of the intermediary's final determination that was covered by the 1985 cost report, that is, a cost or expense that was incurred within the period for which the cost report was filed, the Board had discretion to receive evidence and take action in accord with § 1395oo(d) on this matter even though the interest expense was not expressly claimed and had not been explicitly considered by the intermediary." *Id.* at 1073.

[18] *See Loma Linda* 492 F.3d at 1070-71; *See also* 73 Fed. Reg. 30190, 30197 (May 23, 2008).

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

NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also appealed certain previously unclaimed bad debts (*i.e.*, costs not clamed due to inadvertence rather than futility). The Board dismissed the bad debt claims for lack of jurisdiction because the claims had not been disclosed on the as-filed cost reports, despite there being no legal impediment. The First Circuit in *Maine General* relied on its prior decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, the First Circuit found the *St. Luke's* decision nevertheless addressed the question of whether the Board has the power to decide an issue that was not first raised by the intermediary, holding the Board does have the power, but that the power is discretionary.[20] The First Circuit in *Maine General*, in accordance with *St. Luke's*, held that the Board had statutory jurisdiction to hear *Maine General's* claims, but that it was not required to hear it.[21] The First Circuit reasoned that *St. Luke's and Bethesda*[22] actually deal with the question of the Board's jurisdiction under § 1395oo as a whole as opposed to being confined to specific subsections of the statute.[23] The First Circuit stated in regards to the *St. Luke's* holding:

> This holding is not a narrow one based on a parsing of § 1395oo(d) alone: It relies on legislative history . . . the nature of judicial and administrative appellate bodies . . . other subsections of § 1395oo . . . and the special features of Board review. . . . To confine *St. Luke's* to § 1395oo(d) alone would be to ignore its language and the analytic rationale for its conclusion about the Board's jurisdiction.

In regards to the *Bethesda* decision the court stated:

> *Bethesda* makes nothing of the possible distinction between "subsection (a)" and "subsection (d)" cases. *Bethesda*, which could be characterized as a subsection (a) case, states that it is "resolv[ing] a conflict among the Courts of Appeals," and lists eight circuit opinions, the majority of which could be classified as subsection (d) cases. . . . If the possible distinction between subsection (a) and subsection (d) cases mattered to the *Bethesda* Court, it would not have announced that it was resolving a circuit split involving subsection (d) cases in an opinion focused on subsection (a).[24] A more plausible interpretation of *Bethesda* and the court of appeals cases that it cites (including the *St. Luke's* opinion) is that they actually deal with the question of the Board's jurisdiction under § 1395oo as a whole.[25]

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[20] *Maine General*, 205 F.3d at 497.
[21] *Id.*
[22] *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988).
[23] *Maine General*, 205 F.3d at 498.
[24] *Id.*
[25] *Id.* at 499.

The First Circuit, similar to the Ninth Circuit, has determined that the language of the Medicare statute in 42 U.S.C. §1395oo as a whole provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed;" the Board is not required to hear issues or claims not considered by the intermediary (e.g. unclaimed cost) but has discretionary powers and can chose to hear them or not hear them.

The *St. Luke's* court expressly rejected the provider's assertion that the court should order the Board to hear the case even though it found the hospital had a strong equitable argument favoring review under the particular circumstance.[26] Specifically, the First Circuit stated "[t]he statute [1395oo(d)] does not say that the Board *must* consider matters not considered by the Intermediary. But, it does say the Board may, it can, it has the 'power' to do so."[27] The First Circuit in *Maine General* found that the Board could adopt a policy of hearing such claims or refusing to hear them, or it could opt to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational, given the ability of providers to request the intermediary to reopen an NPR up to three years after it has been issued."[28] Similarly, in *St. Luke's*, the First Circuit opined that even though the Board has legal power to consider matters not specifically raised before the intermediary, whether to exercise that power is for the Board to decide and like many similar powers of courts and agencies, should be exercised only sparingly.[29]

