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
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Refer to:

CERTIFIED MAIL

AUG 03 2015

CHRISTUS Health
Issac Palmer, CEO
1453 E. Bert Kouns Industrial Loop
Shreveport, LA 71105

RE: CHRISTUS Health Shreveport –Bossier, Provider No. 19-0041, PRRB Case No. 15-2886

Dear Mr. Palmer:

The Provider Reimbursement Review Board (the Board) has reviewed the Hospital Value Based Purchasing Program Appeal Request form filed on behalf of the above-captioned Provider on June 26, 2015. The pertinent facts with regard to this appeal and the Board's determination are set forth below.

Pertinent Facts:

The Provider submitted an appeal form titled "Hospital Value-Based Purchasing Program (HVBP) Appeal Request Form" on June 26, 2015. A copy of the final determination in dispute was not included with the appeal request, nor did the appeal specify a fiscal year end (FYE) in dispute.

On July 6, 2015, the Board established case number 15-2886 and issued an Acknowledgement and Critical Due Dates letter. In the Acknowledgement, the Board requested the Provider contact us with regard to the FYE in dispute within 15 days.

In response to the Board's email, Thea Tran of the Provider contacted the Board and advised that she was unaware of the appeal to which the Acknowledgement referred. She also advised that they would withdraw this appeal and would file a Market Basket (Quality Reporting) appeal in the future.

Board Determination:

The Board finds that the subject appeal must be dismissed as it was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules.

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, the Provider is filing an appeal that does not meet the regulatory requirements.

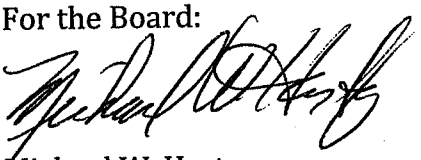
Board Rule 9 also addresses the acknowledgement of an appeal and issuance of critical due dates:

> 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.

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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Refer to: 14-2754GC

AUG 03 2015

Certified Mail

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Donna Kalafut
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RE: MHS 2014 0.2% IPPS Reduction Group
Provider Nos. Various
FFY 2014
PRRB Case No. 14-2754GC
EJR of the 2-Midnight Issue

Dear Mr. MacIntosh and Ms. Kalafut:

Through correspondence dated June 1, 2015, the Provider Reimbursement Review Board (Board) notified the parties that it was considering issuing a decision regarding expedited judicial review (EJR) for the issue under appeal in the above-referenced appeal. The Board asked for the parties' comments and the Group Representative responded. Set forth below is the Board's determination with respect to its proposed EJR of the 2-midnight issue.

Background

Issue Under Appeal

Whether the action of the Centers for Medicare & Medicaid Services (CMS) to reduce inpatient hospital prospective payment system (IPPS) payments by 0.2% effective as of Federal Fiscal Year 2014 (October 1, 2014-September 30, 2015), is consistent with the law.[1]

Statutory and Regulatory Background

In the final inpatient prospective payment system (IPPS) rule for Federal fiscal year (FFY) 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[2] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This

[1] Providers' January 28, 2014 Hearing Request, Tab 2.
[2] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).

raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[3]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because the Medicare review contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[4]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[5]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[6] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision. Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment, it is the physician responsible for patient care who determines if the patient should be admitted.[7]

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[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*
[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.
[7] 78 Fed. Reg. at 50,907-08.

In the FFY 2014 IPPS proposed rule,[8] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[9]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[10]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[11] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[12] The

[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.

1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[13]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[14]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[15] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[16]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000 net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per

[13] *Id.* at 50,927.
[14] *Id.* at 50,944.
[15] *Id.*
[16] *Id.* at 50,945.

encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[17] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[18]

Providers' Position

In their hearing request,[19] the Providers note that the Secretary received 630 comments that were submitted in response to the proposed 0.2% reduction to IPPS payments. They contend that there is little support for the Secretary to use the provisions of 42 U.S.C. § 1395ww(d)(5)(I)(i) to adjust IPPS and hospital specific rates, including operating capital and any other aspect of IPPS that was affected by the 0.2% reduction. They are challenging the adjustment on the grounds that it exceeds statutory authority, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, lacks appropriate notice for meaningful comment, and is otherwise defective both procedurally and substantively. The initial detrimental effect will be a 0.2% negative adjustment to all MS-DRG payments for FFY 2014 for every IPPS hospital as well as sole community and Medicare dependent hospitals. This adjustment could be compounded in later FFYs.

The Providers' challenges include whether the Secretary: (1) improperly exercised the authority granted to her through 42 U.S.C. § 1395ww(d)(5)(I)(i); (2) improperly reduced IPPS and hospital specific payments, including operating, capital and any other aspect of IPPS payments that were affected by the 0.2% reduction paid to IPPS hospitals, sole community and Medicare dependent hospitals that were affected by the adoption of the "two-midnight" policy effective October 1, 2013; and (3) should have imposed a positive rather than negative adjustment under 42 U.S.C. § 1395ww(d)(5)(I)(i), because the "two-midnight policy reduces IPPS expenditures.

The Providers commented that they would like the Board to postpone all deadlines in this case for one year while litigation is pending in Federal court on this issue. They believe that the possibility remains that CMS will discover and correct its own error with respect to the issue under appeal and reverse the 0.2% adjustment.

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] Providers' January 28, 2014 hearing request at Tab 2.

Decision of the Board

The Board has reviewed the Providers' request for hearing and comments regarding the proposed own motion EJR determination. The Board does not believe that the Providers' statement regarding other pending litigation is sufficient reason for delaying the Board's determination regarding EJR in this case. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that each of the Providers in the case referenced above timely filed their requests for hearing from the issuance of the August 19, 2013 Federal Register.[20] The amount in controversy in the case exceeds the $50,000 threshold necessary for a group appeal.[21] Consequently, the Board has determined that it has jurisdiction over the appeal. Further the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

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

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount, there are no findings of fact for resolution by the Board;

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

4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year under appeal in this case. The Providers have 60 days

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[20] *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year-end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *District of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

[21] *See* 42 C.F.R. § 405.1837(a)(3).

from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating

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

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosure: 42 U.S.C. § 1395oo(f)(1)

cc: Sharon L. Keyes, BCBSA

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CERTIFIED MAIL

AUG 04 2015

Thomas P. Knight, CPA
President
Toyon Associates, Inc.
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Concord, CA 94520-2546

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

RE: Toyon 2001 DSH Dual Eligible Days Group #3
PRRB Case No.: 09-0272G
FYE: various ending in 2001

Dear Mr. Knight 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

The Board received the Providers' request to establish this CIRP group on November 12, 2008. There are 5 Providers remaining per the updated schedule of Providers received on April 29, 2010. On December 21, 2012, the Providers' representative, Toyon Associates, Inc. , submitted a request to bifurcate the Part C days as a separate and distinct issue from the Dual Eligible Days issue. On March 13, 2014, the Board denied this request because the Part C days issue was not raised in the group appeal request or the Providers' transfer requests. In the same letter, the Board noted that Provider 2, Community Hospital of the Monterey Peninsula, Provider No. 05-0145, FYE 12/31/2001 appeared to be appealing from a revised NPR and lacked supporting documentation to do so. On April 3, 2014, the Provider submitted the requested jurisdictional documentation for appealing from a revised NPR.

