DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
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Refer to: 10-0461

JUL 09 2015

CERTIFIED MAIL

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National Government Services, Inc.
Danene Hartley
Appeals Lead
MP:INA101-AF42
P.O. Box 6474
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RE: Trinity Medical Center – Rock Island
Provider No. 14-0280
FYE December 31, 2003
PRRB Case No. 10-0461

Dear Mr. Blumberg and Ms. Hartley:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal in response to the Medicare contractor's jurisdictional challenge. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

TIMELINE AND BACKGROUND

Trinity Medical Center – Rock Island (the Provider) filed an appeal on January 19, 2010 from a revised Notice of Program Reimbursement ("NPR") dated July 27, 2009. The appeal request contained two issues including DSH - Medicaid Eligible Days and Inpatient Rehabilitation Facility ("IRF") LIP payments-Medicaid Rehab Days.

The Medicare Contractor filed a jurisdictional challenge to the IRF LIP payments-Medicaid Rehab Days and DSH - Medicaid Eligible Days issues on February 21, 2013 and February 25, 2013, respectively. The Provider did not file a responsive brief to the Medicare Contractor's challenges. The Provider filed a response to Board Alert 10 relative to this case on July 14, 2014.

MEDICARE CONTRACTOR'S CONTENTIONS

IRF LIP Payment

The Medicare Contractor states that the appeals are based on the revised NPR that was issued on July 27, 2009. The Medicare Contractor contends that the Board should dismiss the LIP payment issue for lack of subject matter jurisdiction.[1]

[1] Medicare Contractor's Jurisdictional Briefs at 1.

DSH – Medicaid Eligible Days

The Medicare Contractor contends that the Provider's cost report was reopened on July 27, 2009 based on the Provider's August 6, 2008 reopening request. The Provider requested 631 additional Medicaid eligible days and 5 rehab days.[2] The Medicare contractor allowed 588 additional Medicaid eligible days for Adults & Pediatrics and 5 additional Medicaid days for the IRF. The Medicare contractor reviewed the Provider's documentation and determined that 27 Medicaid patient days were duplicates.

The Medicare contractor contends that the Provider is attempting to add 581 additional Medicaid days. Therefore, the Medicare Contractor did not make a determination with respect to the Provider for the days at issue in the appeals.[3]

PROVIDER'S CONTENTIONS

None

BOARD 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 (2008) 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 (2008), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[4] The regulation provides:

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[2] Medicare Contractor's Jurisdictional Briefs, Exhibit I-4.
[3] Medicare Contractor's Jurisdictional Briefs at 2.
[4] *See also, HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding that the Board's jurisdiction is limited to the specific issues revisited on reopening); *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014) (holding that the "issue-specific" interpretation of the NPR reopening regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been reconsidered).

(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.

(b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

The Board finds that it does not have jurisdiction over the DSH - Medicaid Eligible Days and LIP payment issues in the subject appeal because the Provider fails to document that the days under appeal were specifically revised in the revised NPR. The Provider received 588 Medicaid eligible days and 5 IRF LIP Medicaid days[5] that it requested in the revised NPR.[6] The Provider has not supplied any evidence in the record that the days in dispute were reviewed or revised as part of the revised NPRs under appeal, therefore the Board lacks jurisdiction over the issue under 42 C.F.R. § 405.1889(b).

As the DSH - Medicaid eligible days and IRF LIP payment issues are the remaining issues in the subject appeal the Board hereby closes the subject appeal and removes it from the Board's docket.

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 405.1877

cc: BC BS Association
Sharon L. Keyes, Executive Director
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225 North Michigan Avenue
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[5] It should be noted that the Provider requested 5 IRF days and received 5 IRF days in the revised NPR.
[6] The Medicare contractor disallowed 27 Medicaid eligible days that it determined were duplicates. There is nothing in the record for the other 16 disallowed days.

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RE: Rush University Medical Center
Provider No: 14-0119
FYE: 6/30/01
PRRB Case No.: 05-0626

Dear Mr. Flynn and Ms. Hartley,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's challenge to the Board's jurisdiction over the resident FTEs as "primary care" or "other than primary care" issue in the appeal. The pertinent facts of the case, the Parties' positions, and the Board's jurisdictional determination are set forth below.

Background

The Provider submitted a request for hearing on February 3, 2005, based on a Notice of Program Reimbursement ("NPR") dated August 13, 2004. The Provider filed its Final Position Paper on October 3, 2005, in which it briefed five issues, including the issue of resident FTEs as "primary care" or "other than primary care." The Provider added the SSI% issue to its appeal on October 20, 2008, and subsequently transferred the issue to a group appeal on November 3, 2008. On November 25, 2014, the Provider withdrew two issues from its appeal. The Medicare Contractor filed a jurisdictional challenge on the resident FTEs as "primary care" or "other than primary care" issue on May 19, 2015. The Provider filed a responsive brief on June 17, 2015.

Medicare Contractor's Position

The Medicare Contractor challenges the Board's jurisdiction over this issue, arguing that it made no adjustment to the submitted DGME FTEs to reclassify residents submitted as Obstetrics & Gynecology (IRIS Specialty Code 1750) to Obstetrics & Gynecology Surgery (IRIS Specialty Code 4500).[1] Although the Medicare Contractor did make a number of adjustments to the IME and DGME FTE counts, the reclassifying of residents from Specialty Code 1750 to Specialty

[1] For DGME reimbursement purposes, Obstetrics & Gynecology (IRIS Specialty Code 1750) is classified as "primary care" while Obstetrics & Gynecology Surgery (IRIS Specialty Code 4500) is classified as "other than primary care."

Code 4500 was not one of the adjustments. The Medicare Contractor accepted the classification of residents as Obstetrics & Gynecology Surgery (IRIS Specialty Code 4500) as submitted.[2]

The Medicare Contractor contends that the Provider's right to a Board hearing derives from a Contractor determination, which is defined at 42 C.F.R. § 405.1801(a)(1) 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 Medicare Contractor's position is that §§ 405.1801 and 405.1803 require an identifiable adverse finding, with a corresponding reduction in reimbursement, in order to request a Board hearing under section 405.1835. Since the Contractor made no adjustment, and accepted the submitted classification of residents as Obstetrics & Gynecology Surgery (IRIS Specialty Code 4500), the Contractor contends that the Board lacks jurisdiction over this matter in accordance with 42 C.F.R. § 405.1811.[3]

Provider's Position

The Provider contends it is entitled to a hearing under the statute because it is dissatisfied with the Medicare Contractor's final determination on the Provider's DGME FTE count and resulting reimbursement for FY 2001, the amount in controversy for all appealed issues is in excess of $10,000, and it timely filed a request for hearing within 180 days of the Medicare Contractor's August 13, 2004 NPR. The statute does not refer to the need for an audit adjustment.[4]