The D.C. District Court in *UMDNJ Univ. Hosp. v. Leavitt*, 539 F. Supp. 2d 70 (D.D.C. 2008), reached the same conclusion as the First and Ninth Circuits. As in *Maine General* and *Loma Linda*, the provider filed its appeal based on several intermediary adjustments to its cost report claims with which it was dissatisfied, but it also included an appeal of costs for its clinical medical education programs that were omitted entirely from the cost report. The court stated "the Board may adopt a policy of hearing claims not initially presented to the fiscal intermediary or of refusing to hear them, or it may decide on a case by case basis. This conclusion comports with the plain language of subsection (d)."[30] Similar to the Ninth Circuit in *Loma Linda*, 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).[31]

In contrast, the Seventh Circuit has adopted an interpretation of *Bethesda* that precludes Board jurisdiction where the provider's request would not have been clearly futile. Specifically, in 1994 in *Little Company of Mary Hosp. v. Shalala*, 24 F.3d 984 (7th Cir. 1994) ("*Little Co. I*"), the Seventh Circuit relied on the *Bethesda* dicta, noting that a provider's failure to claim all the reimbursement to which it is entitled under program policies is tantamount to a "failure to exhaust" administrative remedies before the fiscal intermediary, which establishes that the provider is not "dissatisfied" with the intermediary's final reimbursement determination.[32]

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[26] *St. Luke's*, 810 F.2d at 332.
[27] *Id.* at 327-328. (Emphasis in original.)
[28] *Maine General*, 205 F.3d at 501.
[29] *St. Luke's*, 810 F.2d at 327.
[30] *UMDNJ*, 539 F. Supp. 2d at 79.
[31] *Id.* at 77.
[32] *Little Co. I*, 24 F.3d at 992.

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[33] *In Little Co. II*, the Seventh Circuit held that the Board lacked jurisdiction over an appeal of an issue that the intermediary had not considered, and distinguished *Bethesda* on the grounds that the cost issue on appeal in *Little Co. II* did not involve an "issue of policy" like the *Bethesda* plaintiffs' challenge to the malpractice regulations.[34] The Seventh Circuit noted: "[b]ut while the statute is curiously worded, the intent is plain that the provider must give the intermediary a first shot at the issue, provided the issue is within the intermediary's competence."[35]

Citing *Little Co. II*, the preamble to the 2008 final rule (while not controlling for this cost reporting year under appeal) states that it has been the agency's "longstanding view that providers that fail to claim on their cost reports costs that are allowable under the Medicare law and regulations cannot meet the 'dissatisfaction' requirement [of subsection (a)]."[36] The Agency further states that it "interpret[s] section 1878(d) of the Act as permitting the Board to make revisions to cost report items that directly flow from the determination with which the Provider has expressed dissatisfaction and from which the provider has filed a jurisdictionally proper appeal under section 1878(a) of the Act."[37]

In the aggregate, the case law of the Ninth and the D.C. District Court (with similar views in the First Circuit) 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 on the cost report. 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 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*, 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.[38] However, the Provider is located in the Ninth Circuit and, as such, *Loma Linda*, applies to this appeal and serves as controlling precedent for the Board.

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[33] *Little Co. of Mary Hosp. v. Shalala*, 165 F.3d 1162 (7th Cir. 1999).
[34] *Little Co. II*, 165 F.3d at 1165.
[35] *Id.*
[36] 73 Fed. Reg. 30190, 30196 (May 23, 2008).
[37] 73 Fed. Reg. at 30203.
[38] *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* Board Rule 7; 73 Fed. Reg. at 30197.

In *Loma Linda* the Ninth Circuit held:

> [t]hat the Board had jurisdiction pursuant to § 1395oo(a) for a hearing with respect to Loma Linda's 1985 cost report because the provider was dissatisfied with a final determination by Blue Cross as to the amount of total reimbursement due and other jurisdictional prerequisites were met. As a hearing had not yet been held when Loma Linda sought relief on an additional aspect of the intermediary's final determination that was covered by the 1985 cost report . . . the Board had discretion to receive evidence and take action in accord with § 1395oo(d) on this matter even though the interest expense was not expressly claimed and had not been explicitly considered by the Intermediary.[39]

In the instant case, the Provider timely filed an appeal of its cost report challenging eight issues. The Provider timely requested to add the IME/GME historical FTE resident cap and three other issues to the appeal and met the amount in controversy requirement. Thus, pursuant to *Loma Linda*, the Board finds that it has jurisdiction under 42 U.S.C. § 1395oo(a) over the Provider's cost report based on the Provider's dissatisfaction with the Intermediary's final determination of total reimbursement due for the cost year and because the other jurisdictional prerequisites were met.