Board's Decision

The Board finds that it does not have jurisdiction over Community Hospital of the Monterey Peninsula's appeal from a revised NPR. The Board finds that the remaining Providers have met the jurisdictional requirements and will be remanded pursuant to CMS Ruling 1498-R.

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 (2004) 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.

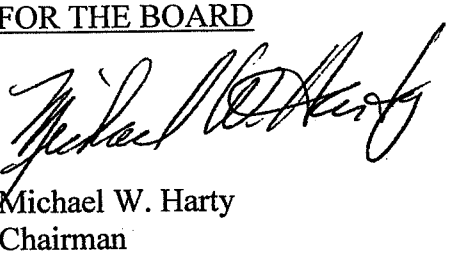
In this appeal, Provider 2, Community Hospital of the Monterey Peninsula, Provider No. 05-0145, FYE 12/31/2001 appealed from a revised NPR that adjusted Capital DSH. Exhibit 2 of Toyon's April 3, 2014 letter specifically shows that Dual Eligible Days were not reviewed or adjusted in the revised NPR. Because there was no revision specifically made to Dual Eligible Days in the revised NPR, the Board finds it lacks jurisdiction over this Provider's appeal from an NPR and dismisses the Provider from group.

The remaining Providers in the group filed jurisdictionally valid challenges, and the Dual Eligible Days issue will be remanded pursuant to CMS Ruling 1498-R under separate cover.

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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AUG 05 2015

Russell Jenkins
Hospital Reimbursement Group
5123 Virginia Way, Suite A-12
Brentwood, TN 37027

RE: Various IPPS Understated Standardized Amount Groups
Case Nos. 05-1826GC et al. (See Attached List)

Dear Mr. Jenkins:

The Provider Reimbursement Review Board (Board) has reviewed the parties' positions with respect to jurisdiction and expedited judicial review (EJR) for the group appeals identified on the attached list of cases. The jurisdictional decision of the Board is set forth below.

Issue under Dispute

The substantive issue under dispute in these cases is:

> Whether the Secretary's failure to distinguish between patient discharges and transfers during the implementation of the inpatient prospective payment system resulted in an understatement of the Federal [diagnosis-related group] DRG Prospective Payment Amounts paid to the Providers in the fiscal year at issue.[1]

The Providers explained in their position papers that the prospective payment system (PPS) payment consists of the product of two figures for each provider: the applicable standardized amount multiplied by the DRG weights. The original standardized amount that was established in 1983 (described more fully below) is understated because it did not distinguish between discharges and transfers in the original calculation.[2] The alleged error in the original standardized amount calculation has been perpetuated because the standardized amount has been updated annually for inflation and not recalculated each year.[3] All of these updates are compounded into the current standardized amount for each facility. The Providers are seeking a

[1] Providers' Position Paper, Case Number 05-1826GC at 3.
[2] *Id.* at 9-10.
[3] *Id.* at 17.

one-time adjustment to the Standardized Amount in fiscal year (FY) 1983 that would allow for correction of the Secretary's alleged error.[4]

Standardized Amount and DRG Background

Standardized Amount

The standardized amount is the average price per case for all Medicare cases during the year.

Base Year Calculation (1981)

When PPS rates were established, 42 U.S.C. § 1395ww(d)(2)(A) required that, in determining allowable costs for the base period, the most recent cost reporting period for which data was available was to be used. Therefore, cost reports ending in 1981 were used.[5]

In calculating the standardized amounts, the Secretary gathered cost reports from nearly all hospitals participating in Medicare. The data extracted from the cost reports included all allowable costs for treating Medicare patients except for excluded units, capital costs, graduate medical education (GME) and nursing differential costs. The total of these costs was divided by the numbers of Medicare discharges during the year to equal the total allowable Medicare inpatient operating costs per discharge. The number of discharges was a monthly tabulation on the cost report. This was the base year cost data.[6] Pursuant to 42 U.S.C. § 1395ww(d)(2)(B), base year cost data is to be updated annually for inflation.

Diagnostic Related Groups (DRGs)

DRGs are created using claims that contain a patient diagnosis and co-morbidity factors which are assigned to one of 499 DRGs based on the diagnosis and complexity of treatment. The DRGs bundle services (labor and non-labor) that are needed to treat a patient with a specific disease. CMS creates a rate of payment for each DRG based on the "average" cost to deliver care to a patient for each specific diagnosis. The average charge allowed for each DRG is calculated by taking the patient charges and removing the effect of regional wage differences, indirect medical education (IME), the disproportionate share (DSH) adjustment, etc. Then all of the charges are summed for all cases involving the DRG and divided by the total number of cases in the DRG. The higher the cost of treatment the higher the weight assigned to the DRG.[7] The DRG is

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[4] *Id.* (The standardized amount for FYE 1983 was developed from 1981 cost report data.) *See* 48 Fed. Reg. 39,740, 39,763 (Sept. 1, 1983).
[5] *Id.*
[6] *Id.* at 39,764.
[7] Medicare Hospital Prospective Payment System: How DRG Rates are Calculated and Updated at 5-6, oig.hhs.gov/oei/reports/oei-99-00-00200.pdf.

multiplied by the standardized amount, described above, to determine the amount of PPS payments (sometimes called DRG payments).

Discharges and Transfers

Prior to the implementation of PPS, acute care hospitals were paid on the basis of reasonable cost (all the direct and indirect costs that were necessary and proper for the efficient delivery of needed healthcare services) and reasonable charges (physicians' services and other medical and health services that are not furnished directly by a provider of services).[8] Consequently, prior to the implementation of PPS there was no need to distinguish between a discharge (the patient receives no further treatment) and a transfer (the patient continues care at another facility). When PPS was implemented, each spell of illness was paid for under one "umbrella" (DRG or PPS rate) that was to be split between the providers of service.

Discharges and transfers were originally codified at 42 C.F.R. § 405.470(c).[9] These actions were created for purposes of payment under PPS, a system that was designed to provide full payment (less co-insurance and deductibles) associated with a particular diagnosis. Generally, Medicare pays a single rate to one hospital for a service. Originally, the Health Care Financing Administration (HFCA)[10] paid the discharging hospital the full prospective rate on the theory that the discharging facility provided the greatest portion of patient care. The transferring hospital was paid based on a per diem rate (the prospective rate divided by the average length of stay for a DRG) and the patients' length of stay at the transferring hospital. Payment could not exceed the full prospective payment.[11]

***Kaiser Foundation Hospital*[12], Predicate Facts and the Changes to 42 C.F.R. § 405.1885**

In the December 10, 2013 Federal Register,[13] the Secretary clarified her position regarding reopening predicate facts in final determinations of reimbursement. Predicate facts were defined as occurring where:

> the factual underpinnings of a specific determination of the amount of reimbursement due a provider may first arise in, or be determined for, a different fiscal period than the cost reporting period under review.

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[8] 48 Fed. Reg. at 39,754.
[9] Recodified at 42 C.F.R. § 412.4.
[10] HCFA is the previous name of the Centers for Medicare & Medicaid Services.
[11] 48 Fed. Reg. at 39,759.
[12] *Kaiser Found. Hosp. v. Sebelius*, 708 F.3d 226 (D.C. Cir. 2013).
[13] 78 Fed. Reg. 74,826, 75,162-69 (Dec. 10, 2013).

