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

FEB 03 2015

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

RE: East Texas Medical Center - Tyler
Provider no.: 45-0083
FYE: 10/31/2012
PRRB Case No.: 15-0084

Dear Mr. Ribner:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's October 8, 2014 request for hearing which was received by the Board on October 9, 2014. The Board's jurisdictional determination is set forth below.

Pursuant to 42 U.S.C. § 1395oo(a)(1)(B) and 42 C.F.R. §§ 405.1835 (a)(3)(ii), a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report if the contractor fails to issue a final determination within 12 months of their receipt of the cost report, and the request for hearing is received by the Board within 180 days of the expiration of the 12 month period.

Decision of the Board:

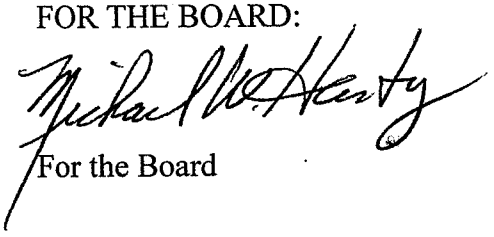
In this case, the appeal was filed from a failure to issue a timely final determination. The Medicare Contractor received the Provider's cost report on April 1, 2013, and the expiration of the 12 month period for issuance of the final determination was April 1, 2014. Per the regulations a cost report hearing request must be received by the Board within 180 days of the expiration of the 12 month period for issuance of the final contractor determination, or September 29, 2014.[1] In this case the appeal was received 191 days later on October 9, 2014. Therefore, the Board hereby dismisses the appeal because it was not filed on a timely basis.

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.

[1] Since the last day of the designated appeal period was Sunday, September 28, 2014, the deadline is the next business day. See 42 C.F.R. 405.1801(d)(3)

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte Benson, C.P.A.

FOR THE BOARD:



For the Board

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

cc: Novitas Solutions, Inc.
Timothy LeJeune
JH Provider Audit & Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

Kevin D. Shanklin, Executive Director, BCBSA

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

RE: Iowa Methodist Medical Center
Provider no. 16-0082
FYE 12/31/2011
PRRB Case No. 15-0843

Dear Mr. Ribner:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for hearing which was dated December 29, 2014 and received by the Board on December 30, 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 date of receipt of the final determination by the provider.

Decision of the Board:

In this case, the Board received the Provider's request for a hearing on December 30, 2014. This appeal was filed from a Notice of Program Reimbursement dated June 27, 2014. Per 42 C.F.R. §405.1801(a)(1)(iii), a provider is deemed to have received the final determination five days after issuance. In this case the presumed date of receipt and the actual date of receipt were both July 2, 2014. The request for hearing was received by the Board 181 days after the date of the receipt of the final determination; therefore, the Board hereby dismisses the appeal because it was not filed on a timely basis.

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 Andersen, Esq.
Charlotte Benson, C.P.A.

FOR THE BOARD:

Michael W. Harty

For the Board

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

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

Kevin D. Shanklin, Executive Director, BCBSA

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Refer to:

CERTIFIED MAIL

FEB 10 2015

Catholic Health Services of Long Island
Daniel Flood
1000 Montauk Highway
West Islip, NY 11795

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

RE: St. Charles Hospital, Provider No. 33-0246, FYE 12/31/2009
PRRB Case No. 14-2681

Dear Mr. Flood and Mr. Blumberg:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

Blumberg Ribner filed an individual appeal for St. Charles Hospital on February 27, 2014. The appeal request did not include a copy of the Notice of Program Reimbursement (NPR), nor did it include a signed authorization letter from the Provider appointing Blumberg Ribner to handle the appeal.

The Board established case number 14-2681 and sent an acknowledgement letter by email on March 1, 2014. The Board also sent a Request for Additional Information on the same date, requesting a copy of the final determination and a letter from the Provider authorizing Blumberg Ribner's representation.

To date neither the final determination, nor an authorization of representation, has been received.

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).

42 C.F.R 405.1835(a) clearly states that only a Provider has a right to a hearing before the Board. Without a representation letter signed prior to the appeal request, Blumberg Ribner had no authorization to file an appeal on behalf of the Provider. If a Provider has not provided Blumberg Ribner with a representation letter, it is acting without the authority to file an appeal with the Board.

In addition, 42 C.F.R 405.1835(b) specifically requires the Provider to include the final determination it is appealing with the timely request, and authorizes the Board to dismiss with prejudice any appeal that does not include a copy of the determination under appeal with its filing. The Board finds that since the Provider did not supply Blumberg Ribner with a copy of the final determination prior to them filing the appeal, Blumberg Ribner is purposely filing an appeal that does not meet the regulatory requirements.

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

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

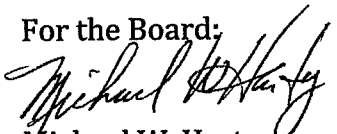
The information was not supplied, even after the Board sent a Request for Information which advised that the appeal could be dismissed if not submitted. The Board notes that, on October 21, 2014, Blumberg Ribner filed notice that it filed a preliminary position paper with the Medicare Administrative Contractor. In the preliminary documentation list submitted with the cover letter, the NPR is listed as an exhibit. The Board does not, however, receive the full copy of the preliminary position paper nor the exhibits.

Because the appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, and the Provider has not complied with the Board's Request for Additional Information within the allotted timeframe, 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
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:



Michael W. Harty
Chairman

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

cc: Kyle Browning, Appeals Lead, National Government Services
Kevin D. Shanklin, Executive Director, BC BS Association

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FEB 10 2015

The Rybar Group, Inc.
Ronald K. Rybar
3150 Owen Road
Fenton, MI 48430

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

RE: Logansport Memorial Hospital
Provider No.: 15-0072
FYEs: 12/31/2005 and 12/31/2006
PRRB Case Nos.: 08-0270 and 09-0488

Dear Mr. Rybar and Mr. Lamprecht,

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeals in response to jurisdictional challenges concerning the subject provider:

Issues

1. For fiscal year 2005, does the Board have jurisdiction over the DSH – labor and delivery room ("LDR") days, DSH - Medicaid eligible days, Observation bed days, Observation bed charges, and Hospital discharge count issues in the appeal?

2. For fiscal year end 2006, does the Board have jurisdiction over the Observation bed charges issue in the appeal?

The pertinent facts as they relate to these appeals, as well as the Parties' contentions and the Board's determinations are set forth below.

Timeline & Background

Logansport Memorial Hospital (the Provider) filed appeals for fiscal years 2005 and 2006. The five issues in the 2005 appeal request include DSH – LDR days, DSH – Medicaid eligible days, Observation bed days, Observation bed charges, and Hospital discharge count. The sole issue in the 2006 appeal request is Observation bed charges. A listing of these appeals and relevant dates follows:

Appeal No.	Fiscal Year End	NPR Date	Appeal Date
08-0270	12/31/2005	5/30/2007	11/19/2007
09-0488	12/31/2006	6/25/2008	12/12/2008

On February 20, 2014, the Intermediary filed a jurisdictional challenge on four of the issues in the 2005 appeal: DSH – LDR days, Observation bed days, Observation bed charges, and Hospital discharge

count. The Intermediary stated the Board lacks jurisdiction over the issues because the issues were not claimed on the cost report and/or no adjustment was made at final settlement. On February 27, 2014, the Intermediary filed a jurisdictional challenge to the Observation bed charges issue in the 2006 appeal stating that the Board lacks jurisdiction over the issue because the issue was not claimed on the cost report and/or no adjustment was made at final settlement.[1] The Provider filed a single response to both challenges on April 2, 2014.