As a hearing has not yet been held, the Board has discretion to receive evidence and take action in accord with 42 U.S.C. § 1395oo(d). Therefore, the Board must now determine whether to exercise its discretion under § 1395oo(d) to address reimbursement for the items and services that were not expressly claimed or explicitly considered by the Intermediary. In the current case, the Provider claimed 241.27 FTEs as its historical cap for GME and claimed 222.86 as its historical cap for IME on its as-filed cost report. The Provider concedes that the Intermediary made no modification to the historical caps it reported. The Provider maintains that it now believes that the actual number of residents to be used is 250.39 FTEs for GME purposes and 232.78 FTEs for IME purposes. There was no statutory, regulatory or manual provision preventing the Provider from claiming the higher FTE caps. Only in hindsight did the Provider determine that it should have reported additional FTEs, thereby increasing the amount of reimbursement. As such, the Board declines to hear the IME and GME historical FTE resident cap issues pursuant to its discretionary powers under § 1395oo(d), consistent with its decision in *St. Vincent,*[40] and closes the case as these are the sole issues remaining in the case.

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[39] *Loma Linda*, 492 F.3d at 1073.

[40] *St. Vincent Hospital & Health Center v. Blue Cross Blue Shield Ass'n*, PRRB Decision No. 2013-D39 (September 13, 2013) at 15, 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."

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

Board Members Participating
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.

For the Board:

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, Blue Cross and Blue Shield Association
Donna Kalafut, Noridian Healthcare Solutions

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Refer to:

13-0791

OCT 17 2014

CERTIFIED MAIL

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James R. Ward
Appeals Resolution Manager
Noridian Healthcare Solutions, LLC
P.O. Box 6722
Fargo, ND 58108-6722

RE: Provider Name: St. Alexius Medical Center
Provider No.: 35-0002
FYE: 06/30/2007
PRRB Case No.: 13-0791

Dear Mr. Ravindran and Mr. Ward,

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

Background

The Provider submitted a reopening request dated December 16, 2011 to the Medicare Administrative Contractor (Contractor). In its request the Provider identified, *inter alia*, 1,712 additional Title XIX eligible days to be included in the Disproportionate Share Hospital (DSH) adjustment.[1] The Notice of Reopening granted a review of the hospital and rehabilitation total Medicaid days, but denied all other issues noted in the reopening request.[2] The Contractor issued a Revised Notice of Program Reimbursement (RNPR) dated August 16, 2012, in which it made an adjustment to allow 1,087 additional Medicaid Title XIX days.[3]

The Provider submitted a timely request for a hearing on February 12, 2013, appealing the RNPR on four issues:

(1) Supplemental Security Income Percentage (SSI%);
(2) Medicaid Eligible Days;
(3) Medicare Managed Care Part C Days; and,

[1] Contractor's Jurisdictional Challenge, Ex. I-3 (Provider's Reopening Req.), Dec. 12, 2013.
[2] *Id.*, Ex. I-4 (Contractor's Notice of Reopening of Cost Report).
[3] *Id.*, Ex. I-5 (Reopening Adjustment Report, Adj. No. 4).

(4) Dual Eligible Days.[4]

In a letter dated September 23, 2013, the Provider requested to transfer three of the four issues raised in its individual appeal (SSI%, Medicare Managed Care Part C Days, and Dual Eligible Days) to group appeals.[5]

The Provider submitted its Preliminary Position Paper (PPP) on September 26, 2013. In its PPP, the Provider requested 86 previously unclaimed Medicaid Eligible days.[6] The Contractor filed a Jurisdictional Challenge on December 12, 2013, claiming that the Board had no jurisdiction over the Medicaid Eligible Days issue. The Contractor filed its PPP on January 22, 2014. The Provider filed a Jurisdictional Response on February 21, 2014. In its Response, the Provider added to its appeal the 625 Medicaid Eligible Days that were disallowed by the Contractor in its reopening review.[7]

Contractor's Position

The Contractor contends that the Board lacks jurisdiction over the Medicaid Eligible Days issue[8] because the newly identified 86 days were not revised in the reopening. The Contractor explains that 42 C.F.R. § 405.1889 requires that appeals from RNPRs are limited to issues that were specifically addressed in the reopening process. The Provider did request a review of 1,712 Medicaid Eligible Days in its reopening; however, the 86 days now being appealed were not included in that list. Consequently, the Contractor avers that it did not make a final determination related to these 86 days and therefore, the Provider has no appeal rights related to those days. The Contractor argues that since the Provider lacks a final determination related to those 86 days, it fails to meet the jurisdictional requirements under 42 U.S.C. § 1395oo(a) that it be dissatisfied with a final determination of the Contractor.

