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

Phone: 410-786-2671
Internet: www.cms.gov/PRRBReview FAX: 410-786-5298

Refer to:

CERTIFIED MAIL

DEC 01 2014

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

RE: Sycamore Shoals Hospital, Provider No. 44-0018, FYE 6/30/2012, Case No. 14-3705
Request for Reconsideration & Reinstatement of Add Issue Request

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (the Board) has reviewed your Request for Reconsideration and Reinstatement of the Add Issue you filed on September 22, 2014. The pertinent facts of the case and the Board's determination are set forth below.

PERTINENT FACTS:

Quality Reimbursement Services, Inc. (QRS) filed an appeal on behalf of the Provider based on the Medicare Administrative Contractor's (MAC's) failure to issue a timely determination. The appeal is dated June 19, 2014 and was received by the Board on June 23, 2014.

Upon filing of this appeal, the Provider failed to include evidence of the date the cost report was filed, as is required in the Model Form A - Individual Appeal Request. As the Provider failed to include all required documentation with the appeal request, the Board sent a request on June 25, 2014 for the missing information, giving 30 days to respond. The Provider Representative followed up via email on July 23, 2014, supplying a copy of the MAC Tentative Settlement letter, evidencing acceptance of the cost report on December 3, 2012.

QRS requested the addition of multiple issues (including SSI Percentage/Provider Specific; SSI Percentage/Systemic; SSI Fraction Part C Days, Medicaid Fraction Part C Days; SSI Fraction Dual Eligible Days and Medicaid Fraction Dual Eligible Days.) The Request to Add Issues was dated August 29, 2014 and was received by the Board on September 3, 2014.

Because the Request to Add was more than 245 days, a computer generated letter dismissing the issues was sent.[1]

QRS requested a reconsideration and reinstatement of the add issue request by letter dated September 19, 2014, which was received by the Board on September 22, 2014. In its

[1] The letter dismissing issues was erroneously sent by email on September 16, 2014.

reinstatement request, QRS states that the cost report was filed on January 7, 2013, and that the 1 year deadline passed on January 7, 2014. Based on this date, the 180 day limit to file an appeal was July 6, 2014 and the deadline to add issues was September 4, 2014. Based on these dates, the Representative claims the September 3, 2014 request to add issues was timely.

BOARD DETERMINATION:

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 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 Notice of Program Reimbursement (NPR).

Specifically, 42 C.F.R. § 405.1835(a)(3) states:

> Unless the provider qualifies for a good cause extension under § 405.1836 of this subpart, the date of receipt by the Board of the provider's hearing request is—
>
> ***
>
> (ii) If the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter), no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination. The date of receipt by the intermediary of the provider's perfected cost report or amended cost report is presumed to be the date the intermediary stamped "Received" unless it is shown by a preponderance of the evidence that the intermediary received the cost report on an earlier date.

The Board notes that the Provider's FYE is 6/30/2012. Based on this FYE, the cost report was due to be filed by the Provider 5 months later, which would have been Saturday, December 1, 2012. The evidence submitted by the Representative on July 23, 2014 establishing the MAC's receipt of the cost report shows the receipt date as Monday, December 3, 2012.[2] The cost report settlement was due one year later, which would have been Tuesday, December 3, 2013.

In its reinstatement request, the Provider contends that the cost report was filed on January 7, 2013, however it provided no documentation to support that date (and it is contrary to the earlier documentation it submitted). Based on the documentation in file,

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[2] Pursuant to 42 C.F.R. 405.1801(d)(3), when the "... last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday ... the deadline becomes the next day that is not one of the aforementioned days."

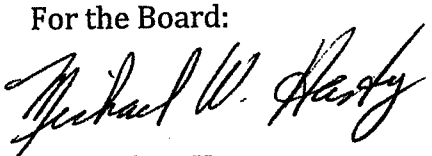
the Board finds that the appeal was filed 202 days after the expiration of the 12 month period for issuance of the MAC's determination (which was December 1, 2013).[3] Therefore, the Board finds that the initial appeal request was not timely filed from the MAC's failure to issue a timely determination and hereby dismisses the subject case.

Further, pursuant to 42 C.F.R. 405.1835 (c), a request to add issues to an appeal is timely if the Board receives the request to add issues no later than 60 days after the expiration of the applicable 180 day appeal period set forth in 42 C.F.R. § 405.1835(a)(3). In this case, the Request to Add Issues was received 274 days after the MAC's receipt of the cost report, which is more than the allowed 240 days. Moreover, because the initial request for an appeal was untimely, there was not a valid appeal to which the Provider could add an issue. Consequently, the Representative's Request to Reconsider and Reinstate the Add Issue is also denied.

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.
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 .1877

cc: Cahaba Government Benefit Administrators, LLC
Renee Rhone, Senior Auditor/Appeals Specialist
P.O. Box 1448
Birmingham, AL 35201 1448

BC BS Association
Kevin D. Shanklin, Executive Director
Senior Government Initiatives
225 North Michigan Avenue
Chicago, IL 60601 7680

[3] See 42 C.F.R. 405.1801(d)(3) – Since the actual due date fell on a Saturday, the deadline became the following Monday, December 3, 2013.