Intermediary's Contentions

The Intermediary maintains that the Provider's right to a Board hearing derives from an Intermediary determination, which is defined at 42 C.F.R. § 405.1801(a) as "...[A] determination of the amount of total reimbursement due the provider, pursuant to § 405.1803 following the close of the provider's cost reporting period...." The regulations, § 405.1803, further describe the requirements for intermediary notices. The Intermediary argues that, implicit throughout §§ 405.1801 and 405.1803, is the rule that an identifiable adverse finding [with a corresponding reduction in reimbursement] is necessary to request a Board hearing under § 405.1835.[2]

Concerning fiscal year 2005, the Intermediary asserts that it made no changes to the observation bed days and hospital discharge count as claimed by the Provider. With respect to DSH – LDR days, the Intermediary asserts that it made no changes to the total Medicaid days claimed by the Provider. Furthermore, the Intermediary asserts that it did not adjust the Provider's total patient days used in the Disproportionate Share calculation. Lastly, the Intermediary asserts that the Provider did not claim any Medicare Inpatient charges relative to Observation bed services on its as-filed cost report. The Intermediary made no changes to Medicare charges for Observation relative to the inpatient services as claimed by the Provider. The Provider's appeal is a request to change the handling of observation charges related to inpatient services claimed – this is a change in election made on the as-filed cost report.[3]

Concerning fiscal year 2006, the Intermediary asserts that the Provider did not claim any Medicare Inpatient charges relative to Observation bed services on its as-filed cost report. The Intermediary made no changes to Medicare charges for Observation relative to the inpatient services as claimed by the Provider. The Provider's appeal is a request to change the handling of observation charges related to inpatient service claimed – this is a change in election made on the as-filed cost report.[4]

The Intermediary concludes that the facts are irrefutable that the Provider did not make a claim for these particular issues on its as-filed cost report and the Intermediary did not make any adjustments. The Intermediary argues that in relevant part 42 C.F.R. § 405.1835 suggests that the Provider does not have a right to a hearing before the Board on the issues because the Intermediary did not make any adverse findings with respect to the issues under appeal. The issues here were not presented to the Intermediary for audit so there is no final determination with regard to unclaimed costs. Therefore, the Provider

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[1] Intermediary's Jurisdictional Briefs at 1.
[2] *Id.*
[3] Intermediary's 2005 Jurisdictional Brief at 2.
[4] Intermediary's 2006 Jurisdictional Brief at 2.

cannot claim dissatisfaction with the Intermediary's determination and the Board must dismiss the issues from the appeals.[5]

Provider's Contentions

The Provider only responded to the challenge on the Observation bed charges issue for the 2005 and 2006 appeals. The Provider maintains its position that the Intermediary made audit adjustments to reconcile provider Inpatient PPS charges on Worksheet D-4 to the PSR [Provider Statistical & Reimbursement Report] and omitted Observation bed charges on line 62. This point is in contrast to the Intermediary claim that it did not adjust Observation bed charges. The reconciliation made by the Intermediary and subsequent audit is a standard Intermediary process and the fact that there were no charges on line 62 on the as filed cost report does not change the audit requirements of the Intermediary to reconcile charges to the PSR. This appears to be an omission of the Intermediary audit process unrelated to any cost report election.[6]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) (2007) and 42 C.F.R. §§ 405.1835-405.1841 (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 (or $50,000 for a group), and the request for a hearing is received by the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider. The Board has *discretionary power* under 42. U.S.C. § 1395oo(d) after jurisdiction is established under 42 U.S.C. § 1395oo(a) to make a determination over all matters covered by the cost report. The Board can affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and make any other revisions on matters covered by the cost report even though such matters were not considered by the intermediary in making its final determination.

The Board finds that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) over the DSH – Medicaid eligible days, Observation bed days, Observation bed charges, and hospital discharge count issues for the fiscal year 2005 appeal as well as the Observation bed charges issue for the fiscal year 2006 appeal. Also, the Board declines to hear these matters under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d). The Board finds that it does have jurisdiction under 42 U.S.C. § 1395oo(a) over the DSH – LDR days issue for fiscal year 2005. Set forth below are the Board's findings and conclusions with respect to the issues.

Observation bed days, Observation bed charges, and Hospital discharge Count

The crux of this dispute centers around the gateway to Board jurisdiction under 42 U.S.C. § 1395oo(a), which provides in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –

[5] Intermediary's Jurisdictional Briefs, pp. 2-3.
[6] Provider's Jurisdictional Brief.

> (1) such provider
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report...

After jurisdiction is established under 42 U.S.C. § 1395oo(a) the Board has the discretionary power to make a determination over all matters covered by the cost report under 42 U.S.C. § 1395oo(d) which states in relevant part:

> The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

The Provider did not report observation bed days, observation bed charges, and hospital discharge count for fiscal year 2005, and the Intermediary did not make any adjustments with respect to these items. Therefore, the Provider cannot claim dissatisfaction. The same holds true for observation bed charges for fiscal year 2006. The errors were due solely to the Provider's negligence. Only in hindsight did the Provider determine that it should have reported these items differently, thereby increasing the amount of reimbursement.

In *Bethesda,*[7] the provider failed to claim a cost because a regulation dictated that it would have been disallowed. In that situation, the Supreme Court found section 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court wrote:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[8]

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:

> 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

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[7] *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 404 (1988).
[8] *Bethesda* at 1258, 1259. (Emphasis added).

> its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[9]

In this case, the Board has precisely the situation described by the Supreme Court as being "on different ground."[10] While the Supreme Court has not had an opportunity to squarely address whether the Board must take jurisdiction of an appeal of a cost unclaimed through inadvertence rather than futility, other appellate courts have done so. 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 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 Co. of Mary Hosp. v. Shalala* ("*Little Co. I*"),[11] 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.[12]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[13] 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.[14] The Seventh Circuit noted:

> But 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...[15]

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 Medicare law and regulations cannot meet the 'dissatisfaction' requirement" of subsection (a).[16] The Agency policy of presentment aims to prevent an end-run around the Intermediary. 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."[17]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have

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[9] *Id.* at 1259. (Emphasis added).
[10] Emphasis added.
[11] 24 F.3d 984 (7th Cir. 1994).
[12] *Little Co. I,* 24 F.3d at 992.
[13] *Little Co. of Mary Hosp. v. Shalala*, 165 F.3d 1162 (7th Cir. 1999).
[14] *Little Co. II*, 165 F.3d at 1165.
[15] *Id.*
[16] 73 Fed. Reg. at 30196.
[17] 73 Fed. Reg. at 30203.

been inadvertently omitted or "self-disallowed."[18] Both circuits rejected the Seventh Circuit's interpretation of the statute, finding it contained neither an exhaustion requirement to obtain a hearing before the fiscal intermediary, nor a limitation on the Board's scope of review once its jurisdiction was invoked. The progeny of decisions in these circuits have generally regarded subsection (a) to be read in conjunction with subsection (d) and supports the discretionary nature of subsection (d).

The seminal case in the 9th Circuit is the 2009 decision in *Loma Linda Univ. Med. Ctr. v. Leavitt* ("*Loma Linda*").[19] In *Loma Linda,* 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 Court 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.*[20]

This holding suggests that the "dissatisfaction" requirement to exercise a right to appeal under § 1395oo(a) applies only to the total amount of program reimbursement reflected on the NPR and that "dissatisfaction" does not need to be tied to a specific gateway claim or issue under § 1395oo(a) before the Board can exercise discretion under § 1395oo(d) to hear a claim or issue not raised with the intermediary (*e.g.*, unclaimed costs).[21] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[22] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[23] which were decisions issued in 2000 and 1987 respectively.[24]

MaineGeneral 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 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 claimed 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 *MaineGeneral* relied on its prior pre-*Bethesda* decision in *St. Luke's* in which costs were self-disallowed, not inadvertently omitted. However, that 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

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[18] *See Loma Linda Univ. Med. Ctr. v. Leavitt,* 492 F.3d at 1065; *MaineGeneral Med. Ctr. v. Shalala,* 205 F.3d 493 (1st Cir. 2000).
[19] 492 F.3d 1065 (9th Cir. 2007).
[20] *Id.* at 1068 (emphasis added).
[21] *See* 73 Fed. Reg. at 30197.
[22] 205 F.3d 493 (1st Cir. 2000).
[23] *St. Luke's Hosp. v. Secretary,* 810 F.2d 325 (1st Cir. 1987).
[24] *See Loma Linda,* 492 F.3d at 1068.

the Board does have the power, but that the power is discretionary. In *St. Luke's*, the First Circuit 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 circumstances.[25] Specifically, the First Circuit wrote: "The statute [*i.e.*, § 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."[26]

The First Circuit in *MaineGeneral* then 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."[27] 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.[28] Although the First Circuit in *MaineGeneral* analyzed appeal rights on a "claim" or issue specific basis, the First Circuit included the following dicta:

> That a cost is listed in a cost report says nothing about whether the provider is "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse costs. . . . [N]othing in St. Luke's suggests that the hospital would not have been "dissatisfied" if it omitted to list the cost on a worksheet in the cost report (whether through inadvertence or in reliance on the agency's earlier determination that the costs were not recoverable). ...Under *St. Lukes's*, the statutory word '"dissatisfied"' is not limited to situations in which reimbursement was sought by the hospital from the intermediary."[29]

This dicta suggests that, similar to the Ninth Circuit in *Loma Linda*, the First Circuit would interpret § 1395oo(a) as not requiring that a specific gateway issue or claim be established under § 1395oo(a) before the Board could exercise discretion under 1395oo(d) to hear an issue or claim not considered by the intermediary (*e.g.*, unclaimed cost). Rather, the First Circuit appears to decouple the listing of costs claimed in the cost report from the ability of the provider to be "dissatisfied" with the later decision by the intermediary to reimburse or not reimburse.