The Provider contends that the regulation in effect at the time that it filed its request for hearing links the Provider's right to a hearing to a Contractor's determination of the total program reimbursement due, not a specific audit adjustment. There is no regulatory support for the standard created and advanced by the Medicare Contractor in its jurisdictional challenge. The Provider explains that the Medicare Contractor admits that the Provider's FY 2001 reimbursement does not include the reimbursement resulting from the proper classification of the DGME FTEs in dispute. Thus, the Medicare Contractor's determination of the amount of total reimbursement due the Provider does not include any of the aspects being challenged in the appeal. The Provider argues that it has properly invoked the Board's jurisdiction to challenge this determination in accordance with the law in effect at the time.[5]

The Provider cites to the United States Supreme Court decision in *Bethesda Hosp. Ass'n v. Bowen* [6] in support of its position. The Provider further argues that the federal appeals courts have determined that the language of the Medicare statute provides for Board jurisdiction over costs not included in the initial cost report, whether they be inadvertently omitted or self-disallowed.[7] Additionally, the Provider explains that the District Court for the District of Columbia in *UMDNJ – Univ. Hosp. v. Leavitt*[8] addressed the Board's scope of review under 42 U.S.C. § 1395oo(d), which is a separate part of the jurisdictional statute that addresses the scope of matters that may be considered by the Board. It states:

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[2] Medicare Contractor's jurisdictional brief at 2.
[3] *Id* at 3.
[4] Provider's jurisdictional brief at 2.
[5] *Id* at 4.
[6] 485, U.S. 399 (1988). ("Bethesda").
[7] The Provider cites to *Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007) and *MaineGeneral Med. Ctr. v. Shalala*, 205 F.3d 493 (1st Cir. 2000).
[8] *UMDNJ – University Hospital v. Leavitt* , 539 F.Supp. 2d 70 (D.D.C. 2008).

> Decisions of Board. A decision by the Board shall be based upon the record made at such hearing, which shall include the evidence considered by the intermediary and such other evidence as may be obtained or received by the Board, and shall be supported by substantial evidence when the record is viewed as a whole. 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.[9]

The Provider argues, in sum, the decisions of the United States Supreme Court, Circuit Courts, and District Courts all support a finding of jurisdiction in this appeal. The Provider argues that it is entitled to a hearing before the Board under 42 U.S.C. § 1395oo(a) and the Board is authorized to make a decision on this issue pursuant to 42 U.S.C. § 1395oo(d) "even though such matters were not considered by the intermediary in making such final determination."[10]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) (2004) and 42 C.F.R. §§ 405.1835 – 405.1841 (2004), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that the Provider does not have a right under 42 U.S.C. § 1395oo(a) to a hearing on the resident FTEs as "primary care" or "other than primary care" issue in this appeal. The Provider received reimbursement for the items and services claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear this matter under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d).

The crux of the 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 –
>
> (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 . . .

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[9] *Id.* at 6.
[10] Provider's jurisdictional brief at 6-9.

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 the resident FTEs correctly on its as filed cost report. The Medicare Contractor did not make any adjustment with respect to these resident FTEs. Therefore, the Provider cannot claim dissatisfaction.

In *Bethesda,* the provider failed to claim a cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court 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.*[11]

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 its cost report and awarded by the fiscal intermediary, those circumstances are not presented here.[12]

In this case, the Board has precisely the situation described by the Supreme Court as being "on different ground."[13] 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*

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[11] *Bethesda.* at 1258, 1259. (Emphasis added).
[12] *Id.* at 1259. (Emphasis added).
[13] Emphasis added.

Co. of Mary Hosp. v. Shalala ("*Little Co. I*"),[14] 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.[15]

Subsequently, in 1999, the Seventh Circuit addressed the same issue in a case involving the same provider ("*Little Co. II*").[16] 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.[17] 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...[18]

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).[19] 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."[20]

In contrast, the First and Ninth Circuits have determined that the language of the Medicare statute provides for Board jurisdiction over claims not included in the initial cost report, whether they have been inadvertently omitted or "self-disallowed."[21] 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*").[22] In *Loma Linda,* the provider had inadvertently zeroed out reimbursable

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[14] 24 F.3d 984 (7th Cir. 1994).
[15] *Little Co. I,* 24 F.3d at 992.
[16] *Little Co. of Mary Hosp. v. Shalala,* 165 F.3d 1162 (7th Cir. 1999).
[17] *Little Co. II,* 165 F.3d at 1165.
[18] *Id.*
[19] 73 Fed. Reg. at 30196.
[20] 73 Fed. Reg. at 30203.
[21] *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).
[22] 492 F.3d 1065 (9th Cir. 2007).

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.*[23]

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).[24] Further, the Ninth Circuit stated it was joining the First Circuit's view as expressed in *MaineGeneral Med. Ctr. v. Shalala* ("*MaineGeneral*")[25] and *St. Luke's Hosp. v. Secretary* ("*St. Luke's*")[26] which were decisions issued in 2000 and 1987 respectively.[27]

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 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.[28] 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."[29]

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[23] *Id.* at 1068 (emphasis added).
[24] *See* 73 Fed. Reg. at 30197.
[25] 205 F.3d 493 (1st Cir. 2000).
[26] *St. Luke's Hosp. v. Secretary*, 810 F.2d 325 (1st Cir. 1987).
[27] *See Loma Linda*, 492 F.3d at 1068.
[28] *St. Luke's*, 810 F.2d at 332.
[29] *Id.* at 327-328 (emphasis in original).

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."[30] 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.[31] 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."[32]

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*.[33] 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:

> 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), ...[34]

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).[35]

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[30] *MaineGeneral*, 205 F.3d at 501.
[31] *St. Luke's*, 810 F.2d at 327.
[32] *MaineGeneral*, 205 F.3d at 501.
[33] *UMDNJ Univ. Hosp. v. Leavitt*, 539 F.Supp.2d. 70 (D.D.C. 2008) [hereinafter "*UMDNJ*"].
[34] *Id.* at 79.
[35] *Id.*at 77.

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.[36] However, the Provider is located in the Seventh Circuit and, as such, *Little Co. I* and *Little Co. II* apply to this appeal and serve as controlling precedent for the Board.[37]

The Board finds the errors and omissions for the resident FTEs as "primary care" or "other than primary care" issue were due solely to the Provider's negligence in the reporting of such item on the Medicare cost report. Only in hindsight did the Provider determine that it could (and should) have reported the resident FTEs differently, thereby potentially increasing the amount of reimbursement. 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."[38] The Board notes that it has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeals of other

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[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) ("*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.

[37] 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. BlueCross BlueShield 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.

[38] *Bethesda*, 485 U.S. at 404-405.

issues involving unclaimed costs when reimbursement of those costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction.[39]

Therefore, the Board dismisses the resident FTEs as "primary care" or "other than primary care" issue from the 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.