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Refer to: 08-2769

DEC 04 2014

CERTIFIED MAIL

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

Donna Kalafut
Noridian Healthcare Solutions, LLC
P. O. Box 6782
Fargo, ND 58108

RE: Hawaii Medical Center West (formerly Saint Francis Medical Center—West)
Provider No.: 12-0027
FYEs: 01/13/2007
PRRB Case No.: 08-2769

Dear Mr. Blumberg and Ms. Kalafut:

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

Background

The Medicare Administrative Contractor ("MAC") issued Provider's Notice of Program Reimbursement on February 26, 2008. On August 20, 2008, Provider timely filed an individual appeal request with the Board that contained three issues: (1) Medicare Supplemental Security Income ("SSI") Percentage, (2) Medicare/Medicaid Dual Eligible Patient Days, and (3) Medicaid Eligible Patient Days. On April 29, 2009, the Board received Provider's written request to withdraw the Medicaid Eligible Days issue from its appeal.

On April 29, 2009, the Board received a copy of Provider's Preliminary Position Paper ("Position Paper") which contained only one issue—"Medicare SSI Realignment." In describing its remaining issue, Provider argues that its SSI percentage is understated or otherwise inaccurate and challenges CMS' use of the percentage. Provider seeks to analyze the underlying Medicare Provider Analysis and Review ("MEDPAR") data used by CMS to generate the SSI percentage. Provider also states that after it analyzes the data, it will then decide whether to avail itself of the right to an SSI percentage that uses Provider's own cost reporting period.

Board's Decision

On its own motion, the Board has chosen to review whether it has jurisdiction over Provider's "Medicare SSI Realignment" issue in this appeal. The Board finds that although Provider argues only one issue in its Position Paper, there are actually two separate issues—Provider's challenge to CMS' data matching process used to calculate the SSI percentage and Provider's potential

request for realignment.

Provider's Challenge to CMS' Data Matching Process

CMS issued Ruling No.: CMS-1498-R ("Ruling") on April 28, 2010. The Ruling addresses providers' appeals of the data matching process used by CMS in calculating the SSI fraction/percentage. Pursuant to the Ruling, properly pending appeals of the SSI fraction data matching process issue are to be remanded back to the Medicare contractor for recalculation of the disproportionate share hospital payment adjustment. CMS will then apply a revised data matching process when recalculating the providers' SSI fractions.

Accordingly, Provider's challenge to CMS' data matching process will be remanded to the Medicare contractor. The remand, pursuant to the Ruling, will be provided under separate cover.

Provider's Request for Realignment

The Board finds that it does not have jurisdiction over Provider's SSI realignment issue as the appeal is premature. Under 42 C.F.R. § 405.1835 (2007)

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

In this case, the MAC has not made a final determination with respect to realignment and Provider has not decided whether it will request realignment. The Board considers realignment a remedy that a provider may pursue if it is dissatisfied with MEDPAR SSI data. Therefore, Provider's appeal of its SSI realignment is premature and that issue is dismissed.

As there are no remaining issues left in this appeal, case number 08-2769 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.
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

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Refer to:

04-1682G

DEC 08 2014

CERTIFIED MAIL

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

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

RE: Jurisdiction Challenge
QRS 1993 DSH/SSI Proxy Group Appeal
Provider No.: Various
FYE: 1993
PRRB Case No.: 04-1682G

Dear Mr. Ravindran and 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 decision of the Board is set forth below.

Background

The Providers filed an initial request for a group appeal on April 29, 2004. This is a group appeal with one issue, SSI%, covered under Ruling 1498-R. The Board acknowledged the creation of the Group, by sending out a Group Acknowledgement and Critical Due Date letter on May 18, 2004 to the Group Representative.

On November 27, 2012 the Board sent a letter to the Group' representative requesting the Schedule of Providers ("SOP") with associated jurisdictional documentation in order to process the remand under the standard procedure. The Group representative submitted the requested documentation to the Board on January 24, 2013(Received January 25, 2013).

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1841(2004), 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 Notice of the final determination .

The Board finds that it does not have jurisdiction over Sanford USD MC Sioux Falls, Provider No. 43-0027, FYE 4/30/93 (Participant#4) because the Provider appealed from a revised Notice of Amount of Program Reimbursement ("NPR") which did not specifically adjust the SSI % 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).

In accordance with 42 C.F.R. § 405.1889 (2004), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[1] This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case, the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius,* No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). In this case the Court also held that "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

In its January 24, 2013 submission of the SOP with Jurisdictional documentation the Group' representative submitted the revised NPR which reflected that the DSH Generally, DSH Capital Payments, and Title 19 days were adjusted however the Group representative did not submit any Intermediary work papers that noted a change in the SSI% for Sanford USD MC Sioux Falls (Participant #4). 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 Sanford USD MC Sioux Falls (Participant #4) since there was no evidence that SSI% was actually adjusted.

As the Board lacks jurisdiction over Sanford USD MC Sioux Falls (Participant #4) it is dismissed from this group appeal. The case will remain open because the appeal is still pending for the other Providers in the group.

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[1] 42 C.F.R. § 405.1889 (2004) stated "[w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable."

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 this case.

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)
42 C.F.R. §§405.1875 and 405.1877

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

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Refer to: 06-0027GC

DEC 08 2014

CERTIFIED MAIL

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

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

RE: Jurisdiction Challenge
CHW 1997 DSH SSI Ratio CIRP Group
Provider No.: Various
FYE: 1997
PRRB Case No.: 06-0027GC

Dear Mr. Knight and 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 decision of the Board is set forth below.