This application of § 1395oo(d) is further supported by the D.C. District Court in the 2008 case of *UMDNJ-University Hospital v. Leavitt*.[30] As in *MaineGeneral* 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. That court wrote:

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[25] *St. Luke's*, 810 F.2d at 332.
[26] *Id.* at 327-328 (emphasis in original).
[27] *MaineGeneral*, 205 F.3d at 501.
[28] *St. Luke's*, 810 F.2d at 327.
[29] *MaineGeneral*, 205 F.3d at 501.
[30] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].

> 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), ...[31]

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).[32]

In the aggregate, the case law of the First and Ninth Circuits and the D.C. District Court consistently conforms to the notion that § 1395oo(d) bestows the Board with a limited discretion, which is preconditioned on first establishing jurisdiction under § 1395oo(a). The case law does not stand for the proposition that § 1395oo(d) is a grant of "alternate" jurisdiction, but instead, these decisions make it clear that, once the Board acquires jurisdiction over a cost report itself pursuant to 42 U.S.C. § 1395oo(a), the Board has the discretionary power under § 1395oo(d) to hear any discrete items and services 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's interpretation of §§ 1395oo(a) and (d) has generally been more closely aligned with the interpretation of the First Circuit rather than arguably broader interpretation of the Ninth Circuit or the more narrow interpretation of the Seventh Circuit. Specifically, the Board has generally interpreted § 1395oo(a) as: (1) the gateway to establishing Board jurisdiction to hear an appeal; and (2) contrary to *Loma Linda* and *UMDNJ*, 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.[33] However, the Provider is located in the Seventh Circuit, and as such, *Little Co. I* and *Little Co. II* apply to these appeals and serve as controlling precedent for the Board.[34]

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[31] *Id.* at 79.
[32] *Id.* at 77.
[33] *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.
[34] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g. QRS CHW DSH Labor Room Days Groups v. Blue Cross Blue Shield Ass'n*, CMS Administrator Dec. (Apr. 13, 2009), *affirming*, PRRB Dec. No. 2009-D11 (Feb. 27, 2009) (stating "as the *Alhambra* [*Hosp. v. Thompson*, 259 F. 3d 1071 (9th Cir. 2001)] case is binding in the circuit in which the Providers are entitled to seek judicial review, the Administrator hereby affirms the Board's decision...with respect to the LDRP days. The Board's decision is affirmed only on the limited ground that there is binding law in the Ninth Circuit....The decision does not affect the Secretary's ability to continue to defend this issue in other circuits...."); *St. Vincent Mercy Med. Ctr. v. Blue Cross Blue Shield Ass'n*, CMS Administrator Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008) (stating that "[i]n the absence of a controlling decision by the Supreme Court, the respective courts of appeals express the law of the circuit" with citation to *Hyatt v. Heckler*, 807 F. 2d 376, 379 (4th Cir. 1986)). Further, the Board notes that, while the Provider could appeal the Board's decision in the D.C. District Court, the D.C. Circuit has not yet reviewed and ruled on this issue. *See Jordan Hosp. v. Blue Cross Blue Shield Ass'n.* CMS Administrator Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007) (stating with respect to a provider located in Massachusetts that "under § 1878(f)(1), the District of Columbia is the judicial district in which this Provider may file suit and, thus, *St. Elizabeth's* [*Med. Ctr. of Boston v. Thompson*, 396 F.3d 1228 (D.C. Cir. 2005)] is binding case law here"). Accordingly, the Board applies the law of the Seventh Circuit as controlling precedent.

The Board finds the errors for the Observation bed days, Observation bed charges, and the Hospital discharge count raised in the 2005 appeal and the Observation bed charges raised in the 2006 appeal were due solely to the Provider's negligence in understanding the Medicare regulations governing the reimbursement of such items on the Medicare cost report. Only in hindsight did the Provider determine that it could (and should) have reported these items differently, thereby potentially increasing the amount of reimbursement. However, uncertainty as to the interpretation of a regulation does not necessarily make a claim for reimbursement futile. Rather, this case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[35] The Board notes that it has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeals of other issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction.[36]

Therefore, the Board dismisses the Observation bed days, Observation bed charges, and Hospital discharge count issues from the fiscal year 2005 appeal. Likewise, the Board dismisses the Observation bed charges issue from the fiscal year 2006 appeal. The Board does not have jurisdiction under 42 U.S.C. § 1395oo(a) or § 1395oo(d) to address items and services not claimed or not properly reported on the cost report where the failure to claim was due to inadvertence rather than futility.

DSH – Medicaid eligible days

Although the Intermediary did not challenge jurisdiction over the DSH – Medicaid eligible days issue in the fiscal year 2005 appeal, the Board nonetheless finds that it does not have jurisdiction over this issue. In its initial appeal request, the Provider requested inclusion of additional Medicaid eligible days.

At the outset, the Board recognizes that CMS' computation of DSH payment has been shaped by decisions from the Supreme Court and administrative tribunals. In particular, the Board recognizes that the following decisions are relevant to this case in connection with whether the Board has jurisdiction to conduct a hearing on it: (1) the Supreme Court's decision in *Bethesda*; and (2) the Board's recent decision in *Danbury Hospital v. BlueCross BlueShield Ass'n* ("*Danbury*")[37].

Similar to its decision in *Danbury*, the Board finds that: (1) a provider does have an obligation to submit Medicaid eligible days information as part of the cost reporting process; and (2) this obligation is separate and distinct from the DSH adjustment determination process handled by its intermediary.

In support of these findings, the Board notes that the preambles to the May 1986 Interim Final Rule and the September 1986 Final Rule confirm that providers have been required (both prior to and following 1986 when the DSH adjustment payment was added) to submit the Medicaid days data as part of the normal cost reporting process and that this information has been and continues to be subject to the normal cost report audit and settlement process.[38]

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[35] *Bethesda*, 485 U.S. at 404-405.
[36] *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). This would not be a case in which the Board would deviate from this practice.
[37] PRRB Dec. No. 2014-D3 (Feb. 11, 2014).
[38] The Board further notes that 42 C.F.R. § 413.24(f) describes a provider's cost report as a "report[] of its operations" which necessarily would include not only a report of costs but also certain occupancy and volume statistics such as Medicaid eligible days. *See also* Provider Reimbursement Manual, CMS Pub. No. 15-2 ("PRM 15-2"), § 3600.

Second, the Board notes that the addition of the DSH adjustment in 1986 did not alter the scope of the providers' obligation to submit Medicaid days data. Specifically, in implementing the DSH adjustment in 1986, CMS did not substantively change the scope of providers' then-existing obligation to report Medicaid *paid* days on the cost report. In the preamble to the September 1986 Final Rule, CMS stated that its interpretation of the Medicaid days as used in the Medicaid percentage of the DSH calculation was "consistent with the way we require Medicaid days to be reported on the Medicare cost report."[39] CMS explained that its initial interpretation was based, in part, on CMS' belief that Congress did not intend that "an additional reporting mechanism, possibly tied to State eligibility records, be developed to obtain Medicaid statistics on noncovered patient days."[40] As a result, the Board concludes that the then-existing obligation to report Medicaid *paid* days data was not subsumed into the DSH adjustment decision process (*i.e.*, that obligation remained separate and distinct from the DSH adjustment decision process).

Third, the preamble to the May 1986 Interim Final Rule confirms that, if a provider is dissatisfied with the intermediary's "determination of its Medicaid days" (whether for purposes of interim DSH adjustment determination or for the final DSH adjustment determination), the provider as part of the "year-end settlement on a cost reporting period basis" has "the . . . responsibility to demonstrate to the intermediary that the Medicaid statistics reported on its cost report are incorrect or were improperly applied."[41] This discussion confirms that CMS viewed decisions on Medicaid days as separate and distinct from the DSH adjustment determination itself. The separate and distinct nature of Medicaid days is supported by the facts that it is reported on a separate line and in a separate worksheet from where the DSH adjustment is claimed. Specifically, a provider claims Medicaid eligible days in Worksheet S-3 and claims a DSH adjustment in Worksheet E, Part A.