As there are two issues remaining in the appeal (Hospital-based physicians compensation costs and IME – research), the appeal remains open.

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

Board Members Participating
Michael W. Harty
Clayton J. Nix, 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: Sharon L. Keyes, Executive Director, Blue Cross Blue Shield Association

[39] *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.

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Refer to: 13-3478

CERTIFIED MAIL

JUL 13 2015

William A. Rees
Blue & Co., LLC
One American Square, Suite 2200
Box 82062
Indianapolis, IN 46282

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

RE: Schneck Medical Center
Provider Nos.: 15-0065, 15-U065, 15-7155 and 15-1529
FYE: 12/31/2008
PRRB Case No.: 13-3478

Dear Mr. Rees and Mr. Lamprecht:

This case involves Schneck Medical Center's ("Schneck's") appeal of its Medicare reimbursement for the fiscal year ending on December 31, 2008 ("FYE 12/31/2008"). The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional documents in the above-referenced appeal and determined that it has jurisdiction over Schneck's available bed count for the fiscal year at issue and, secondarily, Schneck's eligibility to claim a transitional corridor payment, also known as transitional outpatient payments ("TOPs") for the same fiscal year.

Pertinent Facts

On September 3, 2013, the Board received Schneck's Request for Hearing ("RFH") in which Schneck appealed its March 7, 2013 Notice of Amount of Program Reimbursement ("NPR") for FYE 12/31/2008. In its RFH, Schneck challenged the Medicare Contractor's determination of its available beds for the fiscal year at issue and claims that if its as-filed available bed count calculation is correct, it is entitled to TOPs for FYE 12/31/2008.

On March 12, 2014, the Board received the Medicare Contractor's jurisdictional challenge that questions whether the Board has jurisdiction over Schneck's TOPs issue. The Medicare Contractor states that, in Schneck's as-filed cost report, Schneck answered "N[o]" to the "control question" that asks whether a provider qualifies for TOPs. The Medicare Contractor also claims that it did not adjust the control question during its review of Schneck's cost report for FYE 12/31/2008.

Schneck subsequently filed two responses to the Medicare Contractor's jurisdictional challenge—one on April 7, 2014 ("April 7, 2014 Response"), shortly after the jurisdictional challenge was filed, and one on November 3, 2014 ("November 3, 2014 Response"), after the Medicare Contractor filed its preliminary position paper with Schneck.

Schneck's Contentions

In Schneck's RFH, Schneck claims that it had 87 patient beds (80 adult and pediatric beds and 7 ICU beds) available for the FYE 12/31/2008, and that it submitted this information, contained within its cost report, to the Medicare Contractor. Schneck states that at some point during the Medicare Contractor's desk review of Schneck's cost report, Schneck informed the auditor that it had mistakenly answered "no" to the question found on Worksheet S-2, Line 21.06.[1] According to Schneck, this yes-or-no question asks a small rural provider whether, based on the provider's status and its available patient beds for the year in question, the provider is entitled to TOPs for a particular fiscal year.

Within Schneck's April 7, 2014 Response, and in order to prove its claim, Schneck submitted a copy of a December 9, 2009 email addressed to the Medicare Contractor in which Schneck requested that its response to the question on Worksheet S-2, Line 21.06, of the cost report, be changed.[2] Schneck claims that the Medicare Contractor determined that the request for the change had been "properly documented."[3] Schneck also claims that the Medicare Contractor made its "final determination" regarding the TOPs issue on April 28, 2010, after the Medicare Contractor adjusted the number of Schneck's available patient beds for FYE 12/31/2008 to a count that exceeded the qualifying amount for TOPs.[4] Schneck summarizes its position in the April 7, 2014 Response by stating that "based on the [Medicare Contractor]'s adjustment to the beds, the [Medicare Contractor] did not change the response to Worksheet S-2, Line 21.06[,] even though the Hospital requested the change."[5] Schneck claims that it is appealing the bed count adjustment in the NPR in order to refute the TOPs determination.[6]

In Schneck's November 3, 2014 Response, Schneck asserts that "[i]n the [Medicare Contractor]'s Preliminary Position Paper Argument Section, the [Medicare Contractor] reexamined the bed detail data and indicated that the revised available beds on W/S S-3 should be 100.23 . . ."[7] Schneck states that while it "fully supports the [Medicare Contractor]'s change on Worksheet S-3 beds to 100.23," the adjusted bed count on Worksheet E, Part A, Line 3 (not the bed count on Worksheet S-3), contains the bed count number used to determine TOPs eligibility. Schneck claims that the regulatory provisions at 42 C.F.R. § 412.105(b) govern the determination of the number of beds for Worksheet E, Part A, Line 3, and that it presented this information to the Medicare Contractor. Schneck states that the Medicare Contractor agreed with Schneck's assessment and changed the final bed count on Worksheet E, Part A, Line 3 to 96.24.[8] In support of this claim, Schneck attached a copy of a September 9, 2014 email exchange between Schneck's representative and an employee of the Medicare Contractor in which the Medicare Contractor's employee states the following:

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[1] April 7, 2014 Response, Tab 1, Attachment 2 at 1.
[2] April 7, 2014 Response, Tab 2 at 3.
[3] *Id.*, Tab 2 at 2.
[4] *Id.* at 1.
[5] *Id.*
[6] *Id.*
[7] November 3, 2014 Response at 1.
[8] *Id.* at 2.

> You are correct the swing bed days and the observation days for patients not admitted were not properly removed from the calculation to determine the qualifying threshold in accordance with 42 CFR § 412.105(b). The prior calculation to which I was comparing did not already consider these factors so my calculation carried that method forward. As a result, we would adjust the S-3 beds to 100.23 and the number that would flow to worksheet E part A line 3 would be less than 100 beds (96.24).[9]

Board's Analysis and Decision

Based on a review of the facts in this case, the Board has determined that it has jurisdiction over Schneck's available bed count and TOPs issues as set out in Schneck's appeal of its FYE 12/31/2008 NPR, for the reasons set forth below.

Pursuant to 42 C.F.R. § 405.1835 (2012), 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 Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group) and the request for hearing is filed within 180 days of the receipt of the final determination. Further, a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either: (1) including a claim for the item on its cost report; or (2) self-disallowing the item 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.

In the present case, Schneck has preserved its right to claim dissatisfaction with the amount of its Medicare payment because Schneck's patient bed count, as stated on its FYE 12/31/2008 as-filed cost report, was adjusted by the Medicare Contractor when the Contractor audited the report. After the Medicare Contractor adjusted Schneck's bed count, the Medicare Contractor advised Schneck that its bed count exceeded the qualifying amount for TOPs. However, Schneck's documentation demonstrates that the Medicare Contractor's calculation of Schneck's bed count was, in fact, erroneous. According to the Medicare Contractor's September 9, 2014 email message to Schneck, following discovery of its error, the Medicare Contractor *re*adjusted Schneck's bed count to "less than 100 beds (96.24)" and, therefore, within the qualifying range for TOPs.