Background

The Providers filed an initial request for a group appeal on October 11, 2005. This is a group appeal with one issue, SSI%, covered under Ruling 1498-R. The Board acknowledged the creation of the Group, by sending out a Group Acknowledgement and Critical Due Date letter on October 20, 2005 to the Group Representative.

On September 16, 2013 the Board sent a letter to the Group' representative requesting the Schedule of Providers ("SOP") with associated jurisdictional documentation in order to process the remand under the standard procedure. The Group representative submitted the requested documentation to the Board on October 17, 2013.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1841(2005), 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 Notice of the final determination .

The Board finds that it does not have jurisdiction over Mercy Medical Center Redding, Provider No. 05-0280 (Participant#6) because the Provider appealed from a revised Notice of Amount of Program Reimbursement ("NPR") which did not specifically adjust the SSI % 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).

In accordance with 42 C.F.R. § 405.1889 (2005), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[1] This regulation has also been addressed and explained in the decision *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994). In this case, the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius,* No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014). In this case the Court also held that "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered.

In its October 17, 2013 submission of the SOP with Jurisdictional documentation the Group' representative submitted, the audit adjustments which reflected that the Medicaid eligible days on worksheet S-3 and the corresponding DSH% on worksheet E Part A were adjusted. However, the Group representative did not submit any Intermediary work papers to document if a change in the SSI% for Mercy Medical Center Redding (Participant #6) was made in the revised NPR. This is the same scenario as in the *Emanuel* case. 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 (Participant #6) since there was no evidence that SSI% was actually adjusted.

As the Board lacks jurisdiction over Mercy Medical Center Redding (Participant #6) it is dismissed from this group appeal. The case will remain open because the appeal is still pending for the other Providers in the group.

---

[1] 42 C.F.R. § 405.1889 (2005) stated "[w]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened ... such revision shall be considered a separate and distinct determination or decision to which the provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable."

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 this case.

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)
42 C.F.R. §§405.1875 and 405.1877

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

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Refer to: 06-0027GC

DEC 08 2014

CERTIFIED MAIL

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

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

RE: Participant # 2: Glendale Memorial Hospital Provider No. 05-0058 *as a participant in* CHW 1997 DSH SSI Ratio CIRP Group
FYE: 1997
PRRB Case No.: 06-0027GC

Dear Mr. Knight and 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 decision of the Board is set forth below.

Background

By letter dated March 20, 2000 the Provider requested a hearing before the Board based on the Notice of Program Reimbursement (NPR) dated September 23, 1999. The request for a hearing included eleven issues; one of the issues was Disproportionate Share Adjustment (DSH). The Provider cited various adjustments including the SSI adjustment made by the Intermediary (Adjustment #39). The Board acknowledged the request for a hearing and sent acknowledgment and critical due dates letter on April 4, 2000 assigning Case # 00-2250 to the appeal.

By letter dated October 11, 2005, the group representative submitted a request to establish a group appeal "Catholic Healthcare West ("CHW") 1997 DSH SSI Ratio Group" attached to the request was a list of Providers to establish a Group Appeal. One of the identified participants was Glendale Memorial Hospital, Case No. 00-2250. This submission served as a request for transfer of the SSI issue, from Case No. 00-2250 to CHW 1997 DSH SSI Ratio CIRP Group" which was affirmed by the Group Representative on the Updated Schedule of Providers ("SOP").

By letter dated October 30, 2006 (received October 31, 2006) the Group Representative stated that the group is complete as of November 1, 2006. On June 5, 2007 (received June 7, 2007), the Group Representative submitted a response to the Intermediary Position Paper,

acknowledging that Provider's transfer of the SSI issue from Case No.00-2250 was untimely as the Board's letter dated October 8, 2004 closed the case prior to the Provider's request to transfer to the current group. The Provider also agreed to remove Case No. 00-2250 from the current group. However, the Group Representative also submitted a copy of the updated SOP and supporting jurisdictional documents dated October 11, 2013 (received October 17, 2013), which included Case No. 00-2250 as a participant in the current Group.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 - 405.1841(2005), 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 Notice of the final determination .

Participant #2, Glendale Memorial Hospital &Health Center Provider No. 05-0058 established its original appeal with the Board on March 20, 2000 from a final determination dated September 23, 1999. The Board acknowledged the appeal and assigned Case No. 00-2250. Case No. 00-2250 was closed on October 8, 2004 based on withdrawal letter dated September 22, 2004.[1] The Provider subsequently attempted to transfer the SSI issue from the individual appeal to the newly formed CHW 1997 DSH SSI Ratio CIRP Group Case No. 06-0027GC, through the October 11, 2005 request for Establishment of Group Appeal.

The individual appeal for Glendale Memorial Hospital & Health Center, Case No. 00-2250, was in a closed status at the time the transfer was requested. Therefore, the Board hereby denies the transfer of the SSI issue from the individual appeal to the group and dismisses the Provider from the current group, Case No. 06-0027GC.

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 this case.

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)
42 C.F.R. §§405.1875 and 405.1877

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

[1] Board's Dismissal letter attached.

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DEC 09 2014

Dennis M. Barry, Esq.
King & Spalding
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006-4706

RE: King & Spalding FFY 2014 0.2% IPPS Reduction Groups
PRRB Case Nos.: 14-1826 et al. (see attached Listing of Group Cases)
Provider Nos.: Various (see attached Schedules of Providers)

Dear Mr. Barry:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' November 25, 2014 request for expedited judicial review (EJR) (received November 26, 2014). The Board's response to the request for EJR is set forth below.