The DSH regulations have undergone numerous changes since the creation of the adjustment. Certain of these revisions came in the wake of circuit court decisions that invalidated HCFA's[42] computation of DSH payment, specifically its practices concerning the Medicaid fraction. In issuing HCFA Ruling 97-2, the agency acquiesced to these rulings, noting that:

> HCFA will count in the Medicaid fraction the number of days of inpatient hospital services for patients eligible for Medicaid on that day, whether or not the hospital received payment for those inpatient hospital services.[43]

Ruling 97-2 reiterated that the responsibility for verifying Medicaid eligibility fell on the provider community, noting:

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[39] 51 Fed. Reg. at 31460. *See also* 56 Fed. Reg. 43358, 43379 (Aug. 30, 1991) (cross-referencing the September 1986 Final Rule discussion of CMS' interpretation of Medicaid days being based, in part, on how Medicaid days was then-currently being reported as part of the normal cost reporting process).
[40] 51 Fed. Reg. at 31460.
[41] 51 Fed. Reg. at 16777 (emphasis added) (discussing the DSH adjustment process as being "similar to the process we use to make the additional payment for indirect medical education costs").
[42] CMS was formerly known as the Health Care Financing Administration ("HCFA").
[43] HCFA Ruling 97-2 at 3 (February 27, 1997), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/Downloads/HCFAR972.pdf (last visited December 28, 2012).

> Pursuant to this ruling, Medicare fiscal intermediaries will determine the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. *The hospitals bear the burden of proof and must verify with the State that a patient was eligible for Medicaid (for some covered services) during each day of the patient's inpatient hospital stay. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed.* Days for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted.[44]

In the final rule published on July 31, 1998, CMS conformed the DSH regulations located in 42 C.F.R. § 412.106 "to the new statutory construction issued in HCFA Ruling 97-2."[45] In particular, as part of this final rule, CMS incorporated the hospital's obligation to provide Medicaid eligible days data into regulation at § 412.106(b)(4)(iii).[46] As a result of this revision (as well as other subsequent revisions), § 412.106(b)(4) read as follows during the time at issue:

> (4) *Second computation.* The fiscal intermediary determines, for the same cost reporting period used for the first computation [*i.e.*, the Medicare fraction], the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period. For purposes of this second computation [*i.e.*, the Medicaid fraction], the following requirements apply:
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> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, hospitals may include all days attributable to populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act.

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[44] *Id.* (emphasis added).
[45] *See* 63 Fed. Reg. 40954, 40985 (July 31, 1998).
[46] *Id. See also* Program Memorandum, CMS Pub. No. 60A, Transmittal No. A-01-13 (Jan. 25, 2001) (reissuing Program Memorandum, CMS Pub. No. 60A, Transmittal No. A-99-62 (Dec. 1, 1999)). This memorandum specifies that: "Regardless of the type of allowable Medicaid day, *the hospital bears the burden of proof and must verify with the State* that the patient was eligible under one of the allowable categories during each day of the patient's stay. The Hospital is *responsible for* and must provide adequate *documentation to substantiate the number of Medicaid days* ***claimed.*** *Days for patients that cannot be verified by State* records to have fallen within a period wherein the patient was eligible for Medicare as described in this memorandum *cannot be counted.*" *Id.* (emphasis added).

> (iii) The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[47]

In 2003, Congress addressed a provider's access to information needed to calculate the DSH Medicare and Medicaid fractions, as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA").[48] Specifically, MMA § 951 requires CMS to "*arrange to furnish* to subsection (d) hospitals ... the data necessary for such hospitals to compute the number of patient days used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year."[49]

In the preamble to the final rule published on August 12, 2005,[50] CMS discussed its implementation of MMA § 951. CMS stated that "we interpret section 951 to require CMS to arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records ..., in the case of the Medicaid fraction, against the State-Medicaid agency's records."[51] CMS maintained that it has satisfied its § 951 obligation under this interpretation because the "established mechanisms" in place at the States allow providers to obtain access to this Medicaid days data and these mechanisms are sufficient.[52] Moreover, CMS reiterated the idea that providers bear ultimate responsibility for verifying the Medicaid eligibility of patients claimed on their cost reports since they furnished inpatient care to the patients underlying any claimed days and, thereby, should be in possession of much of the information needed to verify the days:

> In addition, we believe it is reasonable to continue to place the burden of furnishing the data adequate to prove eligibility for each Medicaid patient day claimed for DSH percentage calculation purposes on hospitals because, *since they have provided inpatient care to these patients for which they billed the relevant payers, including the State Medicaid plan, they will necessarily already be in possession of much of this information. We continue to believe hospitals are best situated to provide and verify Medicaid eligibility information.* Although we believe the mechanisms are currently in place to enable hospitals to obtain the data necessary to calculate their Medicaid fraction of the DSH patient percentage, there is currently no mandatory requirement imposed upon State Medicaid agencies to verify eligibility for hospitals. At this point, we continue to believe there is no need to modify the Medicaid State plan regulations to require that State plans verify Medicaid eligibility for hospitals. However, should we find that States are not voluntarily providing or verifying Medicaid eligibility information for hospitals, we will consider amending the State plan regulations to add a requirement that State plans provide certain eligibility information to hospitals.[53]

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[47] 42 C.F.R. § 412.106(b)(4) (2005) (emphasis in original).
[48] Pub. L. No. 108-173, 117 Stat. 2066 (2003).
[49] *Id.* at 2427 (emphasis added.)
[50] 70 Fed. Reg. 47278 (Aug. 12, 2005).
[51] *Id.* at 47438.
[52] *Id.* at 47442.
[53] *Id.* (emphasis added). *See also* 63 Fed. Reg. at 40985 (July 31, 1998) (stating that "[o]ur proposed revisions to §412.106(b)(4), like the Ruling [97-2], would continue to place on the hospital *the burdens of production, proof, and verification* as to each claimed Medicaid patient day" (emphasis added)).

All providers are required to file cost reports annually, with reporting periods based on the provider's fiscal or accounting year. A cost report shows the costs incurred during the relevant fiscal year and the portion of those costs allocated to Medicare.[54] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider, and issues the provider a Notice of Program Reimbursement ("NPR").[55] As noted in HCFA Ruling 97-2, under the "normal procedures," intermediaries determine DSH adjustment payments under the IPPS for a cost reporting period based, in part, on the Medicaid eligible days that providers claim on the relevant cost report forms. An intermediary's determination of a provider's eligibility for a DSH adjustment during a cost reporting period and, if eligible, the amount of that adjustment, is issued as part of the relevant NPR.

Based on the above, the Board concludes that: (1) the provider has an obligation to submit Medicaid days information as part of the cost reporting process; and (2) this obligation is separate and distinct from the DSH adjustment determination process. If a provider is dissatisfied with the intermediary's determination of its Medicaid days, the provider can exercise appeal rights in accordance with the regulations set forth in 42 C.F.R. Part 405, Subpart R.[56]

As previously discussed, HCFA Ruling 97-2 expanded the days included in the numerator of the Medicaid fraction from Medicaid paid days to Medicaid paid and unpaid days (*i.e.*, Medicaid eligible days). Further, as part of HCFA Ruling 97-2 and the subsequent promulgation of 42 C.F.R. § 412.106(b)(4)(iii), CMS codified the provider's obligation to claim only those Medicaid eligible days that have been verified by State records. In this regard, that Ruling states that "[c]laims [for Medicaid eligible days] must, of course, meet other applicable requirements" such as "the requirement for data adequate to document the claimed [Medicaid eligible] days" and that "[d]ays for patients that cannot be verified by State records to have fallen within a period wherein the patient was eligible for Medicaid cannot be counted." Similarly, the preamble to the July 1998 Final Rule that promulgated § 412.106(b)(4)(iii) states "[o]ur proposed revisions to § 412.106(b)(4), like the Ruling, would continue to place on the provider the burdens of production, proof, and verification *as to each **claimed** Medicaid patient day*."[57] Thus, CMS made clear that, following the expansion of Medicaid days to include paid and unpaid days, providers continued to have the responsibility of claiming the relevant Medicaid days on the cost report (*i.e.*, "production") and proving and verifying with the State each of those claimed days.