As Schneck has argued in its submissions to the Board, if not for the Medicare Contractor's erroneous calculation of its bed count, Schneck would have qualified for TOPs. The Board finds that the Medicare Contractor's initial bed count calculation resulted in a "determination" that Schneck did not qualify for TOPs. Based on that finding, the Board concludes that it also has jurisdiction over Schneck's TOPs issue in Schneck's FYE 12/31/2008 NPR appeal.

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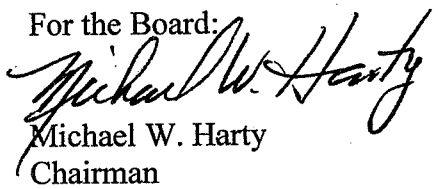
[9] *Id.*, Tab 4 at 1.

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 Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA

For the Board:

Michael W. Harty
Chairman

cc: Sharon L. Keyes, Executive Director, Blue Cross and Blue Shield Association

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Refer to: 10-0207G

CERTIFIED MAIL JUL 15 2015

Quality Reimbursement Services, Inc..
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Novitas Solutions, Inc.
Bruce Snyder
JL Provider Audit Manager
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: QRS 2007 DSH SSI Denominator Days Group
Jurisdictional Review
Fiscal Year 06/30/2007
PRRB Case No. 10-0207G

Dear Mr. Ravindran and Mr. Snyder:

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

BACKGROUND

On November 25, 2009, Quality Reimbursment Services, Inc., ("QRS") requested a group appeal stating the issue as "Whether the Intermediary correctly determined [the] denominator of the SSI percentage of the Disproportionate Share Payment calculation … Among other problems with the SSI denominator, CMS included Medicare Part C/Medicare + Choice pat[i]ents in the calculation of the Provider's SSI percentage."[1]

On March 1, 2013, QRS submitted the Schedule of Providers ("SOP") with jurisdictional documentation. Review of the jurisdictional documentation verified that the group issue limited to the M+C days in the SSI denominator was properly included in all of the individual appeals and timely transferred to Case No. 10-0207G for all providers.

On May 15, 2015, QRS submitted its final position paper briefing the SSI data match issue which was the underlying issue in *Baystate Medical Center v. Leavitt*[2], ("*Baystate*") with no mention of the M+C denominator issue which was the initial issue under appeal in this group.[3]

[1] *See* Provider's initial request for group appeal at Tab 2.
[2] 545 F. Supp. 2d 20 (D.D.C. 2008), amended in part 587 F. Supp. 2d 37 (D.D.C. 2008) and 587 F. Supp. 2d 44 (D.D.C. 2008).

BOARD DECISON

Issue Under Appeal

The subject appeal issue challenged the M + C exclusion from the "old" SSI denominator. All providers included in the subject appeal did appeal separately the *Baystate* SSI data match issue and transfer the *Baystate* old SSI issue to Case No. 10-0153G. Case No. 10-0153G was remanded to the Medicare contractor on April 15, 2013 and closed.

Further, arguments related to the "old" SSI issue are now moot with the release of new SSI percentages and the previous remands of the data match issue to include the new SSI percentage for each of the Providers. All of the Providers in the subject appeal received revised Notices of Reimbursement with new SSI percentages. Once again the same Providers, that are included in Case No. 10-0207G, have appealed the inclusion of Part C days in the new SSI percentage and transferred the revised SSI percentage issue to Case No. 13-2676G.

Position Paper – Filed May 21, 2015

The issue briefed in the Final position paper is not the issue in the appeal (no mention of Part C Days), but is the "old" *Baystate* SSI data match issue, which was in Case No. 10-0153G and remanded. The Board finds that the initial appeal issue of M+C exclusion from the SSI denominator as being abandon per PRRB Rule 41.2.1. The Board finds that the SSI issue as briefed in the Provider's final position paper is not the issue under appeal and is moot. Hereby, the Board dismisses Case No. 10-0207G.

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

Board Members Participating
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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: BC BS Association
Sharon L. Keyes, Executive Director
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[3] *See* Provider's final position paper at 10.

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Palmetto GBA
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Provider Audit – Mail Code AG380
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Camden SC 29020-1728

RE: Jurisdictional Decision
Presbyterian Hospital
Provider No.: 34-0053
FYE: 12/31/2006
PRRB Case No.: 10-1030

Dear Mr. Ravindran and Ms. Huggins:

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

Background

Presbyterian Hospital was issued a Notice of Program Reimbursement ("NPR") for FYE 12/31/2006 on November 24, 2009. On May 10, 2010, the Provider filed an appeal request with the Board in which it appealed the following issues:

1. DSH/SSI Percentage (Provider Specific);
2. DSH/SSI Percentage (Systemic Errors);
3. DSH – Medicaid Eligible Days;
4. DSH Medicare Secondary Payor Days – Medicaid Eligible Days;
5. DSH – Dual Eligible Days;
6. DSH – Medicare Managed Care Part C Days (for cost reporting periods ending on or after September 30, 2005);
7. DSH – Medicaid Eligible Labor Room Days;
8. DSH – Medicaid Eligible North Carolina Charity Days.

On December 8, 2010, the Provider requested to transfer the following issues to group appeals:

Issue:	**Number of case transferred to:**
DSH/SSI Percentage (Systemic Errors)	08-2584GC
DSH/Medicaid Eligible Days	08-2581GC
DSH - Medicaid Eligible Labor Room Days	10-1124GC
DSH - Medicaid Eligible North Carolina Charity Care Days	08-2583GC
DSH Medicare Managed Care/Medicaid Eligible Days	08-2580GC
DSH Exhausted Medicare Benefits Medicaid Dual Eligible Days	10-1123GC

The only issue remaining in the appeal is the SSI Percentage (Provider Specific) issue.

Decision of the Board

The Board finds that it does not have jurisdiction over the SSI Percentage (Provider Specific) issue raised on May 10, 2010 and dismisses the issue from case number 10-1030. The Provider appealed this issue using the following language:

> The Provider contends that [its] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation. This is based on certain data from the State of North Carolina and the Provider that does not support the SSI percentage issued by CMS. … The Provider seeks to reconcile its records with CMS data and identify records that CMS may have failed to include in their determination of the SSI percentage. The Provider may exercise [its] right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.

The Board finds that, to the extent the Provider is arguing that the SSI Percentage is understated and that it needs the underlying data to determine what records were not included, the issue is the same as the systematic errors issue that was transferred to case number 08-2584GC. The basis of each issue is that the Provider does not have the underlying data and cannot determine if the SSI percentage is understated.