The Contractor did not submit a jurisdictional brief related to the 625 days later added to the appeal by the Provider.

Provider's Position

The Provider contends that the Board has jurisdiction over both the 625 days denied during the reopening review and the 86 days newly identified. The Provider states that the Board has

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[4] *See* Provider's Individual Appeal Request, Aug. 16, 2012. It should be noted that the Provider's impact adjustment calculation attached to its Individual Appeal Request only calculated an additional 41 days. *Id.* The Board assumes that the 41 days originally disputed are included in the 86 days submitted with the Provider's Preliminary Position Paper.

[5] DSH SSI% to Case No. 13-2679G; DSH Medicare Managed Care Part C Days to Case No. 13-2676G; and, DSH Dual Eligible Days to Case No. 13-2678G.

[6] Contractor's Jurisdictional Challenge, Ex. I-7. *But see* Provider's Individual Appeal, Tab 5 (41 additional days were requested).

[7] *See* Provider's Jurisdictional Resp. (" . . . the Provider inadvertently omitted these 625 days from its listing of days being pursued in this appeal and instead only included a list of 86 newly identified days.") (1,712 days in reopening request – 1,087 days adjusted by Contractor = 625), Feb. 21, 2014.

[8] The Contractor only challenges the Medicaid Eligible Days issue because it anticipates the filing of separate jurisdictional challenges to the respective group appeals for the transferred issues. Contractor's Jurisdictional Challenge, 3.

jurisdiction over the 625 days since they were clearly submitted and reviewed during the reopening process, but "inadvertently omitted" from the original list of days submitted with this appeal.[9] The Provider claims that the Board has jurisdiction over the 86 days because they are also Medicaid Eligible Days, which was the specific issue addressed during the reopening process. The Provider argues that distinguishing the days previously submitted from the newly added days is "arbitrary and capricious and lacks any rational basis."[10]

Board's Determination

I. Medicaid Eligible Days

Unclaimed Medicaid Eligible Days Identified after RNPR Issued (86 Days)

The Board finds that it lacks jurisdiction over the Medicaid Eligible Days issue in the Provider's appeal because the days in dispute were not adjusted in the RNPR.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2011), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if (1) it is dissatisfied with the final determination of the Contractor, (2) the amount in controversy is $10,000 or more (or $50,000 for a group), and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides an opportunity for a provider to obtain a revised Notice of Program Reimbursement (RNPR) through a reopening of its cost report. 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 §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877, and 405.1885 of this subpart are applicable.

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[9] Provider's Jurisdictional Resp., 1.
[10] *Id.* at 2.

> (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 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. [11]

Here, the Provider requested 1,712 additional Medicaid Eligible Days in its reopening request, of which 1,087 were allowed by the Contractor. Although Medicaid Eligible Days were adjusted in the RNPR, the 86 days currently in dispute are a new universe of days not considered or adjusted by the Contractor in the reopening. Thus, pursuant to 42 C.F.R. § 405.1889(b)(1), the 86 previously unclaimed days are beyond the scope of any appeal of the revised determination. Further, absent a final determination related to these 86 days, the Provider fails to meet the jurisdictional requirement that it was "dissatisfied with a final determination of the Contractor." The Board dismisses the 86 unclaimed Medicaid Eligible Days identified after the RNPR was issued.

Previously Claimed but Recently Contested Medicaid Eligible Days (625 Days)

The Board finds that it lacks jurisdiction over the 625 Medicaid Eligible Days added to the appeal in the Provider's Jurisdictional Response because it did not timely add the issue to the appeal.