This expansion of the types of days included in the numerator of the Medicaid fraction to include State-verified Medicaid eligible days that were unpaid created challenges for providers. Historically, the data needed by providers from the State to verify Medicaid eligibility during a specific fiscal year often had

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[54] *See* 42 C.F.R. §§ 413.20, 413.24.
[55] *See* 42 C.F.R. § 405.1803.
[56] *See* 51 Fed. Reg. at 31458-31459. *See also* Board Rule 8.2; *see generally* Board Rule 8. Board Rule 8.0 addresses how to frame issues for adjustments involving multiple components and Board Rule 8.2 describes a DSH adjustment as the type of adjustment that may involve multiple issue components. Board Rule 8.1 specifies that "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in [Board] Rule 7." Similarly, the Board Rules in effect from March 1, 2002 to August 21, 2008 specified the following in Part I.B.II.a: "You must clearly and specifically identify your position in regard to the issue in dispute. For instance, if you are appealing an aspect of the disproportionate share (DSH) adjustment factor or calculation, do not define the issue as 'DSH.' You must precisely identify the component of the DSH issue that is in dispute."
[57] 63 Fed. Reg. at 40985 (emphasis added).

not been available for months or even years after the cost report filing deadline for that fiscal year had tolled. This lack of availability and/or access to State data created a practical impediment to reporting all Medicaid eligible days (both paid and unpaid) for a given fiscal year at the time of the relevant cost report filing deadline. Specifically, it created situations where none (or only a portion) of the relevant Medicaid eligible days data for a fiscal year was available from the State prior to the cost report filing deadline for that fiscal year. In those situations, as required by HCFA Ruling 97-2, providers were to claim only those Medicaid eligible days that were verified by State records.

Notwithstanding the increased complexity associated with reporting Medicaid eligible days data, CMS did not identify and adjust for that complexity when it implemented HCFA Ruling 97-2 as well as CMS' obligation under MMA § 951 to "arrange to furnish the personally identifiable information that would enable a hospital to compare and verify its records, . . . in the case of the Medicaid fraction, against the State-Medicaid agency's records."[58] In particular, CMS has not addressed how the practical impediment described above (*i.e.*, the fact that only Medicaid eligible days verified by the State can be claimed and that the data needed to verify Medicaid eligibility may not be available through no fault of the provider) may affect a provider's appeal rights under 42 U.S.C. § 1395oo(a).[59] As described below, the Board concludes that this practical impediment is similar to the legal impediment in *Bethesda*.

In *Bethesda*, the Supreme Court was presented a situation where regulations prohibited a provider from claiming certain items on its cost report. The provider filed its report in compliance with the applicable regulations, but later sought to use the Board appeals mechanism as a means to address the perceived reimbursement shortfall. The Supreme Court held that the PRRB's "dissatisfaction" requirement could be met absent an adverse adjustment from a fiscal intermediary, stating:

> 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.[60]

The Supreme Court concluded that "petitioners could claim dissatisfaction within the meaning of the statute, without incorporating their challenge in the cost report filed with their fiscal intermediaries."[61]

Application of the *Bethesda* holding has resulted in a perception that the "dissatisfaction" demonstration threshold has been lowered. This in turn, had led providers to attempt to apply *Bethesda* reasoning to expand the Board's jurisdiction over a variety of claims that might not have been otherwise appealed. However, the precise contours of the *Bethesda* decision are subject to dispute.

The Board recognizes that CMS promulgated regulatory provisions to address *Bethesda* situations in the final rule published on May 23, 2008 (May 2008 Final Rule).[62] Specifically CMS promulgated new

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[58] 70 Fed. Reg. at 47438.
[59] The Board is not aware of CMS ever revisiting its 1986 evaluation of "the need to publish regulations to outline procedures and requirements for hospitals to follow in applying for a disproportionate share adjustment based on the patient revenue criteria under section 1886(d)(5)(F)(i)(II) of the Act." 51 Fed. Reg. at 31457.
[60] *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 404 (1988).
[61] *Id.* at 405.
[62] 73 Fed. Reg. 30190 (May 23, 2008).

regulatory provisions at 42 C.F.R. § 405.1835(a)(1) describing how a provider can preserve its right to claim dissatisfaction and to pursue a Board hearing:

> (a) *Criteria.* 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, only if—
>
> (1) 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 (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).[63]

Significantly, CMS describes the new § 405.1835(a)(1)(ii) as "more akin simply to a presentment requirement" than "an exhaustion requirement."[64]

Section 405.1835(a)(1)(ii) states that the "presentment requirement" is not applicable to FYs that end prior to December 31, 2008 and, thereby, is not applicable to this case. Nevertheless, the regulatory history indicates that CMS anticipated that a provider may protest self-disallowed claims in compliance with § 405.1835(a)(1)(ii) where the cost is unknown and still have appeal rights. In the preamble to the May 2008 Final Rule, CMS recognized that providers can appeal certain situations where the provider is uncertain about the cost of a protested item and does not have access to the underlying data to verify such costs. Specifically, in connection with "Provider Hearing Rights," CMS states the following in the preamble:

> In § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i), we proposed that a provider would be required to explain its dissatisfaction with the amount of Medicare payment for the specific item(s) at issue by stating why Medicare payment is incorrect for each disputed item. *We acknowledge that there may be instances in which a provider may be uncertain as to whether Medicare payment is incorrect because it does not have access to the underlying data* ***(for example, data from a State agency)***. Accordingly, we have revised § 405.1811(b)(2)(i) and § 405.1835(b)(2)(i) to allow a provider to explain why it is unable to determine whether payment is correct as a result of not having access to underlying information.[65]

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[63] *Id.* at 30249 (italics in original).
[64] *Id.* at 30196-30197.
[65] *Id* at 30194 (emphasis added) (quoting from Section II.D entitled "Provider Hearing Rights (§ 405.1803(d), § 405.1811, and § 405.1835)").

This preamble supports the Board's application of *Bethesda* to this case, namely that, prior to the "presentment requirement" specified in § 405.1835(a)(1)(ii) going into effect, a provider was not required to "present" or "claim" Medicaid eligible days which (through no fault of the provider) could not be identified and/or verified with the State because the provider did not have access to the data from the State necessary to identify and/or verify those days.

The Board's application of *Bethesda* is also consistent with Board Rule 7, entitled "Issue Statement and Claim of Dissatisfaction." The portions of Board Rule 7 which apply to this case are only those portions which do not involve the § 405.1835(a)(1)(ii) "presentment requirement" governing self-disallowed items.[66] Specifically, Board Rule 7.1 describes what is required for issue statements that are included in appeal requests and address "NPR or Revised NPR Adjustment." It recognizes in Paragraph B that there may situations where a provider may not have access to data:

> **B. No Access to Data**: If the Provider, *through no fault of its own*, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.[67]

Similarly, Board Rule 7.2 describes what is required for issue statements addressing "Self-Disallowed Items" and recognizes in Paragraph B that there may be situations where a provider may not have access to data:

> **B. No Access to Data**
> If the Provider elects to not claim an item on the cost report because, *through no fault of its own*, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon filing the cost report.[68]

Finally, the Board believes that the basis for above preamble discussion and for Board Rules 7.1.B and 7.2.B continues to exist. In particular, the Board believes that, despite recent improvements in the availability of data, some providers may still experience delays in obtaining access to this State data (*e.g.*, some States will not accept requests relating to a fiscal year until the cost report filing deadline for that fiscal year has tolled).

In a February 2014 published decision, the Board ruled that it did not have jurisdiction over a reimbursement appeal filed by Danbury Hospital under circumstances very similar to the present case.[69] In *Danbury*, the provider claimed that it was unable to obtain the State-maintained information necessary to verify the Medicaid eligibility of its patients. The lack of verified information, it was argued, hindered the provider's ability to fully and accurately claim Medicaid eligible days on its cost report. Therefore, the provider filed a cost report that included only those days that were verified prior to the reporting deadline. The provider subsequently pursued a Board appeal in which it sought additional DSH reimbursement based on the inclusion of newly-verified Medicaid eligible days.