Therefore, the Board finds that the accuracy portion of the issue is duplicative and dismisses this sub-issue from case number 10-1030 as it is already being pursued in a group appeal.[1] To the extent the Provider is preserving its right to request realignment if it so chooses once the data is

[1] Per Board Rule 4.5 "A Provider may not appeal an issue from a final determination in more than one appeal."

made available, the Board finds that this portion of the issue is premature. The Medicare contractor has not issued a final determination on this matter as the Provider has not yet requested realignment.[2] Therefore, the Board finds that it does not have jurisdiction over the question of SSI Realignment and dismisses this issue from case number 10-1030.

Since the SSI issue was the sole remaining issue in the individual appeal, case number 10-1030 is hereby closed. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating
Michael W. Harty
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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: Sharon L. Keyes, BCBSA

[2] *See* 42 C.F.R. § 405.1835, which states: "The provider… has a right to a hearing before the Board about any matter designated in § 405.1801(a)(1), if… [a]n intermediary determination has been made with respect to the provider."

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JE Part A Appeals Coordinator
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RE: Jurisdictional Decision
Sutter Medical Center - Sacramento
Provider No.: 05-0108
FYE: 12/31/2001
PRRB Case No.: 09-0791

Dear Mr. Jaeger and Ms. Kalafut,

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

Background

On August 8, 2008, Sutter Medical Center was issued a revised Notice of Program Reimbursement (NPR) for FYE 12/31/2001. The revised NPR was issued to fully account for all allowable Medi-Cal Eligible days. The Provider filed an appeal request with the Board on January 30, 2009 in which it appealed two issues related to the Disproportionate Share Hospital (DSH) adjustment:

1. DSH – Labor Room Days
2. DSH – Dual Eligible Days

On February 2, 2010, the Provider filed a request to transfer the Labor Room days issue to a group appeal, case number 07-2726G. This group appeal was withdrawn due to an Administrative Resolution on September 16, 2010. The only issue remaining on appeal is the DSH – Dual Eligible Days.

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 (2007)[1] provides, in relevant part:

> A determination of an intermediary... may be reopened with respect to finding on matters at issue in such determination or decision, by such intermediary..., either on motion of such intermediary or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

In accordance with 42 C.F.R. § 405.1889 (2007), a revised NPR is considered a separate and distinct determination from which the provider may appeal.[2] The regulation provides:

> [W]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened... such revision shall be considered a separate and distinct determination or decision to which provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

42 C.F.R. § 405.1889 was recently addressed in *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014). In that case, the Court held that the "issue specific" interpretation of the revised NPR regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been considered.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over Sutter Medical Center's revised NPR appeal. The Board finds that Dual Eligible days were not adjusted in the revised NPR. Page 3 of the Provider's Request for Medicare Cost Report Reopening letter of May 9, 2007 states, "All Dual Medicare Part-A/Medi-Cal eligible days... were excluded from the total Medi-Cal count." As Dual Eligible days were excluded from the request for reopening, they could not have been considered or adjusted in the revised NPR. Therefore, the Board does not have jurisdiction because the appeal did not meet the requirements set forth in 42 C.F.R. § 405.1889.

Because the Dual Eligible Days were not adjusted in the revised NPR, the Board finds that it does not have jurisdiction over the issue and dismisses it from this appeal. The Dual Eligible

---

[1] This revised NPR was issued prior to the regulation change that is effective as of August 21, 2008, therefore, the earlier versions of 42 C.F.R. §§ 405.1885 and 405.1889 is applicable in this case.

[2] In HCA Health Services of Oklahoma v. Shalala 27 F.3d 614 (D.C. Cir. 1994), the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR.

Days issue was the last remaining issue, therefore the Board hereby dismisses case number 09-0791.

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
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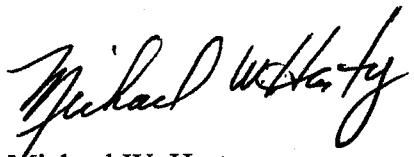
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern

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: Sharon L. Keyes, BCBSA

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James Lowe
Cahaba Safeguard Administrators, LLC
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Morrisville, NC 27560-2008

RE: Seton Medical Center
Provider No.: 05-0289
FYE: 6/30/07
PRRB Case No.: 13-1258

Dear Mr. Knight and Mr. Lowe,

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

Background

The Provider submitted a request for hearing on March 26, 2013, based on a Notice of Program Reimbursement ("NPR") dated October 5, 2012. The hearing request included seven issues, four of which were subsequently transferred to group appeals. One of the issues remaining in the appeal is as follows: Medicare Disproportionate Share Hospital (DSH) Payments – SSI Ratio Alignment to Provider's Cost Reporting Year. The Medicare Contractor filed a jurisdictional challenge on the issue on March 31, 2014. The Provider filed a responsive brief on May 1, 2014.

Medicare Contractor's Position

The Medicare Contractor explains that the Provider requested that the time period upon which the SSI calculation is based be changed from the Federal Fiscal year to the Provider's Cost Report Period. Because there has not been a final determination by the Contractor with respect to this issue, the Board lacks jurisdiction over this issue.[1]

The Medicare Contractor argues that the regulations at 42 C.F.R. § 405.1835 set forth the criteria for a provider's right to a PRRB hearing:

[1] Medicare Contractor's Jurisdictional Brief at 1.

> A provider…has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost report period covered by an intermediary or Secretary determination.

An intermediary or Secretary determination is defined at 42 C.F.R. § 405.1801(a):

> [A] determination of the amount of total reimbursement due the provider, pursuant to 42 C.F.R. § 405.1803 following the close of the provider's cost reporting period.[2]

The Medicare Contractor contends that it did not make a determination in regard to the SSI Ratio Realignment issue. There is no determination for the Provider to contest. Accordingly, the Board does not have jurisdiction.

The Medicare Contactor included copies of two Board jurisdictional decisions in support of its position.[3]

Provider's Position

The Provider contends that the NPR and all audit adjustments within meet the criteria of a final determination by the Contractor. Specifically, audit adjustments 26, 32, 58 and 60 were implemented in the Contractor's own words "To adjust the SSI ratio percentage to agree with the SSI ratio percentage published by CMS for the applicable fiscal year" and "To adjust the SSI% to the latest SSI% updated by CMS in March 2012."[4]

The Provider explains that the SSI ratio was adjusted by the Contractor from 21.75% to a value of 17.04% that is developed by CMS on a federal fiscal year basis. The Provider contends the final SSI ratio value of 17.04% should be higher. The Provider argues that it has a right to be dissatisfied with any aspect of the Contractor audit adjustments, including the aspect of the Contractor's adjustment implementing a SSI ratio that has been developed on a federal fiscal year basis because all other DSH payment elements for this Provider are developed upon a cost reporting period basis. The Provider contends there is nothing in the DSH statute or the Medicare regulations that preclude an appeal of this nature.[5]

The Provider contends that the regulation concerning the "Contents of Request for a Board Hearing"[6] requires the Provider to describe their dispute[7] and provide a remedy describing how and why the Provider believes Medicare payment must be determined differently.[8] The Provider contends that it performed both of these tasks, including identifying two remedies: 1) Request CMS to realign the Provider's SSI percentage to the Provider's cost reporting year, or 2) Use the Provider's own data to