The 625 days were included in the 1,712 Medicaid Eligible Days requested to be reopened by the Provider. While the Provider's Individual Appeal Request's issue language broadly contests the Medicaid Eligible Days issue,[12] the documentation indicates that the Provider did not appeal the 625 disallowed days.[13] The Board was first informed that the Provider was "dissatisfied with the amount of DSH reimbursement that it received on the RNPR based on the Contractor's disallowance of 625 days" in its Jurisdictional Response. The Provider further stated that the 625 days were "inadvertently omitted" from its appeal request, and "[a]ccordingly, the Provider is now submitting the 625 disallowed days to the Contractor under separate cover to be sampled along with" the 86 days.[14]

For a proper appeal of the 625 days under the Medicaid Eligible Days issue, the Provider must meet the requirements outlined in 42 C.F.R. § 405.1835(c) for adding issues to a hearing request:

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[11] 42 C.F.R. § 405.1889; *see also* 42 C.F.R. § 405.1887(d), which states, "[a] reopening by itself does not extend appeal rights. Any matter that is reconsidered during the course of a reopening, but is not revised, is not within the proper scope of an appeal of a revised determination or decision . . . ;" *see also HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 615 (D.C. Cir. 1994) (holding that a provider's appeal of that reopening is limited to the specific issues revisited on reopening).

[12] *See* Provider's Individual Appeal Request, Tab 3, Issue 2.

[13] In fact, the Provider specifically addressed the impact of only 41 additional days in its estimated reimbursement calculation. *See id.*, Tab 5.

[14] Provider's Jurisdictional Resp., 1.

> After filing a hearing request in accordance with paragraphs (a) and (b) of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if the following requirements are met:
> (1) The request to add issues complies with the requirements of paragraphs (a)(1) and (b) of this section as to each new issue.
> (2) The specific matters at issue raised in the initial hearing request and the matters identified in subsequent requests to add issues, when combined, satisfy the requirements of paragraph (a)(2) of this section.
> (3) *The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) of this section.*[15]

The deadline for the Provider to add issues to its appeal was April 19, 2013. Here, by contesting a new category of days in its Jurisdictional Response on February 21, 2014, the Provider attempted to add a new issue well after the 60-day deadline had passed. The Board dismisses the 625 previously claimed Medicaid Eligible Days which were not timely appealed.

II. Transfers

The Board hereby denies the transfers of SSI% to Case No. 13-2679G; DSH Medicare Managed Care Part C Days to Case No. 13-2676G; and, DSH Dual Eligible Days to Case No. 13-2678G as the Board finds that it lacks jurisdiction over these issues. As explained above, a Provider does not have appeal rights to issues not specifically revised during a reopening. The Contractor limited its reopening to "hospital and rehabilitation total Medicaid days."[16] The three issues that the Provider has requested to be transferred to group appeals were not specifically adjusted in the RNPR as required pursuant to 42 C.F.R. § 405.1889. Therefore, the Board dismisses these issues from the individual case.

The Board has found that it lacks jurisdiction over all of the issues raised by the Provider and dismissed them from the appeal. Since there are no issues remaining, the Board hereby closes this case.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 1877.

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

FOR THE BOARD

Michael W. Harty
Chairman

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[15] 42 C.F.R. § 405.1835(c) (emphasis added).
[16] Notice of Reopening, *supra* note 2.

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OCT 17 2014

BKD, LLP
Bob Brandenburg
201 N. Illinois Street, Suite 700
P.O. Box 44998
Indianapolis, IN 46244-0998

RE: Sullivan County Community Hospital
Provider No: 15-1327
FYE: 12/31/2011
PRRB Case No: 14-3889

Dear Mr. Brandenburg,

The Provider Reimbursement Review Board (Board) has reviewed the Provider's July 24, 2014 letter requesting hearing, which was received (filed)[1] on July 28, 2014. The Board's jurisdictional determination is set forth below.

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 cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000, or more and the request for hearing is received by the Board within 180 days of the receipt of the final determination by the provider.

Pertinent Facts

The Board received a one page letter from Bob Brandenburg of BKD, LLP requesting a hearing on July 28, 2014. The letter indicated that copies of the cost report, Notice of Program Reimbursement (NPR), audit adjustment report and a letter authorizing representation were attached. However, there were no documents attached to the letter.