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[66] Subsection C of Board Rule 7.2 addressing the protest of self-disallowed items applies to cost reporting periods ending on or after December 31, 2008. As the cost reporting year in this case ended December 31, 2001, subsection C is not applicable.
[67] (Bold emphasis in original and italics added.)
[68] (Bold emphasis in original and italics added.)
[69] *Danbury Hospital v. BlueCross BlueShield Ass'n/Nat'l Govt. Serv. Inc.* PRRB Decision No. 2014-D3 (February 11, 2014).

The provider argued that Board jurisdiction over its appeal was proper based upon *Bethesda*, claiming that *Bethesda* stands for the idea that a provider may appeal costs which it excludes from its cost report, if the inclusion of such items would be futile. The Provider asserted that the Medicaid eligible days are often not available from the State in time for the Provider to include them on the cost report prior to the filing deadline. In support of its position, the Provider asserted that prior Board jurisdiction decisions have suggested that the "practical difficulties in getting [State] information combined with the Secretary's statement that it is not necessary for hospitals to formally apply for a DSH adjustment create circumstances in which a provider may demonstrate that it is dissatisfied with the Intermediary's determination of reimbursement despite not having made a claim on the cost report." The Provider essentially asserted that the preambles to the May 1986 Interim Final Rule and the September 1986 Final Rule confirm that providers do not need to make a formal claim for a DSH adjustment and that providers can later submit additional Medicaid eligible days data if they believe their cost report is not accurate.[70]

As discussed above, the Board has interpreted and applied *Bethesda* such that, prior to the "presentment requirement" specified in § 405.1835(a)(1)(ii) going into effect, a provider was not required to "present" or "claim" Medicaid eligible days that (through no fault of the provider) could not be identified and/or verified with the State because the provider did not have access to the data from the State necessary for such identification and/or verification. However, a provider does have an obligation to establish that a practical impediment did exist preventing it from obtaining required verification from the State. In this regard, if the practical impediment theory were allowed to proceed, the provider would have a high burden of proof to establish the existence of such a practical difficulty.[71]

As a consequence, in the *Danbury* case, the Board asked the Provider to bolster the record on two separate occasions. However, despite the Board requests, the Provider failed to demonstrate the existence of a practical impediment that prevented it from claiming the additional days on the as-filed cost report. Therefore, the Board concluded that it did not have jurisdiction under 42 U.S.C. § 1395oo(a) to hear the Provider's claim for additional Medicaid eligible days pursuant to *Bethesda* because the Provider failed to establish that there was a practical impediment, through no fault of the Provider, preventing the Provider from identifying and/or verifying the additional days with the State prior to the filing of the cost report.

In light of *Danbury,* the Board issued Alert 10 on May 23, 2014. This Alert allowed parties to an appeal currently pending before the Board that included the Disproportionate Share Payment ("DSH") paid/unpaid Medicaid eligible days issue an opportunity to supplement the record based on the *Danbury* decision. Specifically, the parties were given 60 days from the date of the Alert to supplement the record with additional arguments and/or documentation that would be relevant to the Board making a jurisdictional decision on the issue.

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[70] *Id.* at 12.

[71] *See* Administrator Dec. (May 21, 2012), reversing, PRRB Dec. No. 2012-D14 (Mar. 19, 2012). The *Norwalk* provider appealed to federal district court and the case was later dismissed. The record suggests that the parties settled the case and that the provider requested dismissal of its appeal. *See* Joint Status Rep. at ¶ 1 (Sept. 16, 2013) and Stipulation of Dismissal (Nov. 5, 2013), *Norwalk Hosp. Ass'n v. Sebelius*, Case No. 3:12-cv-01065-JBA (D. CT. filed July 20, 2012 and dismissed Nov. 5, 2013) (stating in the Joint Status Report that "[o]n or about July 23, 2013, the parties reached an agreement in principle with respect to settlement of the...appeal").

In particular, the Board was interested in receiving the following provider-specific information or documentation to the extent it was not already in the record:

- A detailed description of the process that the provider used to identify and accumulate the actual paid and unpaid eligible days that were reported and filed on the Medicare cost report at issue.

- The number of additional paid and unpaid eligible days that the provider is requesting to be included in the DSH calculation.

- A detailed explanation why the additional Medicaid paid and unpaid eligible days at issue could not be verified by the state at the time the cost report was filed. If there is more than one explanation/reason, identify how many of these days are associated with each explanation reason.

With respect to fiscal year 2005, the Provider did not submit any additional arguments and/or documentation in response to Alert 10. No detailed description of the process that the Provider used to accumulate the actual paid and unpaid eligible days was supplied. The Provider has not identified the number or the nature of the days that it seeks to include on appeal. No detailed explanation why the additional days at issue could not be verified by the State at the time the cost report was filed was provided. The Intermediary made no adjustments to the Provider's as filed Medicaid days. [72]

The Board does not have jurisdiction under 42 U.S.C. § 1395oo(a) to hear the claim for additional Medicaid eligible days in the fiscal year 2005 appeal pursuant to *Bethesda* because the Provider failed to establish that there was a practical impediment, through no fault of the Provider, preventing the Provider from identifying and/or verifying these days with the State prior to the filing of the cost report. Therefore, the Board dismisses the Medicaid eligible days issue from the fiscal year 2005 appeal.

DSH – Labor and Delivery Room Days

CMS Ruling 1498-R indicates that the Board lacks jurisdiction over any of the three DSH issues specified in the Ruling, which are (1) SSI data matching; (2) Dual Eligible days; and, (3) LDR inpatient days.[73] The Ruling still indicates, however, that in order to resolve properly pending claims regarding these three DSH issues, "all jurisdictional and procedural requirements" must be satisfied.[74] The Ruling offers the following guidance regarding LDR inpatient days:

> . . . CMS and Medicare contractors will resolve each properly pending claim, in a DSH appeal for a cost reporting period beginning before October 1, 2009, in which the hospital seeks inclusion in the DPP of LDR inpatient days. For such properly pending appeals, CMS and the contractors will recalculate the hospital's DSH payment adjustment for the period at issue by including the LDR days in the Medicaid fraction or the SSI fraction (whichever proves to be applicable), regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking

[72] *See* Intermediary's Final Position Paper at 10.
[73] *See* CMS Ruling 1498-R, Apr. 28, 2010.
[74] *Id.* at 15.

> hour. This resolution of properly pending appeals, for pre-October 1, 2009 cost reporting periods, comports with CMS' view that LDR inpatient days belong in the DPP if such days satisfy the requirements for inclusion in the Medicaid fraction or the SSI fraction, regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal, for a pre-October 1, 2009 cost reporting period, in which the hospital seeks inclusion in the DPP of LDR inpatient days, provided that the disputed LDR inpatient days otherwise meet the requirements for inclusion in the Medicaid fraction or the SSI fraction and the claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. Accordingly, it is hereby held that the PRRB and the other administrative tribunals lack jurisdiction over each properly pending claim on the LDR inpatient day issue for a cost reporting period beginning before October 1, 2009, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements for appeal.[75]

The Ruling outlines the standard remand implementation procedure:

> If the [Board] finds that the applicable jurisdictional and procedural requirements are satisfied for a given claim on one of the three DSH issues, then the appeals tribunal will issue a brief written order, remanding each claim that qualifies for relief under the Ruling to the appropriate Medicare contractor for recalculation of the DSH payment adjustment . . . for the period at issue.
>
> However, if the [Board] finds that a given claim is outside the scope of the Ruling (because such claim is not for one of the three DSH issues) or the claim fails to meet the applicable jurisdictional and procedural requirements for relief under the Ruling, then the [Board] will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling.[76]

While Logansport Memorial Hospital did not specifically claim the exclusion of LDR days on its cost report, it may "self-disallow" the item pursuant to *Bethesda*. *Bethesda* held that providers could meet the dissatisfaction requirement without incorporating their challenges in their cost reports if the item was barred from being claimed or reported because of a specific statute, regulation, or ruling. Providers were barred from reporting the DSH LDR days issue prior to the 2009 DSH policy change.[77]

Accordingly, the Board finds that the LDR days issue was a self-disallowable issue for FYE 12/31/05 and therefore jurisdiction is valid pursuant to *Bethesda*. The issue is subject to a standard remand pursuant to CMS Ruling 1498-R.

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[75] *Id.*, pp.15-16.
[76] *Id.*, pp.17-18.
77 *See* 74 Fed. Reg. 43899 (Aug. 27, 2009) (to be codified at 42 C.F.R. § 412.106) ("Under existing regulations at § 412.106(a)(1)(ii)(B), patient days associated with beds used for ancillary labor and delivery are excluded from the Medicare DSH calculation."). The final policy change allowed inpatient labor and delivery days to be included in the DSH calculation. *Id.* at 43900.