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[2] *Id.* at 1- 2.
[3] PRRB Case No. 07-2322 Eden Medical Center issued February 21, 2013 and PRRB Case No. 09-1034 Tomball Regional Hospital issued April 18, 2013.
[4] Provider's Responsive Brief at 2 (Emphasis included).
[5] *Id.*
[6] 42 C.F.R. § 45.1835(b).
[7] 42 C.F.R. § 45.1835(b) (2)(i).
[8] 42 C.F.R. § 45.1835(b) (2)(ii).

seek a resolution to the issue. The Provider explains that it sought a remedy to the issue by submitting a DSH Ratio Realignment Request to the Contractor on November 12, 2013.[9]

The Provider explains that the Medicare Contractor pointed to two recent Board jurisdiction decisions, where the Board decided they did not have jurisdiction over the SSI Ratio Realignment issue because the issue was premature. The Provider contends that the two cases cited by the Contractor are distinguishable from the issue at hand in this case. Specifically, in the two cases cited, it is clear each hospital had specifically appealed the issue of SSI Ratio Realignment yet both hospitals had not taken any action to pursue a SSI Ratio Realignment.[10]

Board's Decision

The Board finds that it does not have jurisdiction over the SSI Ratio Realignment issue as the appeal of that issue is premature. 42 C.F.R. § 405.1835 (2012) states,

> A provider . . . has a right to a Board hearing . . . for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination only if . . . [t]he provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue. . .

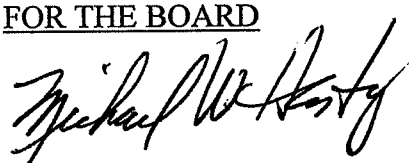
In this case, the Medicare Contractor did not make a final determination with regard to the SSI Ratio Realignment issue. Therefore, because the Medicare Contractor has not made a determination regarding SSI Ratio Realignment with which the Provider could be dissatisfied, the Board finds that the appeal of the SSI Ratio Realignment issue is premature and dismisses the issue from the appeal.

As there are two issues remaining in the appeal (DSH – Eligible Days and IME/DGME Other), the appeal remains open.

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

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Jack Ahern

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: Sharon L. Keyes, Executive Director, Blue Cross Blue Shield Association

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[9] Provider's Responsive Brief at 3.
[10] *Id.* at 4.

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

Refer to: 07-1881GC

CERTIFIED MAIL JUL 24 2015

John M. Maguire
Tenet Healthcare Corporation
Manager, Appeals
1445 Ross Avenue
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Dallas, TX 75202-2703

Bill Tisdale
Novitas Solutions, Inc.
JH Provider Audit and Reimbursement
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: *Century City Hospital*, Provider No. 05-0579, FYE 04/29/2004
Metrowest Hospital, Provider No. 33-0084, FYE 21/31/2004
St. Louis University Medical Center, Provider No. 26-0105, FYE 05/31/2004
As a participant in "Tenet 2004 DSH – SSI Proxy Group"
PRRB Case No.: 07-1881GC

Dear Mr. Maguire and Mr. Tisdale,

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

The Board received the Providers' request to establish this CIRP group on April 10, 2007. There were no jurisdictional challenges to this appeal. The case was dismissed on July 29, 2008 for failure to file a preliminary position paper. The Board granted reinstatement on January 26, 2009 because there was a misunderstanding about the extension of position paper due dates.

Provider 31, Century City Hospital, Provider No. 05-0579

On August 15, 2007, the Tenet representative requested that the Provider be added directly to this appeal, indicating that the copy of the Notice of Program Reimbursement (NPR) and supporting documentation would be supplied in the final Schedule of Providers. The Schedule of Providers and supporting documentation for Case No. 07-1881GC was received on August 14, 2009 and the NPR for this Provider was not included.

Provider 40, Metrowest Hospital, Provider No. 22-0089

On March 5, 2007, the Medicare Administrative Contractor issued an NPR to Metrowest Medical Center, Provider No. 22-0089. On August 14, 2009, the Provider representative filed a Schedule of Providers and supporting documentation with the Board. Although the copy of the

NPR is included in the supporting documentation, there is no documentation to demonstrate that the Provider appealed the NPR or requested to transfer into Group 07-1881GC.

Provider 45, St. Louis University Medical Center, Provider No. 26-0105

On May 26, 2006, the Medicare Administrative Contractor issued an NPR to St. Louis University Medical Center, Provider No. 26-0105. On August 14, 2009, the Provider representative filed a Schedule of Providers and supporting documentation with the Board. Although the copy of the NPR is included in the supporting documentation, there is no documentation to demonstrate that the Provider appealed the NPR or requested to transfer into Group 07-1881GC.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2007), 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 (2007) provides in relevant part:

> A determination of an intermediary… may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary… or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

In accordance with 42 C.F.R. § 405.1889 (2007), a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> [W]here a revision is made in a determination or decision on the amount of program reimbursement after such a determination or decision on the amount of program reimbursement after such a determination or decision has been reopened… such revision shall be considered a separate and distinct determination or decision to which provisions of Secs. 405.1811, 405.1835, 405.1875, and 405.1877 are applicable.

In *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening, and does not extend further to all determinations underlying the original NPR. 42 C.F.R. § 405.1889 was recently

addressed in *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348 (D.D.C. Apr. 17, 2014). In that case, the Court held that the "issue specific" interpretation of the revised NPR regulation is reasonable and that any change to the DSH adjustment is not sufficient to establish that all of the elements of the DSH adjustment have been considered.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over these three Providers.

Provider 31, Century City Hospital, Provider No. 05-0579

The Board finds that it does not have jurisdiction over Century City Hospital because it cannot determine if the Provider has met the dissatisfaction requirement or timely filed its appeal. The Provider did not provide a copy of the Notice of Program Reimbursement (NPR) as supporting documentation. The Board does not know whether the Provider is appealing from an original or revised NPR. If the Provider is appealing from a revised NPR, the Board only has jurisdiction if the Provider has appealed an issue that was specifically adjusted in the revised NPR.[1] The Provider has not shown that the SSI percentage was specifically adjusted, therefore, the Provider's request for an appeal does not the higher standard required for an appealing from a revised NPR. Because the Provider did not submit all of the required documentation with the Schedule of Providers, the Board is unable to determine whether the Provider has met the dissatisfaction requirement. Additionally, without knowing the date the NPR was issued, the Board cannot determine if the appeal was timely filed. Therefore, the Board finds it lacks jurisdiction and dismisses the Provider from the group.