Issues

The issues under appeal are:

> Whether the Secretary's adjustment to the Medicare hospital inpatient prospective payment system (IPPS) standardized amount to account for the adoption of the "two midnight" rule is lawful; and
>
> If lawful, whether the adjustment (-0.2 percent) was in the correct amount or should it have been less of a reduction or an increase in the standardized amount?

The Providers assert that the Board lacks the authority to overturn the Secretary's decision to apply a downward 0.2 percent adjustment to IPPS rates for Federal fiscal year (FFY) 2014 as set forth in the August 19, 2014 Federal Register. [1, 2]

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[3] 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

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[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] 78 Fed. Reg. 50496, 50953-54 (August 19, 2013).
[3] 77 Fed. Reg. 45061, 45155-57 (July 30, 2012) and the final rule with comments, 77 Fed. Reg. 68210, 68426-33 (November 15, 2012).

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.[4]

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). The 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.[5]

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).[6]

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[7] 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.[8]

In the FFY 2014 IPPS proposed rule,[9] 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

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[4] 78 Fed. Reg. at 50907.
[5] *Id.*
[6] *Id.*
[7] Chapter 6, § 20.6 and Chapter 1, § 10.
[8] 78 Fed. Reg. at 50907-08.
[9] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).

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).[10]

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 decisions 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.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued CMS Ruling CMS-1455-P[12] (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.[13] 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.[14]

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.[15]

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[10] 78 Fed. Reg. 50908.
[11] *Id.*
[12] *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.
[13] 78 Fed. Reg. at 50909.
[14] *Id.* at 50927.
[15] *Id.* at 50944.

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).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

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 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.[18] 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.[19]

Providers' Request for EJR

The Providers contend that the Secretary's decision to apply a downward 0.2 percent adjustment to the operating IPPS standardized amount and the capital standard Federal payment rate for FFY 2014 is unlawful and should be reversed because:

- The adjustment exceeds the Secretary's statutory authority to adjust IPPS standardized amounts;

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[16] *Id.*
[17] *Id.* at 50945.
[18] *Id.* at 50952-53.
[19] *Id.* at 50990.

- The amount of the adjustment is unsupported by data and is arbitrary and capricious; and

- The Secretary violated the Administrative Procedure Act notice and comment ruling making requirements because of insufficient discussion of the data and assumptions purporting to support the amount of the adjustments and failing to address or take into account public comments to the proposed rule.

The Providers assert that following a period of notice and comment the Secretary failed to respond adequately to comments opposing the proposed reduction and adopted the 0.2 percent reduction to IPPS to offset the perceived impact of the 2-midnight rule. The Providers do not believe the Secretary's calculations are supported by the data she cites, and she ignored comments identify errors in the agency's reasoning. The commenters used publicly available Medicare files to determine whether they could duplicate the Secretary's conclusions on the number of encounters that would move from inpatient status to outpatient status (and vice versa). The commenters informed CMS that the calculations were not replicable and argued that the adoption of the 0.2 percent payment calculation was improper and not supported by data.[20]

The Providers point out that, although the Secretary asserted that only 360,000 patient days would shift from inpatient to outpatient days, the Providers contend that this is incorrect. In calendar year 2011, the year used by the Secretary to analyze to support the need for the 0.2 percent reduction, she estimated that there were 1,569,693 inpatient stays of one day. The commenters noted that under the 2-midnight rule, nearly all of those inpatient stays would shift to outpatient encounters. The commenters estimate included excluding days for patients who died, transferred to another hospital or SNF or left the hospital against medical advice. But the Secretary asserted that only 360,000 stays would shift to outpatient status without explanation. The Providers assert that a similar lack of reasoned analysis by the Secretary applies to extended observation bed encounters and the shift from outpatient to inpatient stays.

Violation of the Administrative Procedures Act (APA)

The Providers argue that the Secretary's adoption of the 0.2 percent adjustment to IPPS violates the APA, and is arbitrary and capricious in several respects. First, the adopted proposal runs counter to the data upon which it relied and the Secretary offers no explanation for the difference—the Secretary did not explain how 1.5 million one-day stays in 2011 could be reduced to 360,000 or how 400,000 outpatient encounters would move to inpatient status.

Second, the Secretary failed to respond to the commenters' analysis of the data in the final rule. An agency has a duty to respond to significant comments that directly challenge the basis and purpose of an agency rule.

Third, the Secretary failed to articulate a rational connection between the facts found and the choice made. The Supreme Court has stated that an agency must "examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" *Motor Vehicle Mgrs. Ass'n*, 463 U.S. at 43 (internal citations omitted).

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[20] *See* Provider's EJR Request, Ex. 2, Letters dated June 25 and May 17, 2013 to CMS furnishing comments on proposed regulations.

Further, the Secretary's actions violate the APA because the calculations are incorrect and she has refused to acknowledge the error through the rulemaking process. The Secretary did not adequately explain the methodology, including assumptions used to derive the proposed adjustments or the decision to finalize the adjustments. The Providers believe that the Secretary either failed to make a full disclosure of the data that led to her conclusion or bungled the math.