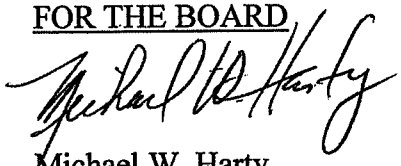
Conclusion

The Board hereby dismisses the DSH – Medicaid eligible days, Observation bed days, Observation bed charges, and Hospital discharge count issues from the Provider's fiscal year 2005 appeal. Likewise, the Board dismisses the Observation bed charges issue from the Provider's fiscal year 2006 appeal. The Board has separately remanded the LDR days issue in the fiscal year 2005 appeal pursuant to CMS Ruling 1498-R. As there are no issues remaining in PRRB Case Nos. 08-0270 and 09-0488, the Board closes the appeals.

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

Board Members Participating:
Michael W. Harty
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 Blue Shield Association
Standard remand of LDR issue for Case No. 08-0270

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FEB 10 2015

CERTIFIED MAIL

Catholic Health Services of Long Island
Dan Flood
Director, Budget and Reimbursement
1000 Montauk Highway
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Blumberg Ribner, Inc.
Isaac Blumberg
Chief Operating Officer
315 South Beverly Drive, Suite 505
Beverly Hills, CA 90212

RE: St. Charles Hospital, Provider No. 33-0246, FYE 12/31/2010, PRRB Case No. 15-0959

Dear Mr. Flood and Mr. Blumberg:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

Blumberg Ribner, Inc. filed an individual appeal for St. Charles Hospital on January 15, 2015. The Board established case number 15-0959 and issued an acknowledgement letter on January 16, 2015. The appeal request did not include a copy of the final determination (the Notice of Program Reimbursement (NPR)) nor did it include a signed authorization letter from the Provider appointing Blumberg Ribner to handle the 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 of the date of receipt of the Notice of Program Reimbursement (NPR).

42 C.F.R 405.1835(a) states that only a Provider has a right to a hearing before the Board. Without a representation letter signed prior to the appeal request, Blumberg Ribner does not have the authorization to file an appeal on behalf of the provider, nor should the Board be corresponding with them on an appeal for which they are not the authorized representative. If a Provider has not provided Blumberg Ribner with a representation letter, it is acting without authority to file an appeal with the Board.

In addition, 42 C.F.R 405.1835(b) specifically requires the Provider to include the final determination it is appealing with the timely request, and authorizes the Board to dismiss with prejudice any appeal that does not include a copy of the determination under appeal with its filing.

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

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

Because the appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, the Board hereby dismisses the individual 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
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: National Government Services
Kyle Browning
Appeals Lead
MP: INA102 - AF42
P. O. Box 6474
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BC BS Association
Kevin D. Shanklin
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225 North Michigan Avenue
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Refer to:

CERTIFIED MAIL

FEB 10 2015

BESLER Consulting
Kathleen Nicholson
Manager
3 Independence Way, Suite 201
Princeton, NJ 08540-6626

RE: Holy Name Hospital, Provider No. 31-0008, FYE 12/31/2010, PRRB Case No. 15-1016

Dear Ms. Nicholson:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

BESLER Consulting filed an individual appeal for Holy Name Hospital on January 23, 2015. The Board established case number 15-1016 and issued an acknowledgement letter on January 27, 2015. The appeal request did not include a copy of the Notice of Program Reimbursement (NPR). To date, there is no record that the final determination was submitted.

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).

42 C.F.R § 405.1835(b) specifically requires the Provider to include the final determination it is appealing with the timely request, and authorizes the Board to dismiss with prejudice any appeal that does not include a copy of the determination under appeal with its filing. In the referenced case, BESLER Consulting is filing an appeal that does not meet the regulatory requirements.

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

> The Board will send an acknowledgement via email indicating that the appeal request has been received and identifying the case number assigned. If the

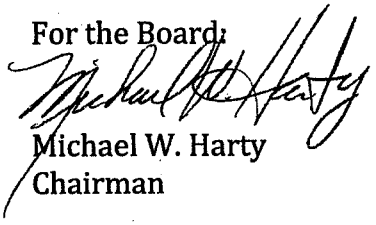
appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient.

Because the appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, the Board hereby dismisses the individual 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.
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: Novitas Solutions, Inc.
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BC BS Association
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Executive Director
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Refer to:

13-2263 **CERTIFIED MAIL** FEB 12 2015

Donald Peak
UC Health
3200 Burnet Avenue
Cincinnati, OH 45229

Judith E. Cummings
CGS Audit & Reimbursement
Two Vantage Way
Nashville, TN 37228

RE: University of Cincinnati Medical Center ("Cincinnati")
Provider No.: 36-0003
FYEs: 06/30/2007
PRRB Case No.: 13-2263

Dear Mr. Peak and Ms. Cummings:

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

Background

On April 22, 2011, the Medicare contractor notified Cincinnati that it was reopening Cincinnati's cost report for the fiscal year ending ("FYE") on June 30, 2007, in order to revise Cincinnati's Medicare Supplemental Security Income ("SSI") fraction to ensure inclusion of Cincinnati's Medicare Advantage ("MA") days.[1] On November 28, 2012, the Medicare contractor issued Cincinnati an Amended Notice of Amount of Medicare Program Reimbursement ("RNPR") for FYE June 30, 2007.

The Board received Cincinnati's appeal of its November 28, 2012 RNPR ("Appeal") on May 23, 2013. In its Appeal, Cincinnati seeks Board review of the Medicare contractor's "failure . . . to include Labor and Delivery room days in the Medicaid fraction when calculating the final [Disproportionate Share Hospital ("DSH")] factor . . ."

On May 8, 2014, the Board received BlueCross and BlueShield's ("BCBS") jurisdictional challenge ("Jurisdictional Challenge") filed on behalf of the Medicare contractor. In its Jurisdictional Challenge, BCBS states that the Board lacks jurisdiction to hear Cincinnati's Labor and Delivery room ("LDR") days issue because the Medicare contractor did not adjust Cincinnati's LDR days in the RNPR. In addition, BCBS states that Cincinnati did not have a properly pending appeal of its LDR days for FYE June 30, 2007, on the date that the Centers for Medicare & Medicaid Services ("CMS") issued Ruling 1498-R.

[1] The Medicare contractor issued Cincinnati its Notice of Program Reimbursement ("NPR") for FYE June 30, 2007, on November 24, 2008.

On June 5, 2014, the Board received Cincinnati's response ("Response") to BCBS's Jurisdictional Challenge.[2]

Cincinnati's Contentions

In its Response, Cincinnati states that the Board has jurisdiction over its Appeal because "the actual substance of the appeal request was the entire calculation of the DSH percentage." Therefore, Cincinnati argues, it "is properly appealing the subject matter of the [Medicare contractor]'s reopening—the overall DSH percentage." Cincinnati claims that while its Appeal requests review of its calculation of its DSH percentage, it specifically referenced the LDR days issue in order to comply with the Board's specificity requirements as stated in Board Rules 8.1 and 8.2.

Cincinnati states that in CMS Ruling 1498-R, CMS acknowledged "that it had previously incorrectly treated [LDR] Days in the DSH calculation." Therefore, Cincinnati argues, it is only seeking "to correct the errors in the DSH calculation that the government acknowledged in CMS Ruling 1498-R."

Lastly, Cincinnati claims that the Medicare contractor "is improperly using a jurisdictional challenge to avoid fixing its substantive error regarding its treatment of [LDR] Days . . ."

Board's Decision

Cincinnati timely filed its Appeal after the Medicare contractor reopened Cincinnati's cost report for FYE June 30, 2007, and issued an RNPR. As such, Cincinnati is bound by the regulations that govern an appeal of an RNPR, not those that govern an appeal of an NPR. The controlling regulations in the instant appeal are found at 42 C.F.R. § 405.1889 (2012) and state the following with respect to the issues that a provider may appeal following a reopening:

> (a) If a revision is made in a[n] . . . intermediary determination . . . after the determination is reopened . . . the revision must be considered a separate and distinct determination . . .
> (b) (1) Only those matters that are specifically revised in a revised determination . . . are within the scope of any appeal of the revised determination . . .
> (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.