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> Predicate facts are determined once, either in the first fiscal period in which they arise or are first determined, or in the first fiscal period that they are used as part of a formula for reimbursement, and then applied as part of that reimbursement formula for several fiscal periods thereafter. These facts are not reevaluated annually to determine whether they support a determination that a particular cost is reasonable because the formula is a proxy for reasonable costs. Instead, the formula itself will provide for changes in costs through an updating factor or otherwise. [14]

The Secretary explained that where an issue is appealed or reopened and the issue is a predicate fact that arose in, or was determined for, an earlier fiscal period and was updated for a later fiscal period, the predicate fact could be redetermined by:

> A timely appeal or reopening of:
>
> (1) [t]he NPR [Notice of Program Reimbursement] for the cost reporting period in which the predicate fact first arose; or
> (2) the NPR for the period for which such predicate fact was first used or applied by the intermediary to determine reimbursement.[15]

Through the following example, the Secretary explained that if base period costs for a target amount were calculated for a 12-month cost reporting period ending in 2001, and then the provider challenges the determination of its target amount in 2008, its appeal rights were limited. The provider could not challenge the determination of the base period predicate facts unless it had appealed the 2001 base period costs within 180 days of the issuance of the 2001 NPR or it had appealed its 2002 NPR when the costs were used to determine reimbursement. In the alternative, the provider could have requested reopening of, or the intermediary could have reopened, the 2001 cost report within three years of the base period determination or application and the base year costs were redetermined.[16]

The Secretary asserts that once the three year reopening period has expired, neither the provider nor intermediary is allowed to revisit the predicate facts that have not been changed through appeal or reopening of the period in which the facts first arose. The base period calculation cannot

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[14] *Id.* at 75,163.
[15] *Id.* at 75,164.
[16] *Id.*

be redone outside this process (at a later time), resulting in different facts (a calculation or base year rate) being applied to a later cost reporting period. There cannot be two different findings for the same base period.[17] The creation of two base year findings is what occurred in the *Kaiser* case.

In *Kaiser*, the D.C. Circuit found that the providers could appeal predicate facts used to determine reimbursement in later fiscal periods where the predicate facts were not timely appealed or reopened in the year in which they were first used to determine reimbursement. The providers had not appealed their GME base year full-time equivalent (FTE) counts nor had the base year counts been reopened. The Court permitted the updated GME FTE caps of later FYEs, where the base years had not been appealed or reopened to recalculate the base year FTE cap and then apply the update to the FYEs under appeal.

As a result of this decision, the Secretary revised 42 C.F.R. § 405.1885(a)(1)(2013) to preclude appeals of predicate facts for an earlier cost reporting period where there was no appeal or reopening which altered the predicate (base year) facts.[18] Without a change to the predicate facts through these mechanisms, the base year calculations could not be altered. This regulatory change was applied retroactively to pending cost reports and appeals.[19]

Decision of the Board

The Board concludes that it lacks jurisdiction over the appeals on the attached list and hereby dismisses the cases. This action closes the appeals. The Providers are seeking a correction of the standardized amount in 1981 to create discharges and transfers which did not exist in that FYE, and then apply the changes to the cost reporting periods under appeal in these cases. Discharges and transfers were codified in 1983 at 42 C.F.R. § 405.470(c), subsequent to the filing of the 1981 cost reports. The relief sought by the Providers is similar to the remedy created by the intermediary in *Kaiser*. In that case, a new FTE cap for the GME base year was created after both the appeal and reopening periods had expired for appealing the per resident amount determination and the first year in which the cap was applied. This new cap was then applied to later cost reporting periods. However, the Secretary addressed *Kaiser* and revised 42 C.F.R. § 405.1885(a)(1) (2013) to specifically bar this type of prospective corrective action. Further, this revision applies to this case because it applies retroactively to pending cost report appeals.

In these cases, the Providers want to create discharges and transfers for FYE 1981 to be used in the calculation of a new standardized amount and then roll the new calculation forward to the

[17] *Id.*
[18] *Id.* at 75,165.
[19] *Id.*

years under dispute (FYs 2002 – 2015). Both the appeal periods and reopening periods for the original PPS rate notices and the first cost reporting periods to which they applied (approximately 1984) expired many years ago. In the preamble changing the reopening regulations, the Secretary asserted that once the three year reopening period has expired, neither the provider nor intermediary is allowed to revisit the predicate facts that have not been changed through appeal or reopening of the cost period in which the facts first arose. The base period calculation cannot be revised outside this process (at a later time), resulting in different facts (a calculation) being applied to a later cost reporting period. There cannot be two different findings for the same base period.[20] The revision of the 1981 base year (the predicate facts) in this case is clearly the type of revision the Secretary wanted to preclude through the December 10, 2013 Federal Register notice.

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, CPA

FOR THE BOARD:

Michael W. Harty (e)
Michael W. Harty
Chairman

Enclosures: 42 U.S.C. 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
List of Standardized Amount Group Cases

cc: Sharon Keyes, BCBSA (w/List of Cases)
Byron Lamprecht, WPS (w/List of Cases)
Beth Wills, Cahaba GBA c/o NGS (w/List of Cases)
Bill Tisdale, Novitas (w/List of Cases)
Bruce Snyder, Novitas (w/List of Cases)

[20] *Id.* at 75,164.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL AUG 11 2015

Strategic Reimbursement, Inc.
Nick Putnam
360 W. Butterfield Road
Suite 310
Elmhurst, IL 60126

RE: Jurisdictional Decision – on revised NPR appeal for
Saint Joseph Hospital (14-0224), FYE 6/30/2004 (participant #6)
As a participant in SRI 2004 SSI Group, PRRB Case No.: 07-2289G

Dear Mr. Putnam:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced group appeal which is subject to CMS Ruling 1498-R. The Board notes an impediment to jurisdiction over one of the participants in the group. The background and the Board's jurisdictional determination are set forth below.

Background

Saint Joseph Hospital was issued a revised Notice of Program Reimbursement (RNPR) on May 10, 2006. On November 2, 2006 the Provider filed an individual appeal of the RNPR to which the Board assigned case number 07-0183. Although the Provider appealed the SSI recalculation error in its individual appeal, it did not appeal the SSI Percentage issue. The Provider referenced audit adjustment 2-003 for the SSI Percentage issue. This adjustment was for Hospital Adults & Pediatrics.

Strategic Reimbursement, Inc. (SRI) filed a request for the SRI 2004 SSI Group on June 22, 2007. The Board assigned the group case number 07-2289G.

In a letter dated June 13, 2008, SRI requested that the SSI recalculation issue be transferred from the individual appeal to the subject group appeal. Because the request for transfer was filed prior to the issuance of the Board's August 2008 Rules, the Board deems the SSI Percentage issue to have been added at the time it was transferred to the group appeal.

Board's Decision

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

can make a determination over all matters covered by the cost report, it must first determine that the Provider has filed a jurisdictionally valid appeal.

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over Saint Joseph Hospital's RNPR appeals because the Provider appealed from a RNPR in which the issue on appeal, SSI Percentage, was not adjusted. 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).

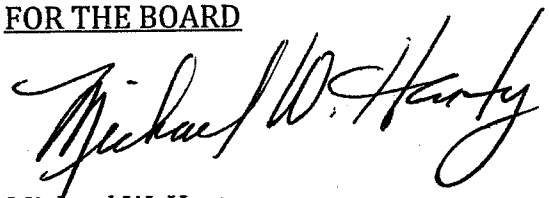
In accordance with 42 C.F.R. § 405.1889, a revised NPR is considered a separate and distinct determination from which the provider may appeal. The regulation provides:

> (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.