Finally, the Providers argue, even if the Secretary's actions were not arbitrary and capricious, she lacks the authority under 42 U.S.C. § 1395ww(d)(5)(I)(i), or any other provision of the law, to make a downward adjustment in the rates set under §1395ww(d) announced in the proposed and final IPPS rules. The 2-Midnight Rule affects the number of cases that would be paid under IPPS rates—that is, it affects the number of cases that are covered under Part A. Applying what the Providers characterize as "budget neutrality adjustments" to volume changes caused by policy decisions violates the fundamental structure and policy that has governed IPPS since its inception in 1983. Specifically, IPPS adjusts automatically to both the service mix and volume of hospital admissions, which vary from year to year, based on many factors. The Providers believe that Congress did not intend to permit the Secretary to use § 1395ww(d) to make changes to account for changes in volume.[21]

Jurisdiction and 42 C.F.R. § 405.1804

The Providers mention that the Board can take jurisdiction over this issue as a budget neutrality matter under § 405.1804[22] based on the December 10, 2013 Federal Register Notice[23] which made a "Technical Conforming Change" to certain matters under IPPS which are not subject to administrative or judicial review.

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 each group 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. With respect to the Providers' assertion regarding jurisdiction under 42 C.F.R. § 405.1804, the Board finds that this assertion is not relevant to the issue before the Board. As explained in the preamble to the final rule, the Secretary exercised her authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to make the 0.2 percent reduction,[24] not as a budget neutrality adjustment pursuant to § 1395ww(e)(1) of the Act.

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 and the capital standard Federal payment rate, there are no findings of fact for resolution by the Board;

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[21] Provider's November 25, 2014 EJR Request at 12.
[22] *Id.* at 5.
[23] 78 Fed. Reg. at 74826, 75162 (December 10, 2014).
[24] 78 Fed. Reg. at 50953.

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 and capital Federal payment rate, is valid.

Accordingly, the Board concludes 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 each of the referenced cases.

Board Members Participating

Michael W. Harty
John Gary Blowers, 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
Listing of King & Spalding FFY2014 0.2 Percent IPPS Rate Reduction Group Cases
Schedules of Providers for Participating Groups

cc: Geoff Pike, First Coast Service Options (w/Listing of Cases and Schedules of Providers)
Cecile Huggins, Palmetto GBA (w/Listing of Cases and Schedules of Providers)
Byron Lamprecht, Wisconsin Physicians Service (w/Listing of Cases and Schedules of Providers)
James Ward, Noridian Healthcare Solutions (w/Listing of Cases and Schedules of Providers)
Timothy LeJune, Novitas Solutions (w/Listing of Cases and Schedules of Providers)
Renee Rhone, Cahaba GBA (w/Listing of Cases and Schedules of Providers)
Danene Hartley, National Gov't Services (w/Listing of Cases and Schedules of Providers)
Judith E. Cummings, CGS Administrators (w/Listing of Cases and Schedules of Providers)
Bruce Synder, Novitas Solutions (w/Listing of Cases and Schedules of Providers)
Kevin Shanklin, BCBSA (w/Listing of Cases and Schedules of Providers)

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Refer to: 09-1518GC

CERTIFIED MAIL

DEC 09 2014

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Cecile Huggins
Palmetto GBA
Supervisor
Provider Audit – Mail Code AG-380
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Camden, SC 29020-1728

RE: Jurisdictional Decision – Baberton Citizens Hospital, *as a participant in*
CHS 1997 DSH SSI Ratio CIRP Group
Provider No.: 36-0019
FYE: 12/31/1997
PRRB Case No.: 09-1518GC

Dear Mr. Hettich & 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

On September 29, 2000, Barberton Citizens Hospital was issued an original NPR for FYE 12/31/1997. The Provider filed its individual appeal request with the Board on March 15, 2001 in which it appealed nine issues. One of the issues the Provider included stated:

> Adjustment #61 properly adjusted the SSI%, but the allowable disproportionate share percentage on line 4.03 of worksheet E, Part A should be decreased from 2.85% to 2.72%. I have sent a computation of the DSH percentage and of the total disproportionate share amount to the intermediary. This would decrease reimbursement $30,774.

On April 19, 2009, the Providers filed a group appeal request with the Board for the SSI ratio issue; the Board assigned case number 09-1518GC to the appeal. Barberton Citizens Hospital requested to transfer the SSI percentage issue to this group appeal on July 5, 2011.

MAC's Position

The MAC did not file a jurisdictional challenge in this appeal.

Providers' Position

The Providers did not submit a jurisdictional brief in this appeal.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2008), 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 (emphasis added). Before the Board can make a determination over all matters covered by the cost report, it must first determine that a Provider has filed a jurisdictionally valid appeal.

The Board finds that it does not have jurisdiction over Participant 4, Barberton Citizens Hospital, as a participant in case number 09-1518GC because the Provider never appealed the SSI percentage issue or added the issue to its appeal request. In its appeal request, the Provider referenced the SSI percentage, but stated that the MAC's adjustment to that cost was proper. Based on the language of the issue statement, it appears that the Provider is challenging the DSH percentage as a whole and the impact to the DSH payment, but not the SSI percentage. The Board has determined that, based on this language, the Provider did not appeal the SSI percentage issue in its appeal request.