Mr. Brandenburg was informed by Board staff on July 30, 2014 that no documents were attached to the letter that requested hearing. On August 5, 2014, BKD, LLP submitted copies of the following documents: NPR dated January 30, 2014; NPR cost report dated January 30, 2014; Audit Adjustment report dated January 30, 2014; and the originally filed cost report dated May 25, 2012. There was no letter of representation submitted authorizing BKD, LLP to act on the provider's behalf.

[1] See, 42 C.F.R. § 415.1835(a)(3) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt of the intermediary's [final] determination.) 42 C.F.R. 405.1801(a)(2)(2008) (the date of receipt means the date stamped "Received" by the reviewing entity).

Decision of the Board

The right to a Board hearing and the information required to constitute an individual appeal is identified in the Code of Federal Regulations at 42 C.F.R. § 405.1835. Specifically, 42 C.F.R. § 405.1835(a) states that "[a] provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination . . . ." Subsection (b) continues that the provider's request for a Board hearing must be submitted in writing to the Board, and the request must include: (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a); (2) An explanation for each specific item at issue including an account of (i) why the provider believes Medicare payment is incorrect as well as (ii) how and why the provider believes Medicare payment must be determined differently; and, (3) A copy of the intermediary or Secretary determination under appeal, and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2).[2]

On July 28, 2014, the Board received a letter from BKD, LLP requesting a hearing. The letter was received 179 days after the issuance of the NPR for FYE 12/31/2011 (dated January 30, 2014) but did not include any supporting documentation. On August 5, 2014, 187 days after the issuance of the NPR, the Board subsequently received a package of supplemental, though incomplete, documentation.

The Board finds that BKD, LLP was not authorized to file the appeal on behalf of the provider as it has not provided a letter of representation. In addition, the Board finds that a proper hearing request, meeting all of the prerequisite elements of an appeal in accordance with Regulations and Board Instructions, was not timely filed within 180 days of the date of receipt of the final determination. Therefore, the Board hereby dismisses this 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

[2] See also, Board Rule 6.1 (To file an individual appeal (1) complete Model Form A – Individual Appeal Request – Initial Filing and (2) include all supporting documentation listed on the request.)

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

cc: Byron Lamprecht, Wisconsin Physicians Service
Kevin D. Shanklin, Executive Director, BCBSA

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14-3916

OCT 17 2014

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Arcadia, CA 91006

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

RE: Provider Name: Heart Hospital of Lafayette
Provider No.: 19-0263
FYE: 06/30/2011
PRRB Case No.: 14-3916

Dear Mr. Ravindran and Mr. Lamprecht,

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

Background

The Provider's Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") June 30, 2011 was issued on February 13, 2014. The Provider timely filed an appeal with the Board on August 5, 2014. The sole issue in the appeal was whether the Provider received the reimbursement Congress intended under the Medicare Act for treating certain cases that incurred extraordinarily high costs. Namely, the Provider was appealing whether the fixed loss threshold ("FLT") for outlier payments was set properly.

The Provider claims that the Secretary's final determination of outlier payments for fiscal year 2004 was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law. It is important to note that the Provider refers to the 2004 FLT although the appeal is for FY 2011. The Provider states that the FLT was set too high and therefore the resulting amount of outlier payments fell short of the percentage required and hospitals did not receive the amount of outlier payments that Congress intended. The Provider references Audit Adjustment Numbers 3, 8, 9, 15, 17, 18, and makes a claim for a self-disallowed amount. The estimated reimbursement amount involved is $36,461.00.

Contractor's Position

The Medicare Administrative Contractor ("Contractor") filed a jurisdictional challenge on August 14, 2014. The Contractor contends that the Board has no jurisdiction over "Outlier payments – FLT" because it is not an appealable issue. The Contractor argues that the issue being appealed centers on amounts paid with respect to Part A individual beneficiary claims covered under 42 C.F.R. Part 405 Subpart G. The Contractor states the Board should find it lacks jurisdiction because the Board is unable to review an appeal of individual beneficiary claims.