The Board finds that it does not have jurisdiction over Saint Joseph Hospital's RNPR appeal because the documentation submitted is not sufficient to establish that there was an adjustment to the SSI Percentage in the revised NPR for FYE 06/30/2004. Therefore, Saint Joseph Hospital (participant 6) is hereby dismissed from case number 07-2289G. 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.

Enclosed, please find a Standard Remand of the SSI Percentage Under CMS Ruling CMS-1498-R for the remaining participants in the group.

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 of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R
Schedule of Providers

cc: Sharon L. Keyes, Executive Director, BCBSA (w/enclosures)
Danene Hartley, Appeals Lead, National Government Services, Inc. (w/enclosures)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

Certified Mail AUG 12 2015

Emerson Hospital
Craig W. Cowan
Director, Patient Account Services
133 Old Road to Nine Acre Corner
Concord, MA 01742

Re: Emerson Hospital, Provider No. 22-0084, FYE 09/30/11, Case No. 15-2871

Dear Mr. Cowan:

The Provider Reimbursement Review Board ("Board") is in receipt of the Provider's recent appeal request, which was assigned Case No. 15-2871. The background of the case and the decision of the Board are set forth below.

Background

On June 26, 2015, the Board received Emerson Hospital's appeal ". . . to recover $441,672 denied in the findings on [its] cost report for Part A and Part B claims." On July 1, 2015, the Board established the appeal and issued an acknowledgement in accordance with Board Rule 9.[1]

Decision of the Board

The Board finds that the Provider's appeal request is deficient because it failed to provide the final determination under appeal, an explanation of the specific issue(s) in dispute, or any documentary evidence to support the Provider's dissatisfaction.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835, 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 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 after the date of receipt by the provider of the intermediary determination.

Pursuant to 42 C.F.R. § 405.1835(b), if a Provider's appeal request does not meet the requirements of paragraphs (b)(1) through (b)(3) of the same section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate. Paragraphs (b)(1) through (b)(3) states in part that the following must be included in the Provider's request:

[1] Board Rule 9 states in part, "The Board will send an acknowledgement via e-mail indicating that the appeal request has been received and identifying the case number assigned. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action. An acknowledgement does not limit the Board's authority to require more information or dismiss the appeal if it is later found to be jurisdictionally deficient."

(1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of the same section, including a specific identification of the intermediary's or Secretary's determination under appeal.

(2) An explanation (for each specific item at issue of the same section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal.

(3) A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements and an explanation of the provider's dissatisfaction with said determination.

Therefore, the Board hereby dismisses with prejudice the Provider's appeal for insufficient documentation to support the regulatory requirements for filing an appeal at the Board and closes Case No. 15-2871.

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, C.P.A.
Jack Ahern, MBA

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: National Government Services, Inc.
Danene Hartley
Appeals Lead
MP INA 101-AF42
P.O. Box 6474
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Blue Cross and Blue Shield Association
Sharon L. Keyes
Executive Director
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Refer to: 05-0543GC; 05-0862GC; & 06-0910GC

CERTIFIED MAIL AUG 12 2015

Christopher L. Keough
Akin, Gump, Strauss, Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Suite 400
Washington, DC 20036-1564

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

RE: Jurisdictional Decision
HCA DSH Medicare + Choice Days CIRP Groups
FYEs: 2000, 2002, 2003, 2004
PRRB Case Nos.: 05-0543GC; 05-0862GC; & 06-0910GC

Dear Mr. Keough and Mr. Lamprecht,

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

Background

In each of the three following groups, Providers have filed appeals from both original and revised Notices of Program Reimbursement (NPR). The Board issued letters in each appeal requesting additional documentation related to the revised NPR appeals, and is issuing this decision after reviewing the requested documents.

05-0543GC, HCA 2002, 2002 DSH – Medicare + Choice Plan Days CIRP Group

Participant 1, Riverside Community Hospital (provider no. 05-0022, FYE 4/30/2002), filed an individual appeal request with the Board from its revised NPR. Riverside Community Hospital later requested to transfer into case number 05-0543GC. Riverside Community Hospital did not appeal from an original NPR in this group.

05-0862GC, HCA 2003 DSH – Medicare + Choice Plan Days CIRP Group

There are 30 Providers that have filed appeals from revised NPRs in case number 05-0862GC, HCA 2003 DSH – Medicare + Choice Plan Days CIRP Group.[1] Twenty-eight of those 30 Providers have also appealed from original NPRs in the same appeal.[2]

[1] Some Providers have appealed from more than one revised NPR in this group.
[2] The thirteen revised NPR appeals are from the following Providers on the Schedule of Providers: Participants 1, 3, 5, 6, 7, 8, 9, 15, 17, 24, 25, 28, 30, 32, 34, 37, 39, 42, 44, 45, 47, 49, 50, 51, 56, 58, 63, and 66.

Participants 4 and 14 on the Schedule of Providers have appealed from revised NPRs but did not also appeal from original NPRs. Participant 4, Good Samaritan Hospital (provider no. 05-0380, FYE 1/31/2003) was issued a revised NPR and filed directly into this group appeal. Participant 14, Central Florida Regional Hospital (provider no. 10-0161, FYE 5/31/2003) was also issued a revised NPR and filed directly into this group appeal.

06-0910GC. HCA 2004 DSH – Medicare + Choice Plan Days CIRP Group

Twenty-seven of the Providers included on the Schedule of Providers have appealed from both original and revised NPRs for the same provider and fiscal year end ("FYE"). All of the Providers that appealed from revised NPRs also appealed from an original NPR.[3]

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.

Regarding appeals from revised NPRs, the applicable regulations explain that a revised NPR is considered a separate and distinct determination, and, depending on when the revised NPR was issued, the issue on appeal must have been either reviewed[4] or revised[5] as a prerequisite for Board jurisdiction.

For those Providers that have appealed from both original and revised NPRs in case numbers 05-0543GC; 05-0862GC; & 06-0910GC, the Board will not issue a jurisdictional determination for the revised NPR appeals. The Board has determined that these Providers have jurisdictionally valid appeals pending for the same fiscal year ends from the original NPRs; therefore reaching a decision on the revised NPR appeals is futile as the outcome for these Providers will not be affected.

05-0543GC, HCA 2002, 2002 DSH – Medicare + Choice Plan Days CIRP Group

The Board finds that it does have jurisdiction over Riverside Community Hospital's appeal from its revised NPR. The Provider submitted additional workpapers which show that 593 Medicare + Choice days were removed as part of the reopening of the Provider's cost report.[6] Because

---

[3] The revised NPR appeals are from the following Providers on the Schedule of Providers: 2, 3, 6, 7, 8, 10, 17, 19, 25, 32, 33, 37, 38, 44, 47, 49 – 56, 59, 60, 67, and 73.

[4] 42 C.F.R. § 405.1885, 1889; *see also HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding 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).

[5] 42 C.F.R. § 405.1885, 1889 (2008), "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" (emphasis added).

[6] *See* page 1m of the Additional Jurisdictional Documentation letter (submitted December 13, 2013).

Medicare + Choice days were actually adjusted in the revised NPR, the Provider's revised NPR appeal satisfies the requirements of 42 C.F.R. § 405.1885 and 1889 for Board jurisdiction.