Provider 40, Metrowest Hospital, Provider No. 22-0089

The Board finds that it does not have jurisdiction over Metrowest Hospital because the Provider did not submit documentation to establish that it timely filed its appeal. The Provider did not provide copies of an appeal or transfer request. Because of this, the Board is unable to determine whether the Provider's individual appeal was timely filed or if the SSI percentage was appealed or timely added, and properly transferred into this group. Therefore, the Board finds it lacks jurisdiction and dismisses the Provider from the group.

Provider 45, St. Louis University Medical Center, Provider No. 26-0105

The Board finds that it does not have jurisdiction over Metrowest Hospital because the Provider did not submit documentation to establish that it timely filed its appeal. The Provider did not provide copies of an appeal or transfer request. Because of this, the Board is unable to determine whether its individual appeal was timely filed or if the SSI percentage was appealed or timely added, and properly transferred into this group. Therefore, the Board finds it lacks jurisdiction and dismisses the Provider from group.

The remaining Providers in case number 07-1881GC are still pending in the appeal; the group will be remanded pursuant to CMS Ruling 1498-R under separate cover.

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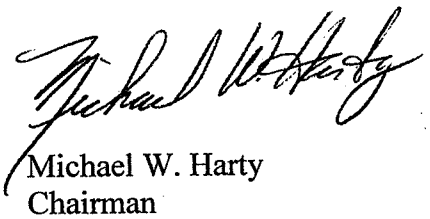
[1] 42 C.F.R. § 405.1885 (2007)

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
Jack Ahern

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: Sharon L. Keyes, BCBSA

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CERTIFIED MAIL

JUL 24 2015

Russell T. Burke, Esq.
Nexsen Pruet, LLC
1230 Main Street
Suite 700
Columbia, SC 29201-2426

RE: Self Regional Healthcare
Provider No.: 42-0071
FYE: 09/30/2005
PRRB Case No.: 09-1263

Dear Mr. Burke:

The Provider Reimbursement Review Board (Board or PRRB) has reviewed the jurisdictional documents for case number 09-1263. The Board's decision regarding jurisdiction is set forth below.

Background

On September 23, 2008, the Medicare Contractor issued a Notice of Program Reimbursement (NPR) to Self Regional Healthcare, provider no. 42-0071, for the cost reporting period ending September 30, 2005. On March 30, 2009, Self Regional Healthcare filed an appeal of the NPR challenging disproportionate share hospital (DSH) Medicare advantage days, DSH labor and delivery room days and the DSH supplemental security income (SSI) percentage. The Board assigned case number 09-1263 to the appeal.

On November 12, 2009, the Medicare Contractor issued a revised NPR to Self Regional Healthcare. On May 12, 2010, Self Regional Healthcare filed an appeal of the revised NPR challenging the same issues appealed in its original NPR, DSH Medicare advantage days, DSH labor and delivery room days and the DSH SSI percentage. The Board incorporated Self Regional Healthcare's appeal from the revised NPR into case number 09-1263.

Decision of the Board

Timely Filing

Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) (2008) and PRRB rules, an appeal must be filed with the Board no later than 180 days after the Provider has received the final determination the Provider is appealing. In addition, there is a five day presumption for mailing (42 C.F.R. § 405.1801(a)(1)(iii) (2008)). Pursuant to 42 C.F.R. § 405.1801(a) (2008) and PRRB Rule 21, for appeal requests filed after August 21, 2008, the date of filing is the date of receipt by the Board

or the date of delivery by a nationally-recognized next-day courier. In the instant case, Self Regional Healthcare's original NPR was issued on September 23, 2008. The appeal request was delivered by Federal Express and received by the Board on March 30, 2009. Thus, the date of filing was 188 days after the date of the final determination. Because Self Regional Hospital did not timely file its appeal request of the original NPR, the Board finds that it does not have jurisdiction over Self Regional Healthcare's appeal from the original NPR and dismisses Self Regional Healthcare's appeal from the original NPR from case number 09-1263.

Self Regional Healthcare's revised NPR was issued on November 12, 2009. The appeal request was delivered by Federal Express and received by the Board on May 12, 2010. Thus, the date of filing was 181 days after the date of the final determination. As the date of filing was within the 185 days permitted for filing appeals, the Board finds that Self Regional Healthcare's appeal from the revised NPR was timely filed.

Jurisdiction

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 ($50,000 for a group) and the request for a hearing is filed within 180 days of the NPR.[1] A revised NPR is considered a separate and distinct determination from which the provider may appeal.[2] A Provider's appeal of a revised NPR is limited to the specific issues revised on reopening and does not extend further to all determinations underlying the original NPR.[3]

In the instant case, Self Regional Healthcare indicated in its May 12, 2010 Appeal Request from the revised NPR that the DSH Medicare Advantage days issue "was not claimed on the cost report because 42 C.F.R. § 412.106(b)(2)(i)(B) predetermined that the claim for MA days in the numerator of the Medicaid Fraction would be disallowed,"[4] and thus, they self-disallowed costs. However, Providers cannot self-disallow from a revised NPR as it is a distinct determination from which only issues revised can be appealed. Self Regional Healthcare did not include supporting documentation (such as the audit work papers) to determine the full scope of the issues reviewed within the revised NPR process. As Self Regional Healthcare failed to provide evidence that the DSH Medicare Advantage days issue was specifically revised in the reopening, the Board finds that it lacks jurisdiction over the DSH Medicare Advantage days issue and dismisses the DSH Medicare Advantage days issue from Self Regional Healthcare's revised NPR appeal.

Self Regional Healthcare also indicated in its Appeal Request that it appealed the DSH labor and

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[1] 42 U.S.C. § 1395oo(a)(2008) and 42 C.F.R. §§ 405.1835-1840(2008).
[2] 42 C.F.R. §405.1889 (2008).
[3] *See, HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614 (D.C. Cir 1994); *see also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. sup. 3d 348, 357 (D.D.C. 2014) (holding that the Secretary's "issue-specific" interpretation of her NPR reopening regulations is reasonable and entitled to substantial deference).
[4] Provider's May 12, 2010 Appeal Request at 5.

delivery room days issue from an audit adjustment report (adjustments nos. 7 and 40).[5] However, Self Regional Healthcare did not include the audit adjustment reports for adjustments numbers 7 and 40 nor include supporting documentation (such as the audit work papers) to determine the full scope of the issues reviewed within the revised NPR process. As Self Regional Healthcare failed to provide evidence that the DSH labor and delivery room days issue was specifically revised in the reopening, the Board finds that it lacks jurisdiction over the DSH labor and delivery room days issue and dismisses the DSH labor and delivery room days issue from Self Regional Healthcare's revised NPR appeal.