Provider's Position

The Provider filed a response on August 19, 2014. The Provider stated that it treated patients whose care qualified under the statute for outlier payments, referencing 42 U.S.C. § 1395ww(d)(5)(A)(iv). The Provider asserted that during the review of its cost report, the Contractor made audit adjustments as to the proper amount of outlier payments (the adjustments noted above). The Provider went on to state that the FLT used to calculate the outlier adjustment resulted in lower additional payments. The Provider contends that this was inherently faulty and must be corrected and that the Provider is dissatisfied with these determinations.

The Provider further contends that notwithstanding the audit adjustments, the Board has jurisdiction even though the Provider failed to expressly disallow the item on its cost report. The Provider stated that the erroneously computed outlier payments were not costs which could be claimed on its cost report, and that the Board's jurisdiction is not contingent upon claiming each disputed item in a cost report. The Provider cited *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399 (1988) and asserted that the 2008 revised regulations in 42 C.F.R. § 405.1835(a)(1) are inconsistent with the plain language of the governing statute, and there is no requirement for a provider to submit a claim first to its Contractor in order to preserve an appeal right.

Board's Determination

The Board finds that it lacks jurisdiction in this case.

The Board denies jurisdiction over the appeal because this appeal does not comply with the requirements of 42 C.F.R. § 405.1835(a)(1)(ii) (2013), which requires that a Provider protest any self-disallowed item. Moreover, the FLT question is not a claims problem, as asserted by the Contractor. Rather, it is an amount set by the Secretary in the Federal Register that determines whether a Provider receives an outlier payment reimbursement.

Pursuant to 42 C.F.R. § 405.1835(a)(1), in addition to the amount in controversy and time of filing requirements, a provider has a right to a Board hearing for specific items claimed for a cost reporting period covered by a Contractor or Secretary determination, only if the provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—

(i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or

(ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy.[1]

The Provider states that adjustments made by the Contractor regarding its outlier payments were covered by Adjustment Nos. 3, 8, 9, 15, 17, and 18; however, none of these items reference the outlier payments' FLT. In fact, the FLT will not appear on the audit adjustment report since there is no adjustment to the outlier payment identified by the Provider. Although the Provider is appealing its lack of adequate reimbursement because the FLT determined by the Secretary used in calculating any outlier payment was too high, it failed to protest the reduced reimbursement as required. Consequently, the Provider cannot meet the jurisdictional requirements in 42 C.F.R. § 405.1835(a)(1)(i). In order for the Board to have jurisdiction, then, the Provider must meet the requirements under 42 C.F.R. § 405.1835(a)(1)(ii).

Effective with cost report periods that end on or after 12/31/2008, CMS amended the regulations governing cost report appeals to incorporate Provider Reimbursement Manual (PRM) 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." Here, the Provider's cost report was for FYE 06/30/2011; therefore, any self-disallowed items are required to be protested. The Provider did not file the item under protest, which the Provider concedes in its Jurisdictional Response. Therefore, the Provider failed to preserve its rights, and lacks any legal basis to appeal the item to the Board under 42 C.F.R. § 405.1835(a)(1)(ii) for self-disallowed costs. As this issue is the sole issue in this appeal, the case is dismissed.

Contractor's Argument Regarding Individual Beneficiary Claims

The Contractor contends that the outlier issue in this case is centered on the amounts paid with respect to individual beneficiary claims, and therefore is not an appealable issue before the Board. That is incorrect. Pursuant to 42 U.S.C. § 1395oo(a), the Board has jurisdiction if such provider is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (d) of § 1395ww of Title 42. Subsection (d)(5)(A) of § 1395ww concerns outlier payments, which is the issue raised by the Provider in the instant case. Outlier payments fall under the prospective payment systems for inpatient hospital services. Additional payments are made for outlier or extremely costly cases that exceed the typical costs for a

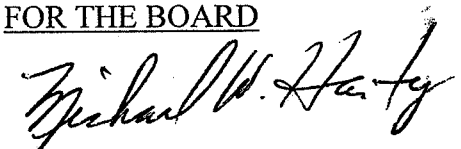
[1] 42 C.F.R. § 405.1835(a)(1).

diagnostic-related group ("DRG").[2] In order to receive an outlier payment, a hospital's estimated costs to treat the case must exceed the FLT set each year by the Secretary.[3] Therefore, the jurisdictional statutes and regulations establish that the issue of outlier payments are not individual beneficiary claims and may be appealed to the Board. However, for reasons stated above, the Board finds that it lacks jurisdiction in this case.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 1877.