05-0862GC, HCA 2003 DSH – Medicare + Choice Plan Days CIRP Group

The Board finds that it does not have jurisdiction over Providers 4 and 14 as participants in case number 05-0862GC. Participant 4, Good Samaritan Hospital, explains that the Medicare contractor reopened its cost report in order to add 4,991 Medicaid eligible days by adjust R1-001.[7] The Provider goes on to explain that its revised NPR contains 7,998 Medicaid days on Worksheet S-3, which does not include 229 Medicare + Choice days. The Provider states that adjustment R1-001 did not remove any Medicare + Choice days, but that it is appealing the days in order to make sure the amount in controversy is updated to the latest settlement. Participant 4, Good Samaritan Hospital, is appealing from a revised NPR that did not review Medicare + Choice days, therefore the Board does not have jurisdiction over this Provider and it is hereby dismissed from case number 05-0862GC.

Participant 14, Central Florida Regional Hospital, indicates that it did not include M+C Days on its filed cost report and that the Medicare contractor did not make any adjustments to Medicaid days for the original NPR. Central Florida Regional Hospital submitted a document it prepared that outlined the days it requested; it backed those days out of its reopening request as the Medicare contractor required.[8] As the Provider backed the days out in its reopening request, the Medicare contractor did not review the Medicare + Choice days, therefore the Board does not have jurisdiction over Central Florida Regional Medical Center. The Provider is hereby dismissed from case number 05-0862GC.

Review of these determinations 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 appeals.

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

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

[7] *See* revised NPR documents submitted on December 13, 2013.
[8] *See* revised NPR documents submitted on December 13, 2013.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL AUG 12 2015

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

RE: Jurisdictional Decision – on revised NPR appeals for
Baylor Medical Center - Garland (45-0280), FYE 12/31/1999 and
Baylor Medical Center (45-0021), FYE 6/30/2002

As participants in QRS BHCS 1997- 9/30/2004 DSH Exhausted Part A/Dual Eligible Days CIRP Group, PRRB Case No.: 09-0541GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced common issue related party (CIRP) group appeal which is subject to CMS Ruling 1498-R. The Board notes an impediment to jurisdiction over two of the participants in the group. The background and the Board's jurisdictional determination are set forth below.

Background

Baylor Medical Center - Garland (Participant 6)

The Provider was issued a revised Notice of Program Reimbursement (RNPR) on October 7, 2004. On March 24, 2005 the Provider filed an individual appeal of the RNPR to which the Board assigned case number 05-1231. In a letter dated November 26, 2007, the Provider added the Dual Eligible Days issue to its individual appeal and requested that it be transferred to the subject group appeal. The Representative did not provide copies of the audit adjustment pages of the RNPR, nor did it supply any of the other documentation required to support an adjustment to Dual Eligible Days on the RNPR.

Baylor Medical Center (Participant 9)

The Provider was issued a RNPR on April 23, 2010. On October 19, 2010, the Provider filed a Model Form E – Request to Join An Existing Group Appeal: Direct Appeal From Final Determination. The Provider referenced audit adjustment #1 which is "To adjust Medicaid days and DSH % per audit findings." No other documentation was submitted in support of the adjustment.

Board's Decision

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

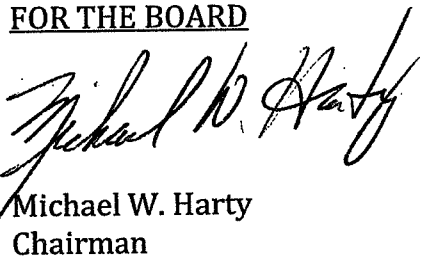
Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over Baylor Medical Center – Garland's and Baylor Medical Center's RNPR appeals. The applicable regulations explain that a revised NPR is considered a separate and distinct determination, and, depending on when the revised NPR was issued, the issue on appeal must have been either reviewed[1] or revised[2] as a prerequisite for Board jurisdiction. In this case, the documentation is not sufficient to document that Dual Eligible Days were either reviewed or revised for Participants 6 or 9.

Therefore, Baylor Medical Center – Garland (Participant 6) and Baylor Medical Center (Participant 9) are hereby dismissed from case number 09-0541GC. 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.

Enclosed, please find a Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R for the remaining participants in the group.

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

FOR THE BOARD



Michael W. Harty
Chairman

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[1] 42 C.F.R. § 405.1885, 1889 (2004); *see also HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding 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 *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014) (holding that an "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).

[2] 42 C.F.R. § 405.1885, 1889 (2008), "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" (emphasis added).

Enclosures:

42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R
Schedule of Providers

cc: Sharon L. Keyes, Executive Director, BCBSA (w/enclosures)
Bill Tisdale, Novitas Solutions, Inc. (w/enclosures)

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CERTIFIED MAIL

AUG 13 2015

Mridula Bhatnagar
Director – Client Services
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

James Lowe
Cahaba Safeguard Administrators, LLC
2803 Slater Road, Suite 215
Morrisville, NC 27560-2008

RE: Community Hospital of San Bernardino
Provider No.: 05-0089
FYE: 6/30/08
PRRB Case No.: 13-1269

Dear Ms. Bhatnagar 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 jurisdictional decision regarding the SSI Ratio Realignment issue is set forth below.

Background

The Provider submitted a request for hearing on March 20, 2013, based on a Notice of Program Reimbursement ("NPR") dated September 25, 2012. The hearing request included seven issues, five of which were subsequently transferred to group appeals on September 25, 2013. One of the seven issues appealed was Medicare Disproportionate Share Hospital (DSH) Payments – SSI Ratio Alignment to Provider's Cost Reporting Year.

On May 28, 2013, the Provider added two issues to the appeal, both of which were simultaneously transferred to group appeals.

The Medicare Disproportionate Share Hospital (DSH) Payments – Medicaid Eligible Days issue in the appeal was resolved through a partial administrative resolution received on July 16, 2015.

The last issue remaining in the appeal is the SSI Ratio Realignment issue. The Medicare Contractor filed a jurisdictional challenge on the issue on March 10, 2014. The Provider filed a responsive brief on March 18, 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:

> 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. There is no determination for the Provider to contest. Accordingly, the Board does not have jurisdiction.

The Medicare Contractor cited 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 25, 27, 40 and 41 were implemented in the Contractor's own words "To properly state the SSI%" and "To adjust the SSI% and the Disproportionate Share Amount based on the latest SSI% update dated 3/2012."[4]

The Provider explains that the SSI ratio was adjusted by the Contractor from 30.33% to a value of 26.54% that is developed by CMS on a federal fiscal year basis. 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.[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

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[1] Medicare Contractor's Jurisdictional Brief at 1.
[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.
[5] *Id* (Emphasis included).
[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).

Provider's SSI percentage to the Provider's cost reporting year, or 2) Use the Provider's own data to seek a resolution to the issue. The Provider explains that it sought a remedy to the issue by submitting a DSH SSI Ratio Realignment Request to the Contractor on March 28, 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 the 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. . .