Further, the Board has determined that the Provider never requested to add the SSI percentage issue prior to its July 5, 2011 request to transfer the issue to this group appeal. New Board rules went into effect on August 11, 2008, limiting the ability of Providers to add issues to appeals. Providers had 60 days to add issues to appeals pending at the time the rules went into effect.[1] Barberton Citizens Hospital did not request to add the SSI percentage issue to its pending appeal, case number 01-1893, by the October 20, 2008 add-issue deadline established in the Federal Register. Therefore, the Board finds that Barberton Citizens Hospital did not timely add the SSI percentage issue to its appeal request prior to requesting to transfer the issue to this group appeal. The Board hereby dismisses Barberton Citizens Hospital from case number 09-1518GC. This group appeal will remain open as there are other Providers pending in the appeal.

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

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

FOR THE BOARD

Charlotte F. Benson for

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] 73 Fed. Reg. 30190-01, 30236 (May 23, 2008).

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Refer to:

CERTIFIED MAIL

DEC 11 2014

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

RE: St. Mary Medical Center, Provider No. 14-0064, FYE 9/30/2007, Case No. 14-0529

Dear Mr. Hettich:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal in response to the Blue Cross & Blue Shield Association's (Blue Cross) challenge to jurisdiction over two of the issues appealed by St. Mary Medical Center (St. Mary). The Board finds that it lacks jurisdiction over the two issues in the case because they were not adjusted in the revised Notice of Program Reimbursement (NPR) from which they were appealed.

Pertinent Facts:

King & Spalding filed a request for appeal on November 5, 2013. The appeal was filed from the receipt of St. Mary's revised NPR dated May 9, 2013. The Board acknowledged the appeal and assigned it case number 14-0529.

Blue Cross filed an objection on behalf of the Medicare Administrative Contractor (MAC), Wisconsin Physicians Service (WPS). Blue Cross objected to the Board's jurisdiction over St. Mary's appeal of the SSI Percentage and Dual Eligible Days issues. Blue Cross contends that WPS made no adjustment for either issue on the revised NPR. The revised NPR was only issued to incorporate 29 Medicaid Eligible days that St. Mary's requested in its Reopening Request.[1]

King & Spalding did not submit a responsive jurisdictional brief to Blue Cross' challenge. Instead, on July 31, 2014, it requested the transfer of the SSI Fraction Medicare Advantage Days issue and the Medicaid Fraction Medicare Advantage Days issues to optional group appeals (case numbers 14-1135G & 14-1136G, respectively). Once transferred, King & Spalding advised that the case could be closed as there would be no remaining issues in the individual appeal.

Board Determination:

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 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

[1] Although the MAC characterized the issues as SSI Percentage & Dual Eligible Days, the issue statement describes the SSI Fraction Part C Days & Medicaid Fraction Part C Days issues.

$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 Notice of Program Reimbursement (NPR).

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

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

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

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

In its Reopening Request, St. Mary's requested reimbursement for 29 additional Medicaid eligible days.[2] In the Notice of Reopening, dated October 1, 2012, WPS indicated that it would review the Medicaid Days claimed for the computation. The adjustment report submitted further shows the additional 29 days (that St. Mary's requested) were incorporated in audit adjustment #4.[3]

The Board has applied the reasoning set forth in *Illinois Masonic Medical Center v. BCBSA (Illinois Masonic)*, PRRB Dec. 2010-D47, in this case.[4] In *Illinois Masonic*, the Provider appealed Medicaid eligible days and transferred the issue to a group appeal. Ultimately, that group appeal resulted in an Administrative Resolution in which the Provider and the Intermediary jointly agreed that the Provider's representative (QRS) was to submit documentation to support the days claimed are not exempt unit days. QRS submitted this documentation; the Intermediary reviewed it and subsequently issued a revised NPR on December 3, 2007. The

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[2] MAC's Jurisdictional Challenge at Attachment 2.
[3] MAC's Jurisdictional Challenge at Attachment 3.
[4] This decision was upheld by D.C. District Court. See *Illinois-Masonic Med. Ctr. v. Sebelius*, 859 F. Supp. 2d 137 (D.D.C. 2012)

inclusion of 1,175 additional Medicaid eligible days. On November 25, 2009, the Provider identified a total of 2,244 additional unpaid, but Medicaid eligible days in dispute, including the 1,175 days noted in the appeal request. The Board determined that it lacked jurisdiction under 42 U.S.C. § 1395oo(a) because the Provider could not be "dissatisfied" with the Intermediary's final determination in the revised NPR. The Provider conceded that there was no overlap between the 230 days the Provider originally requested, and the 2,244 days it requested in its appeal from the revised NPR. The Board therefore concluded that the Intermediary could not have reviewed those 2,244 days when it revised the cost report, therefore the Provider could not have been dissatisfied with the final determination because the days were not part of the Intermediary's determination.

In this case, St. Mary's requested a reopening to ask WPS for an additional 29 Medicaid eligible days. The Notice of Reopening issued by WPS states that the cost report was reopened to increase Medicaid eligible days utilized in the DSH adjustment. Based on the workpapers submitted, WPS reopened the cost report and gave St. Mary's those 29 days. The revised NPR reflects the additional 29 days that results in a total of 2,071 days. Because St. Mary's received the 29 days it requested, the Board finds that the appeal does not meet the dissatisfaction requirement, which is one of the prerequisites for Board jurisdiction.