In the present case, the Medicare contractor reopened Cincinnati's FYE June 30, 2007 cost report in order "[t]o revise the Medicare SSI fraction in the DSH calculation to ensure the accurate inclusion of [MA] data submitted by providers, which will be included in revised SSI ratios to be published by CMS." However, the Medicare contractor did not specifically revise Cincinnati's LDR days or its Medicaid fraction when it reopened Cincinnati's cost report and, therefore, the regulations prohibit the Board from considering Cincinnati's LDR days issue in this appeal.

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[2] James F. Flynn of Brickler & Eckler, Attorneys at Law, filed Cincinnati's cover page of its preliminary position paper and its June 5, 2014 Response with the Board. However, neither Mr. Flynn nor Brickler & Eckler are Cincinnati's representative on record with the Board as neither has filed a notice of appearance or letter of representation in this case.

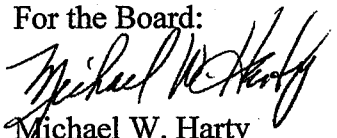
Alternatively, Cincinnati argues that it "is entitled to request remand to the [Medicare contractor] for implementation of the remedies set forth in [CMS Ruling 1498-R], namely the proper treatment of the [LDR] Days in the FY[E] 2007 DSH calculation."

CMS Ruling 1498-R, published on April 28, 2010, requires the Board to remand to the Medicare contractor any properly pending claim in a DSH appeal, for cost reporting periods beginning before October 1, 2009, in which a provider challenges the exclusion of LDR inpatient days from the disproportionate patient percentage ("DPP"). However, in order for the Board to remand a provider's appeal of its LDR days, that provider must first have a properly pending appeal before the Board regarding that issue.

In the present case, Cincinnati did not file an appeal of its LDR days after the Medicare contractor issued its NPR. Instead, Cincinnati filed an appeal of these days after the Medicare contractor reopened its June 30, 2007 cost report and issued an RNPR. As noted prior, Cincinnati does not have a properly pending appeal of its LDR days based on its RNPR appeal and Cincinnati did not appeal its LDR days following receipt of its NPR. Therefore, Cincinnati does not have a properly pending appeal in which it seeks inclusion of LDR inpatient days in the DPP and, thus, its appeal does not qualify for Board remand under CMS Ruling 1498-R.

As Cincinnati's sole issue in its RNPR appeal involves its LDR days, there are no remaining issues left in this appeal and case number 13-2263 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
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

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: 09-0068GC

FEB 20 2015

CERTIFIED MAIL

Stephanie A. Webster
Akin, Gump, Strauss, Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Suite 400
Washington, DC 20036-1532

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

RE: Jurisdictional Decision
Southwest Consulting Iasis Healthcare 03 DSH LDR Days CIRP Group
Provider No.: Various
FYE: Various
PRRB Case No.: 09-0068GC

Dear Ms. Webster and Mr. Ward,

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

Mid-Jefferson Hospital, provider no. 45-0514, FYE 7/31/2003

Mid-Jefferson Hospital, listed as participant 6 on the Schedule of Providers, was issued a revised Notice of Program Reimbursement (NPR) for FYE 7/31/2003 on August 4, 2010. The revised NPR was issued as the result of an Administrative Resolution (AR) in the Provider's individual appeal, case number 05-1357. The Provider requested to be directly added to this group appeal on January 13, 2011.

Park Place Medical Center, provider no. 45-0518, FYE 7/31/2003

Park Place Medical Center, listed as participant 7 on the Schedule of Providers, was issued a revised NPR for FYE 7/31/2003 on July 19, 2010. The revised NPR was issued as the result of an AR in the Provider's individual appeal, case number 07-0356. The Provider requested to be directly added to this group appeal on January 13, 2011.

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 costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is

$10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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, a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (a) If a revision is made in a Secretary or intermediary determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of § 405.1811, § 405.1834, § 405.1835, § 405.1837, § 405.1875, § 405.1877 and § 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over either Mid-Jefferson Hospital's revised NPR appeal or Park Place Medical Center's revised NPR appeal. The Board finds that the revised NPRs for both appeals stemmed from signed administrative resolutions which document the Providers' agreement that the dissatisfaction had been resolved for the issues under appeal. Administrative Resolutions include the following statement: "The provider's signature serves as the provider's request to withdraw this case from appeal." The Board finds that this statement establishes a Provider's decision to withdraw any remaining issues in the appeal. PRRB Rule 4.7, Dismissed or Withdrawn Issues, states, "Once an issue is dismissed or withdrawn, the issue may not be appealed in another case." Had the Providers been dissatisfied with the MAC's resolution of the prior appeal, the Providers could have come to a Board hearing on the remaining outstanding issues. However they chose to withdraw their appeals, hence claiming satisfaction of the resolution.

In the case of Mid-Jefferson Hospital, the administrative resolution was not provided, but a letter from the MAC to the Provider was submitted on July 24, 2014, which states that 27 Labor and Delivery Days were removed from the sample. The Provider proceeded with a resolution and withdrew its appeal, even with the knowledge that 27 days would not be included in the revised NPR. The regulations applicable to the revised NPR dated August 4, 2010, are clear that, "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."[1]

Park Place Medical Center's documentation provided July 24, 2010 indicates that the listing provided to the MAC to audit "self-disallowed" 111 labor and delivery days, which were therefore not included in the sample audited by the MAC prior to the issuance of the revised NPR. Those days were not considered by the MAC as the Provider notified it that the labor and delivery days had been removed from the population. Issues that are self-disallowed are not appealable from a revised NPR, as revised NPR appeals are limited to issues specifically revised in the revised NPR.

In summary, the Providers' revised NPRs were issued as the result of Administrative Resolutions, neither of which included labor and delivery days. The Providers did not meet the dissatisfaction requirement for Board jurisdiction, therefore, the Board finds that the Providers cannot show the dissatisfaction necessary to appeal their revised NPRs as required by 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835, 405.1837. Additionally, the appeals did not meet the appeal requirements from a revised NPR in 42 C.F.R. § 405.1889. Both Mid-Jefferson Hospital and Park Place Medical Center are dismissed as participants in case number 09-0068GC.

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
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Kevin D. Shanklin, BCBSA

[1] 42 C.F.R. § 405.1889(b)(2)(2010).

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to:

09-1675GC

FEB 26 2015

Certified Mail

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Elizabeth A. Elias
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Box 82064
Indianapolis, IN 46282

Wisconsin Physician Services
Byron Lamprecht
P.O. Box 1604
Omaha, NE 68101

RE: Jurisdiction Decision
Community Health Systems 2005 SSI Days Proxy Group
PRRB Case No.: 09-1675GC

Dear Ms. Elias and Mr. Lamprecht,

The Provider Reimbursement Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal, and noted procedural impediments for four Providers in this group appeal. The Board dismisses Barberton Hospital, Brandywine Hospital, Carlsbad Medical Center and Lake Granbury Medical Center for their 2005 cost report periods.

Background

The Providers filed an initial request for a CIRP group appeal on April 14, 2009. This is a CIRP group appeal with a single issue, DSH SSI percentage, covered under Ruling 1498-R. On March 28, 2014 the Appeal Group submitted the Schedule of Providers (SOP) and requested the Board to process the remand under the standard procedure.

Board's Decision

The Board finds that Barberton Citizens Hospital (36-0019, FYE 12/31/2005), Brandywine Hospital (39-0076, FYE 06/30/2005), Carlsbad Medical Center (32-0063, FYE 08/31/2005) and Lake Granbury Medical Center (45-0596, FYE 11/30/2005) are part of a separate SSI% CIRP group appeal, 08-1963GC, and hereby dismisses these providers from 09-1675GC.

The Provider Reimbursement Review Board sets their own rules per 42 U.S.C. § 1395oo(e), which states in part "The Board shall have full power and authority to make rules and establish procedures, not inconsistent with the provisions of this subchapter or regulations of the Secretary, which are necessary or appropriate to carry out the provisions of this section." Provider Reimbursement Review Board rule 4.5 states "A Provider may not appeal an issue from a final determination in more than one appeal." Participants 1, 3, 4 and 17 were all part of a second SSI Days group appeal, case number 08-1963GC. Therefore, the Board dismisses these Providers from

the group appeal as they cannot be part of two different appeals for the same issue.

Board Members
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA

FOR THE BOARD

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand Letter
Schedule of Providers
Schedule for Providers for case no. 08-1963GC

cc: Kevin Shanklin, Executive Director, BCBSA