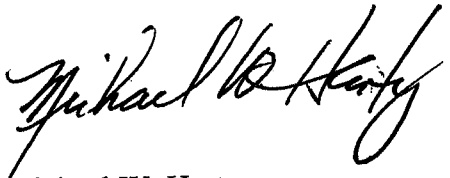
In this case, the Medicare Contractor did not make a final determination with regard to the SSI Ratio Realignment issue. Therefore, because the Medicare Contractor has not made a determination regarding SSI Ratio Realignment with which the Provider could be dissatisfied, the Board finds that the appeal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

As the SSI Ratio Realignment issue was the last issue remaining in the appeal, the Board hereby closes the 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
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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CERTIFIED MAIL

AUG 13 2015

Sandra Lee
Assistant Director – Client Services
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Danene Hartley
Appeals Lead
National Government Services, Inc.
MP INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: St. Joseph's Medical Center
Provider No.: 24-0075
FYE: 6/30/09
PRRB Case No.: 13-3484

Dear Ms. Lee and Ms. Hartley,

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

Background

The Provider submitted a request for hearing on September 5, 2013, based on a Notice of Program Reimbursement ("NPR") dated March 19, 2013. The hearing request included seven issues, four of which were subsequently transferred to group appeals on May 23, 2014. One of the seven issues appealed was Medicare Disproportionate Share Hospital (DSH) Payments – SSI Ratio Alignment to Provider's Cost Reporting Year.

In its Final Position Paper received on December 23, 2014, the Provider withdrew the Medicare Settlement Data (Including Outlier Payments) and Medicare Disproportionate Share Hospital (DSH) Payments – Medicaid Eligible Days issues from the appeal.

The last issue remaining in the appeal is the SSI Ratio Realignment issue. The Medicare Contractor filed a jurisdictional challenge on the issue on February 4, 2015. The Provider filed a responsive brief on February 13, 2015.

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. The request was forwarded to CMS and is currently awaiting a decision.[1]

[1] Medicare Contractor's Jurisdictional Brief at 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:

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

The Medicare Contractor contends that the Provider's appeal of SSI Realignment is premature, which is consistent with the PRRB's conclusion in PRRB Case No. 07-2296 Saint Jude Medical Center issued March 8, 2010. CMS has not yet recalculated the Provider's SSI percentage and, therefore, no adjustment has been made to its SSI for this issue.[2]

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 adjustment 24 was implemented in the Contractor's own words "To properly report current year operating DSH SSI percentage."[3]

The Provider explains that the SSI ratio was adjusted by the Contractor from 4.90% to a value of 3.45% that is developed by CMS on a federal fiscal year basis. 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.[4]

The Provider contends that the regulation concerning the "Contents of Request for a Board Hearing"[5] requires the Provider to describe their dispute[6] and provide a remedy describing how and why the Provider believes Medicare payment must be determined differently.[7] 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 seek a resolution to the issue. The Provider explains that it sought a remedy to the issue by submitting a DSH SSI Ratio Realignment Request to the Contractor on December 6, 2013.[8]

The Provider explains that the Medicare Contractor pointed to a Board jurisdiction decision 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 case cited by the Contractor is distinguishable from the issue at hand in this case. Specifically, in the case cited, it is clear the hospital had specifically appealed the

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[2] *Id.*
[3] Provider's Responsive Brief at 2.
[4] *Id* (Emphasis included).
[5] 42 C.F.R. § 45.1835(b).
[6] 42 C.F.R. § 45.1835(b) (2)(i).
[7] 42 C.F.R. § 45.1835(b) (2)(ii).
[8] Provider's Responsive Brief at 3.

issue of SSI Ratio Realignment yet the hospital had not taken any action to pursue a SSI Ratio Realignment.[9]

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. . .

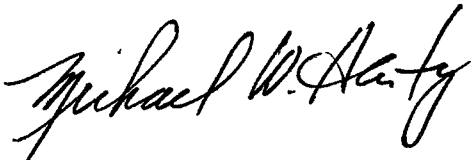
In this case, the Medicare Contractor did not make a final determination with regard to the SSI Ratio Realignment issue. Therefore, because the Medicare Contractor has not made a determination regarding SSI Ratio Realignment with which the Provider could be dissatisfied, the Board finds that the appeal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

As the SSI Ratio Realignment issue was the last issue remaining in the appeal, the Board hereby closes the 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
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

[9] *Id.* at 4.

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CERTIFIED MAIL **AUG 14 2015**

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

RE: **Broward General Medical Center**
Provider Number: 10-0039
FYE: 6/30/2006
Case Number: 09-0958

Dear Mr. Ravindran:

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

Pertinent Facts:

The Provider timely filed its individual appeal request on February 26, 2009, from an original Notice of Program Reimbursement (NPR) dated September 15, 2008. The Provider appealed the following issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – SSI Percentage (Systemic Errors)
3. DSH – Medicaid Eligible Florida Charity Care Days

In two separate requests dated October 19, 2009, the Provider requested to transfer the DSH – SSI Percentage (Systemic Errors) to Group Case No. 09-1769GC and the DSH – Medicaid Eligible Florida Charity Care Days issue to Group Case No. 09-1770GC. The only remaining issue in this appeal is the DSH – SSI Percentage (Provider Specific).

Board Determination:

In its description, of the SSI Ratio Alignment issue, the Provider states:

> "... The Provider is seeking SSI data from 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....*" (Emphasis added.)

The Board finds that it does not have jurisdiction over the SSI Realignment issue in this appeal, as this issue is premature. 42 C.F.R. §405.1835 states:

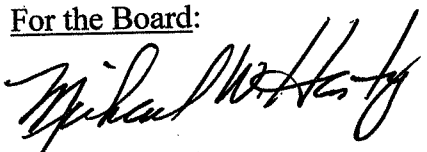
> "The provider … has a right to a hearing before the Board about any matter designated in §405.1801(a)(1), if … [a]n intermediary determination has been made with respect to the provider."

In this case, there was no final determination made by the Intermediary and the Provider has not requested realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. The Board hereby denies jurisdiction over the SSI Percentage (Provider Specific) issue. Since there are no remaining issues in this appeal, the Board hereby closes this appeal and removes it from the Board's docket.

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
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:



Michael W. Harty
Chairman

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

Sharon L. Keyes
Executive Director
Senior Government Initiatives
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CERTIFIED MAIL

AUG 17 2015

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

RE: Jurisdictional Review of Blumberg Ribner 96/98 Dual Eligible Days Group
PRRB Case No.: 06-0092G

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the Schedule of Providers and the associated jurisdictional documents for case number 06-0092G. The Board's decision regarding jurisdiction for specific Providers is set forth below.

Background

The appeal was filed on October 12, 2005. The revised final schedule of providers dated July 12, 2012 identified 30 providers in the group appeal, but four were subsequently transferred to CIRP group appeals. 24 providers remain on the schedule.

The Board has identified potential jurisdictional problems with the following providers:

Provider 7, Lenox Hill Hospital, Provider No. 33-0119
Provider 8, Lenox Hill Hospital, Provider No. 33-0119
Provider 15, Saint Joseph Riverside Hospital, Provider No. 36-0161
Provider 16, Saint Joseph's Hospital Health Center, Provider No. 33-0140
Provider 25, Sutter Merced Medical Center, Provider No. 05-0444
Provider 26, Sutter Merced Medical Center, Provider No. 05-0444
Provider 30, Wilson N Jones Medical Center, Provider No. 45-0469

Decision of the Board

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 ($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 (2004) 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 (2004) 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 7, Lenox Hill Hospital (provider no. 33-0119, FYE 12/31/1998), and Provider 25, Sutter Merced Medical Center (provider no. 33-0119, FYE 12/31/1998), appealed solely from revised NPRs. Both Providers supplied audit adjustment reports which show adjustments to Medicaid days, but there is no adjustment specific to dual eligible days. Neither Provider supplied supporting documentation (such as the request for reopening, reopening notice, or audit work papers) to determine the full scope of the issues reviewed within the revised NPR process. It is the providers' burden to prove that the days under appeal were specifically revised in the revised NPR. The Board finds that the record lacks evidence that the days were revised in the revised NPR. Therefore, the Board finds that it lacks jurisdiction over Provider 7 and 25, and dismisses the Providers from the appeal.