In its Appeal Request under Tab 2, Self Regional Healthcare supplied an audit adjustment report for the revised NPR (has a run date of November 9, 2009) for adjustment numbers 1 and 2; adjustment number 1 shows an adjustment "[t]o adjust the Supplemental Security Income Percentage (SSI%) to the revised amount determined by CMS and to adjust DSH% accordingly." Self Regional Healthcare also supplied a Notice of Intent to Reopen dated November 9, 2009, under Tab 2, which states that the cost report was being reopened "[t]o adjust the federal fiscal year 2005 supplemental security income percentage (SSI%) to the revised amount determined by CMS. Worksheet E, Part A, Line 4 has been adjusted from 7.63% to 7.65% to agree with the most updated SSI% determined by CMS and to adjust the DSH allowable percentage accordingly." As Self Regional Healthcare provided evidence that the DSH SSI percentage issue was specifically revised in the reopening and the other jurisdictional requirements have been met, the Board finds that it has jurisdiction over the DSH SSI percentage issue appealed from the revised NPR.

The DSH SSI percentage issue falls under CMS Ruling 1498-R and will be remanded under separate cover and the case closed as the DSH SSI percentage issue is the last remaining issue in the appeal.

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

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern

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: Cecile Huggins, Palmetto GBA
Sharon L. Keyes, Blue Cross and Blue Shield Association

[5] *Id.* at 7.

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CERTIFIED MAIL

JUL 24 2015

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

RE: *Avista Adventist Hospital*, Provider No. 06-0103, FYE 06/30/03,
Bay Medical Center, Provider No. 10-0026, FYE 09/30/04,
Central Texas Medical Center, Provider No. 45-0272, FYE 12/31/99 and
Tennessee Christian Medical Center, Provider No. 44-0135, FYE 6/30/00,
as participants in "AHS 2001-2003 SSI% III Calculation Group" PRRB Case No.: 05-1322GC

Dear Ms. Erde:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 05-1322GC. The Board's decision regarding jurisdiction for the above referenced Providers is set forth below.

Background

Provider 1, Avista Adventist Hospital, Provider No. 06-0103

On February 23, 2005, the Medicare Contractor issued a Notice of Program Reimbursement (NPR) to Avista Adventist Hospital, provider no. 06-0103, for the cost reporting period ending June 30, 2003. On March 29, 2005, Avista Adventist Hospital, filed a request for a group appeal from a direct appeal of the NPR. The Board assigned case number 05-1322G to the appeal. On August 15, 2005, the Medicare contractor issued a revised NPR to Avista Adventist Hospital. On November 7, 2005, Avista Adventist Hospital requested to join the current group appeal, case number 05-1322GC, from a direct appeal of the revised NPR.

Provider 3, Bay Medical Center, Provider No. 10-0026

On March 22, 2006, the Medicare Contractor issued a revised NPR to Bay Medical Center, provider no. 10-0026, for the cost reporting period ending September 30, 2004. On April 24, 2006, Bay Medical Center, requested to join the current group appeal, case number 05-1322GC, from a direct appeal of the revised NPR.

Provider 12, Central Texas Medical Center, Provider No. 45-0272

On March 16, 2005, the Medicare Contractor issued a revised NPR to Central Texas Medical Center, provider no. 45-0272, for the cost reporting period ending December 31, 1999. On September 9, 2005, Central Texas Medical Center, requested to join the current group appeal, case number 05-1322GC, from a direct appeal of the revised NPR.

Provider 33, Tennessee Christian Medical Center, Provider No. 44-0135

On October 12, 2005, the Medicare Contractor issued a revised NPR to Tennessee Christian Medical Center, provider no.44-0135, for the cost reporting period ending June 30, 2000. On January 4, 2006, Tennessee Christian Medical Center requested to join the current group appeal, case number 05-1322GC, from a direct appeal of the revised NPR.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) (2005) and 42 C.F.R. § 405.1835-405.1841 (2005), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more ($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 Medicare Contractor's determination was mailed to the provider.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2005) provides in relevant part:

> A determination of an intermediary . . . may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary . . . either on motion of such intermediary . . . or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings.

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889 (2005) states:

> [w]here a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened . . . such revision shall be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1835, 405.1875 and 405.1877 are applicable.

In *HCA Health Services of Oklahoma v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994), the court held that when a fiscal intermediary reopens its original determination regarding the amount of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening and does not extend further to all determinations underlying the original NPR. More recently, this regulation has also been addressed in the decision *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F. Supp. 3d 348, 357 (D.D.C. 2014), the court held that the Secretary's "issue-specific" interpretation of her NPR reopening regulations is reasonable and entitled to substantial deference.

In this case, Provider 1, Avista Adventist Hospital (provider no. 06-0103, FYE 6/30/2003), lists on the Schedule of Providers that they are appealing from an original NPR dated February 23, 2005, and a revised NPR dated August 19, 2005.[1] The Provider cites N/A as their audit adjustment for their appeal from the original and revised NPR which indicates that they self-disallowed costs. The Board has jurisdiction over Avista Adventist Hospital's appeal from the original NPR pursuant to *Bethesda.*[2] However, Providers cannot self-disallow from revised NPRs as it is a distinct determination from which only issues revised can be appealed. The Provider did not include any audit adjustment reports or supporting documentation (such as the request for reopening, reopening notice or the audit work papers) to determine the full scope of the issues reviewed within the revised NPR process. As such, the Board finds that it lacks jurisdiction over Avista Adventist Hospital's appeal from the revised NPR and dismisses Avista Adventist Hospital's appeal from the revised NPR from the appeal.

Provider 3, Bay Medical Center (provider no. 10-0026, FYE 9/30/2004), Provider 12, Central Texas Medical Center (provider no. 45-0272, FYE 12/31/1999), and Provider 33, Tennessee Christian Medical Center (provider no. 44-0135, FYE 6/30/2000), cites N/A as their audit adjustment for their appeals from their revised NPRs which indicates that they self-disallowed costs. However, as stated above providers cannot self-disallow from revised NPRs as it is a distinct determination from which only issues revised can be appealed. The Providers did not include any audit adjustment reports or supporting documentation (such as the request for reopening, reopening notice or the audit work papers) to determine the full scope of the issues reviewed within the revised NPR process. As such, the Board finds that it lacks jurisdiction over Provider 3, Bay Medical Center (provider no. 10-0026, FYE 9/30/2004), Provider 12, Central Texas Medical Center (provider no. 45-0272, FYE 12/31/1999), and Provider 33, Tennessee Christian Medical Center (provider no. 44-0135, FYE 6/30/2000), and dismisses these Providers from the appeal.

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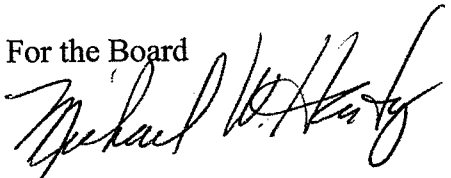
[1] The Revised NPR under Tab 1A shows that the date of the Revised NPR is August 15, 2005, not August 19, 2005.

[2] *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988).

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

Board Members Participating:
Michael W. Harty
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), 42 C.F.R. §§ 405.1875 and 405.1877

cc: Geoff Pike
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