The Board finds that the two issues appealed, SSI Fraction Medicare Advantage Days and Medicaid Fraction Medicare Advantage Days, were not specifically adjusted when WPS reopened St. Mary's cost report. Because the Board lacks jurisdiction over the two issues in St. Mary's appeal of the revised NPR, case number 14-0529 is hereby dismissed. Consequently, the Board denies King & Spalding's requests to transfer these two issues for St. Mary's to case numbers 14-1135G and 14-1136G.

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:
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For the Board:

Michael W. Harty
Chairman

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

cc: Byron Lamprecht, Cost Report Appeals, WPS
Kevin D. Shanklin, Executive Director, BC BS Association
David Sayers, BC BS Association

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08-2971GC

DEC 18 2014

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Re: Request for Expedited Judicial Review
BMHCC 2006 Medicare DSH SSI Percentage Group
Case No.: 08-2971GC

Dear Mr. Marcus and Ms. Rhone:

Baptist Memorial Health Care Corporation, a group of commonly owned hospitals (hereinafter "Baptist Memorial Hospitals"), requests that the Provider Reimbursement Review Board ("Board") grant expedited judicial review over the provisions of CMS Ruling 1498-R. The Board concludes that it lacks jurisdiction and cannot grant Baptist Memorial Hospitals' request.

CASE HISTORY

Five Baptist Memorial Hospitals in this case have appealed the amount of Medicare Reimbursement as determined by the Medicare Administrative Contractor. At issue in this appeal is the Supplemental Security Income ("SSI") percentage used to compute Baptist Memorial Hospitals' Disproportionate Share Hospital ("DSH") qualifications and payments for fiscal year end 09/30/2006. The DSH - SSI percentage issue falls under CMS Ruling 1498-R, which directs the Board to remand the issue to the Medicare Administrative Contractor for recalculation.

The Board received Baptist Memorial Hospitals' expedited judicial review request on November 20, 2014. Baptist Memorial Hospitals contend that the Board should grant its request for expedited judicial review because the Board is without authority to decide the validity of the remand provisions of CMS Ruling 1498-R. Specifically, Baptist Memorial Hospitals state, "the remand provisions of the Centers for Medicare and Medicaid Services ("CMS") Ruling 1498-R (the "Ruling") are invalid, and should be set aside, to the extent that those provisions of Ruling (1) would divest the Board of jurisdiction over the [Baptist Memorial Hospitals] Appeals and (2) result in a remand that would not properly adjust the SSI fraction of the DSH Adjustment."

Baptist Memorial Hospitals make several arguments as to why the Board should grant its request, including an assertion that the Board recently granted numerous similar expedited judicial review requests.

ANALYSIS AND DECISION

The Medicare statute at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), require the Board to grant expedited judicial review if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling. Therefore, the Board must first determine if it "has jurisdiction to conduct a hearing on the specific matter at issue" in order to grant expedited judicial review.[1]

CMS Rulings are binding on all CMS components, including the Board.[2] CMS Ruling 1498-R provides that " . . . the [Board] . . . lack[s] jurisdiction over provider appeals of any of three issues . . . regarding the calculation of the Medicare [DSH] payment adjustment," namely, the SSI fraction, dual eligible patients, and labor and delivery room inpatient days.[3] The Ruling "requires the [Board] to remand each qualifying appeal to the appropriate Medicare contractor."[4] The Ruling explains that, to be "qualifying," the appeal has to be properly pending before the Board and satisfy "applicable jurisdictional and procedural requirements."[5] The Board finds that Baptist Memorial Hospitals' DSH - SSI percentage issue qualifies under CMS Ruling 1498-R, and the issue must be remanded to the Medicare Administrative Contractor for recalculation.

Although Baptist Memorial Hospitals point to prior cases in which the Board granted expedited judicial review in reference to the Ruling,[6] those prior cases involved a different issue than the one presented by Baptist Memorial Hospitals. Here the Hospitals recognize that the Ruling is applicable to them and challenge the validity of the Ruling itself. In these prior cases, the providers focused on a threshold question of jurisdiction. Specifically, the providers in the prior cases challenged the Board's authority to determine whether the Ruling deprives it of continued jurisdiction.

CMS Ruling 1498-R specifically provides that the Board lacks jurisdiction over DSH - SSI fraction appeals; therefore, the Board does not have "jurisdiction to conduct a hearing on the

[1] 42 C.F.R. § 405.1842(f)(1).
[2] CMS Ruling 1498-R at 1, Apr. 28, 2010.
[3] *See id.* at 1, 4, 7, and 14.
[4] *Id.* at 1.
[5] *See id.* at 6, 11, and 15.
[6] *See* Baptist Memorial Hospitals' Request for Expedited Judicial Review at 7.

specific matter at issue" as required to grant expedited judicial review.[7] The Board concludes that it cannot grant an expedited judicial review and therefore the Board need not address Baptist Memorial Hospitals' other arguments. The DSH-SSI percentage issue has been remanded under the Ruling, and this appeal is now closed.

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

For the Board:

Michael W. Harty
Chairman

Enclosures: Standard Remand with Schedule of Providers, 42 U.S.C §1395oo(f)

cc: Kevin D. Shanklin, Blue Cross Blue Shield Association

[7] 42 C.F.R. § 405.1842(f)(1).

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:

14-1372

Certified Mail

DEC 30 2014

Mercy Medical Center
Anita Bright
Reimbursement Analyst
2700 Stewart Parkway
Roseburg, OR 97471

Re: Provider Name: Mercy Medical Center
Provider No.: 38-0027
FYE: 06/30/2009
PRRB Case No.: 14-1372

Dear Ms. Bright:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's appeal request dated December 3, 2013 and received (filed) in our office December 13, 2013.[1] The Board's determination is set forth below.