Provider 8, Lenox Hill Hospital (provider no. 33-0119, FYE 12/31/1999), Provider 15, Saint Joseph Riverside Hospital (provider no. 36-0161, FYE 12/31/2002), Provider 16, Saint Joseph's Hospital Health Center (provider no. 33-0140, FYE 12/31/2001) and Provider 30, Wilson N Jones Medical Center (provider no. 45-0469, FYE 12/31/1999), appealed from original and revised NPRs. For each of the Providers' appeals from

the original NPR, whether there was an audit adjustment or a claimed "self-disallowance," the Board takes jurisdiction over the appeals pursuant to *Bethesda.*[1] For the appeals from the revised NPRs, the Providers did not supply supporting documentation (such as the request for reopening, reopening notice, or the audit work papers) to determine the scope of the issues reviewed within the revised NPR process. The Providers have not provided evidence that the revised NPR appeals meet the requirements of 42 C.F.R. § 405.1889. The Board finds that the record lacks evidence that the dual eligible days were revised in the revised NPRs. Therefore, the Board finds that it lacks jurisdiction over the revise NPR appeals for Provider 8, 5, 16, and 30 and dismisses the Providers' revised NPR appeals from the case.

Provider 26, Sutter Merced Medical Center (provider no. 05-0444, FYE 12/31/1999), requested to add the dual eligible days issue to its individual appeal, case number 04-0660, on October 25, 2006. Sutter Merced Medical Center's individual appeal, case number 04-0660, was already closed on September 27, 2006, by PRRB decision 2006-D56. Thus, the dual eligible days issue could not be added to the individual appeal. As Sutter Merced Medical Center failed to timely add the dual eligible days issue to the individual appeal, the Board dismisses Provider 26, Sutter Merced Medical Center (provider no. 05-0444, FYE 12/31/1999), from the group appeal as the issue could not have been properly transferred.

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: Donna Kalafut, Noridian Healthcare Solutions
Sharon L. Keyes, Blue Cross & Blue Shield Association

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

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AUG 17 2015

CERTIFIED MAIL

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

Cahaba GBA c/o National Government Services
Beth Wills
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206

RE: Fayette Medical Center
Provider No. 01-0045
FYE 09/30/2008
Case No.: 13-3438

Dear Mr. Ravindran and Ms. Wills:

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

Background

The Medicare Contractor issued a Notice of Program Reimbursement ("NPR") for FYE 09/30/2008 on May 15, 2013. On August 28, 2013, the Provider submitted an appeal request to the Board, appealing the Rural Floor Budget Neutrality Adjustment ("RFBNA"). The Provider subsequently transferred the RFBNA issue to a group appeal and added 8 issues to this individual appeal, including the SSI Provider Specific issue and the SSI systemic errors issue. On February 10, 2014, the Provider transferred 6 of those issues to relevant mandatory CIRP groups, leaving Medicaid Eligible Days and the SSI Provider Specific issue. The Provider withdrew the Medicaid Eligible Days Issue on April 17, 2014. The SSI Provider Specific issue is the only issue remaining in the appeal. The Medicare Contractor filed a jurisdictional challenge on June 9, 2014. On July 3, 2014, the Provider filed a reply brief.

Medicare Contractor's Position

The Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge on June 9, 2014, on the basis that the Provider is not appealing from a final determination. The MAC also contends that the amount in controversy is not supported adequately.

The MAC contends that the DSH/SSI Provider Specific issue is premature because the Provider has not submitted a request for recalculation. 42 C.F.R. § 412.106(b)(3) states that if a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part

A/SSI percentage for that period." Because the Provider has not requested SSI realignment, the MAC contends that there has been no final determination as required under 42 C.F.R. § 405.1835.

The MAC's second jurisdictional challenge is that there is no support that the estimated reimbursement impact will exceed $10,000 for the SSI Provider Specific issue. 42 C.F.R. § 405.1839(a)(1) requires that "[T]he provider must demonstrate that if its appeal was successful, the provider's total program reimbursement for each cost report period under appeal... by at least $10,000 for a Board hearing." The MAC noted that the Provider's hearing request, the Provider estimated an increase of $9,066, but in its preliminary position paper, the Provider uses the same calculation to estimate an increase of $12,692 for the SSI adjustment. The MAC contends that the Provider has failed to provide any information or analysis establishing how it arrived at the amount in controversy it claims and that the amount in controversy is insufficient to establish jurisdiction before the board.

Provider's Position

The Provider contends that the Board has jurisdiction over issue #1 because it is not addressing a realignment of the SSI percentage, but errors of omission that do not fit into the "systemic errors" category. The Provider states that the MAC specifically adjusted its SSI percentage and the Provider is dissatisfied that it received as a result. The provider believes that it can specifically identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS. Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage. Therefore, the Provider requests that the Board find that it has jurisdiction over the DSH/SSI issue.

The provider does not respond to the "amount in controversy" issue.

Board's Decision

The Board finds that although the amount in controversy is met, it does not have jurisdiction over the SSI Provider Specific issue as the appeal is premature.

The Board finds that the amount in controversy is sufficient for Board jurisdiction. An individual appeal request must have a total amount in controversy of at least $10,000 and provide a calculation or support demonstrating the amount in controversy.[1] Here, the individual appeal request filed on August 26, 2013 stated that the total amount in controversy was $52,000 and provided a calculation under tab 5 to support this estimated impact. When the individual appeal was filed, the amount in controversy met the jurisdictional requirements.

However, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue, as the issue is premature. Issue 1, the SSI Provider Specific issue, is a combined issue, addressing SSI percentage and SSI Realignment. The Board finds that to the extent the Provider is arguing that the SSI Percentage is understated, and in need of the underlying data to determine

[1] PRRB Rule 6.3; 42 C.F.R §§ 405.1835 and 405.1839.

what is or is not included; the issue is the same as the systemic issue in Issue 2, which has been transferred to a group appeal. The basis of each SSI percentage issue is that the Provider does not have the underlying data, and cannot determine if the percentage is understated.

The other part of the SSI Provider specific issue is SSI Realignment. The Board finds that it does not have jurisdiction over the Provider's appeal of SSI realignment. A Provider has a right to a Board hearing for specific issues covered by a final contractor determination.[2] In this case, the issue is premature because the Intermediary has not yet issued a final determination and the Provider has not yet decided whether it will request realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. Therefore, the SSI realignment issue is premature and the Board should find that it does not have jurisdiction. The case is hereby closed because the SSI Provider Specific Issue is the last remaining issue in Case No. 13-3438.

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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

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] 42 C.F.R. 405.1835.

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Refer to: 09-1630

AUG 17 2015

CERTIFIED MAIL

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

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

Re: Provider: Indian River Memorial Hospital
Provider No.: 10-0105
FYE: 09/30/2005
PRRB Case No.: 09-1630

Dear Mr. Ravindran and Mr. Pike:

The Provider, Indian River Memorial Hospital ("Indian River"), appealed the amount of its Medicare reimbursement calculated by the Medicare Administrative Contractor, First Coast Service Operations, Inc. ("First Coast"). The Provider Reimbursement Review Board ("Board") determined that: (1) the Supplemental Security Income ("SSI") Realignment issue should be dismissed; (2) although appealed as two separate issues, Indian River's SSI percentage ("SSI%") is actually one issue for appeal purposes; and, (3) Indian River failed to provide the required documentation for its appeal. For the reasons set forth below, the Board hereby closes this case.