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

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 Shanklin, BCBSA (without enclosures)

[2] *See generally* 42 C.F.R. § 412.80 *et seq.*
[3] *Id.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
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Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to: 08-0693G

CERTIFIED MAIL OCT 17 2014

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Blumberg Ribner, Inc.
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

Kyle Browning
National Government Services, Inc.
P. O. Box 6474
Indianapolis, IN 46206-6474

RE: Blumberg Ribner 2004 Dual Eligible Days Group
Provider Nos.: Various
FYEs: 6/30/2004-12/31/2004
PRRB Case No.: 08-0693G

Dear Mr. Blumberg and Mr. Browning:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal and has determined that the case must be bifurcated for compliance with the Centers for Medicare & Medicaid Services (CMS) Ruling-1498-R.

On January 24, 2008, the Board received the Providers' initial request to establish the Blumberg Ribner 2004 Dual Eligible Days group appeal. There were initially two providers included in the request, but the group now consists of nine providers including:

- Provider 1, Benedictine Hospital, FYE 12/31/2004
- Provider 2, Cayuga Medical Center, FYE 12/31/2004
- Provider 3, Crouse Hospital, FYE 12/31/2004
- Provider 4, Fremont Area Medical Center, FYE 6/30/2004
- Provider 5, Hershey Medical Center, FYE 6/30/2004
- Provider 6, MidState Medical Center, FYE 9/30/2004
- Provider 7, Niagara Falls Memorial Medical Center, FYE 12/31/2004
- Provider 8, Saint Luke's Hospital, FYE 6/30/2004
- Provider 9, Tucson Medical Center, FYE 12/31/2004

The Providers identified the following common issue in their initial request:

> Disproportionate Share (DSH) Adjustment—The Providers contend that their respective DSH adjustments are understated due to the exclusion from the Medicaid proxy calculation of certain days relating to patients dually eligible for both Medicaid and Medicare. Further, the Providers assert that the HCFA Administrator's decision pertaining to said days in *Edgewater Medical Center v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Illinois* (June 19, 2000) is inconsistent with applicable Medicare Regulations.

CMS issued Ruling No.: CMS-1498-R (Ruling) on April 28, 2010. The Ruling deals with the DSH treatment for two types of patient days: (1) non-covered inpatient hospital days for patients entitled to Medicare Part A and days for which patients' Part A inpatient hospital benefits are exhausted (referred to as dual eligible days); and (2) labor/delivery room inpatient days. The Ruling also requires a change in the data matching process used in the calculation of the SSI fraction.

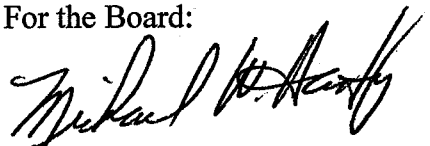
Pursuant to the Ruling, appeals of the dual eligible days issue that meet the applicable jurisdictional and procedural requirements and involve patient discharges before October 1, 2004, are to be remanded to the Medicare administrative contractor for recalculation of the DSH payment adjustment. Fiscal periods covering patient discharges on or after October 1, 2004, are not subject to the Ruling. Therefore, this group appeal must be bifurcated in order to accommodate the portion of the fiscal year subject to the Ruling.

Accordingly, for Providers 1-3, 7 and 9, the appealed Medicare dual eligible days issue for the period of October 1, 2004, to December 31, 2004, will be transferred into the group representative's open appeal for FYE 2005, Blumberg Ribner 2005 Dual Eligible Days Group, PRRB case number 08-0694G. This case will be renamed the Blumberg Ribner 10/1/2004-2005 Dual Eligible Days Group and should be so referenced in all future correspondence.

The Medicare dual eligible days issue for the Providers in this group appeal for periods prior to October 1, 2004, will remain in Blumberg Ribner 2004 Dual Eligible Days Group, PRRB case number 08-0693G. This includes the period January 1, 2004, to September 30, 2004, for Providers 1-3, 7 and 9, as well as the full fiscal period for all other Providers. The remand, pursuant to CMS Ruling-1498-R, will be provided under separate cover.

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

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, Executive Director, Blue Cross and Blue Shield Association