On June 7, 2013, Mercy Medical Center was issued its Notice of Program Reimbursement (NPR) for fiscal year ending (FYE) 06/30/2009 by Novitas Solutions, Inc. The individual appeal request was received by the Board on December 13, 2013 (appeal request is dated December 3, 2013). The Provider appealed the exclusion of operating and capital labor and delivery room days from the disproportionate share hospital (DSH) calculation. Included with hearing request enclosures was a copy of Novitas Solutions' July 3, 2013 acknowledgment of the Provider's request to reopen FYE 06/30/2009.

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 final the determination by the provider.[2]. 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.

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[1] *See* 42 C.F.R. § 405.1801(a)(2) (2010) (The date of receipt of documents by a reviewing entity is presumed to be the date of delivery or stamped "Received" by the reviewing entity on the document or other submitted material.)

[2] *See* 42 C.F.R. § 405.1835(a)(3) (2010) (A provider has a right to a hearing before the Board if, among other things, the Board receives the provider's hearing request within 180 days of the date of receipt of the intermediary's [final] determination by the provider.)

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.

For calculating time periods and deadlines, pursuant to 42 C.F.R. § 405.1801(d)(3), [i]f the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday..., or a day on which the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days."

Decision of the Board

Mercy Medical Center was issued its NPR on June 7, 2013, and is presumed to have received it on June 12, 2013. The Provider did not present evidence that the NPR was received later than the five day presumption. An appeal request from the original NPR was delivered by the United States Postal Service and received by the Board on December 13, 2013. As the 185th day fell on Monday, December 9, 2013, the provisions set forth in 42 C.F.R. § 405.1801(d)(3) do not apply to the present appeal. Thus, the date of filing was 189 days after the date of the NPR.

The appeal request was not received by the Board within 180 days of the date of receipt, as required by 42 C.F.R. § 405.1835(a)(3)(i). Therefore, it was not timely filed. The Board lacks jurisdiction to grant a hearing on the matters at issue in this appeal. Consequently, The Board hereby dismisses 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, Esquire
L. Sue Anderson, Esquire
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: Bruce Snyder, Novitas Solutions, Inc.
Kevin D. Shanklin, BCBSA

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DEC 31 2014

Refer to: 09-2046

CERTIFIED MAIL

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

Timothy LeJeune
Novitas Solutions, Inc.
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: INTEGRIS Baptist Medical Center ("INTEGRIS")
Provider No.: 37-0028
FYEs: 06/30/2006
PRRB Case No.: 09-2046

Dear Mr. Ravindran and Mr. LeJeune:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal and dismisses INTEGRIS' appeal request for the reasons set forth below.

Background

The Medicare Administrative Contractor ("MAC") issued INTEGRIS a Revised Notice of Program Reimbursement on February 27, 2009. On July 21, 2009, INTEGRIS timely filed an individual appeal request with the Board that contained two issues: (1) Disproportionate Share Hospital ("DSH") Payment/Supplemental Security Income ("SSI") Percentage (Provider Specific) ("the SSI Provider Specific issue"), and (2) DSH Payment/SSI Percentage (Systemic Errors).

On February 23, 2010, the Board received INTEGRIS' request to transfer the DSH Payment/SSI Percentage (Systemic Errors) issue to a group appeal, which became case number 10-0741GC. On April 4, 2013, case number 10-0741GC was remanded to the MAC pursuant to the Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1498-R.

Board's Decision

On its own motion, the Board has chosen to review whether it has jurisdiction over INTEGRIS' sole remaining issue in this appeal, its SSI Provider Specific issue.

In describing its SSI Provider Specific issue in its appeal request, INTEGRIS states that the

> SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

This is based on certain data from the State of Oklahoma and the Provider that does not support the SSI percentage issued by CMS.

The Board finds that this description of INTEGRIS' SSI Provider Specific issue is a challenge to CMS' SSI data matching process, and, on April 4, 2013, the Board remanded this issue to the MAC pursuant to CMS-1498-R.

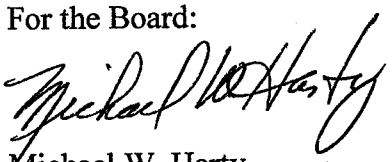
However, INTEGRIS concludes its description of its SSI Provider Specific issue with the following sentence "[t]he Provider may exercise its[] right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Based on this description, the Board finds that the remaining portion of INTEGRIS' SSI Provider Specific issue is a potential appeal of its SSI realignment.

Under 42 C.F.R. § 405.1835(b)(2) (2008), a provider's request for a Board hearing must contain the following element (among others): "[a]n explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the intermediary's . . . determination under appeal . . ." However, as INTEGRIS has not yet decided whether it will request realignment, and the intermediary has not made a determination with respect to that realignment, INTEGRIS is unable to demonstrate "dissatisfaction" with its determination as required by the regulations. Therefore, INTEGRIS' appeal of this issue is premature and outside the scope of Board review. Accordingly, the Board dismisses INTEGRIS' SSI Provider Specific issue from this appeal for lack of jurisdiction.

As there are no remaining issues left in this appeal, case number 09-2046 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.
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 D. Shanklin, Executive Director, Blue Cross and Blue Shield Association