Background

Indian River appealed its revised Notice of Program Reimbursement ("RNPR") to the Board on the basis of Disproportionate Share Hospital ("DSH") SSI%.[1] Indian River listed SSI% as two separate issues, but both were framed as, "[w]hether the [Contractor] used the correct [SSI%] in the DSH calculation."[2] Although the issues had the same issue statement, the argument section, on its face, appeared to describe the issues differently.

Indian River failed to detail in its Individual Appeal Request which adjustment number(s)

[1] Although Indian River specified in its Individual Appeal Request that it was appealing from an *original* NPR, it actually appealed from a *revised* NPR. *See* Request for Medicare Appeal Model Form A ("Model Form A") at 1, May 8, 2009.
[2] Individual Appeal Request Tab 3 at 1-2, May 8, 2009.

it was appealing.[3] Indian River also failed to include a copy of its RNPR and Audit Adjustment Report, which it acknowledged in its cover letter to the Board. Indian River wrote, "[o]ur package, however, does not include Exhibits 1 and 4 as we are still in the process of obtaining copies of the Notice of Program Reimbursement and the audit adjustment report from the Provider. These will be sent to you in due course."[4]

In order to follow up with the missing documents, the Board sent an e-mail to Indian River on May 11, 2009, indicating that the Individual Appeal Request failed to supply the Board with a copy of the final determination and a copy of the audit adjustment pages.[5] The e-mail stated:

> We note that the Provider's hearing request failed to supply the Board with the following information:
>
> ____ A copy of the final determination being appealed.
> ____ A copy of the audit adjustment pages relating to the issue(s) in dispute, if applicable. ***NOTE: Tab 1 did not have any documents attached.***
>
> Please submit the information checked above within 30 days of the date of this letter, or your appeal will be dismissed. Please consult the Board's instructions for the detailed explanations regarding the filing of this information.[6]

Indian River sent correspondence to the Board on May 12, 2009. Indian River wrote, "[f]urther to our letter dated May 7, 2009 enclosing a request for Medicare appeal for the above referenced fiscal year, attached herewith are copies of the relevant Notices of Program Reimbursement dated 11/10/08 and 1/20/09 that were not included with the original appeal."[7] Indian River, however, never submitted its Audit Adjustment Report to the Board.

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[3] *See id.* Tabs 3-4.
[4] Individual Appeal Request Cover Letter, May 8, 2009.
[5] Board e-mail to Indian River, May 11, 2009.
[6] *Id.* (emphasis in original).
[7] Indian River letter to Board, May 12, 2009.

Board Determination

SSI Realignment

Although not separately listed as an appealed issue, Indian River argued that, "[t]he Provider may exercise its' [sic] right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period."[8] However, any SSI realignment request must first go to the contractor. Here, there is no indication that First Coast issued a determination regarding realignment. Therefore, the Board dismisses this issue from the appeal.

DSH SSI%

The Board finds that the two DSH SSI% issues, as originally appealed, should not be considered separate issues. Indian River argued, under Issue 1, that the SSI% was "... incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in [its] calculation."[9] Under Issue 2, Indian River set forth several contentions: (1) that it does not have access to all of the necessary data to verify that its SSI% is correctly calculated; (2) that the denominator of the DSH Medicare fraction should include only Medicare-paid days; (3) that CMS may have failed to include all patients in the SSI%; (4) that the match process is flawed; and, (5) that the SSI% is "deflated due to the inclusion of both Medicare Part A and Part B days."[10] The Board finds that the underlying dispute surrounds CMS' calculation of Indian River's SSI%, which is one issue for appeal purposes. Therefore, the Board is consolidating the two SSI% issues.

The Board requires certain documentation from a provider filing an appeal. Board Rule 6.1 states, "[t]o file an individual appeal (1) complete Model Form A – Individual Appeal Request – Initial Filing and (2) include all supporting documentation listed on the request."[11] Further, Board Rule 7.1(B) provides: "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."[12]

First, the provider is required to identify the adjustment number it is appealing. The Board Rules and Model Form A's instructions clearly indicate that an adjustment must be

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[8] Individual Appeal Request Tab 3 at 1.
[9] *Id.*
[10] *Id.* at 2-4.
[11] Board Rule 6.1 at 5, Aug. 21, 2008.
[12] Board Rule 7.1 at 5.

identified in order for a provider to have a valid appeal. Board Rule 7.1(A) states, "[g]ive a concise issue statement describing the adjustment, including the adjustment number . . . "[13] These requirements are also outlined on Model Form A (emphasis in original):

> UNDER A **TAB LABELED 3** YOU MUST SUBMIT A STATEMENT FOR EACH ISSUE. The statement of the issue must conform to the requirements of the regulations found at 42 CFR § 405.1835 et seq. and the Board's Rules and include: . . . the audit adjustment numbers . . . [14]

Second, the provider is required to include the elements described in 42 C.F.R. § 405.1835(b) (2008) in its hearing request. Those elements applicable to this case are described as:

> (1) A demonstration that the provider satisfies the requirements for a Board hearing . . . including a specific identification of the [contractor's] . . . determination under appeal.
> (2) An explanation (for each specific item at issue . . .) of the provider's dissatisfaction with the [contractor's] . . . determination under appeal . . .
> (3) A copy of the [contractor] . . . determination under appeal, and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements . . . . [15]

If the provider submits a hearing request that does not meet the requirements of this regulation, the Board may dismiss the appeal with prejudice, or take any other remedial action it considers appropriate.[16]

The rules cited above are especially important in the context of a RNPR appeal. Since different regulations apply to RNPRs, it is imperative that the Board receive a copy of the necessary audit adjustment report pages in order to verify that it has jurisdiction over a particular issue. The regulation states:

> (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

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[13] *Id.*
[14] Model Form A at 2.
[15] 42 C.F.R. § 405.1835(b)(1)-(3) (2008).
[16] 42 C.F.R. § 405.1835(b).

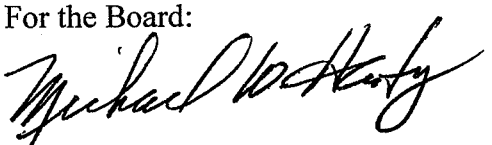
> determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the 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.[17]

Here, Indian River never submitted the documentation necessary (its Audit Adjustment Report), or the adjustment numbers in dispute, in order for the Board to make a jurisdictional determination on the SSI% issue. Instead, Indian River wrote "See Tab 4" where it was required to identify an adjustment number, and included a copy of its entire cost report behind Tab 4.[18] The Board finds this unacceptable and contrary to Board Rules. Moreover, Indian River was given the opportunity to supplement the record, yet it still did not provide its Audit Adjustment Report.

Indian River provided no way for the Board to verify that the issue under appeal was specifically revised in its RNPR. Additionally, if Indian River did not have access to that information, it was required to explain to the Board why it lacked access. Since the Board did not receive the required documentation, the Board hereby dismisses this appeal and closes the case. Review of this jurisdictional decision is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1835(a) 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: Sharon L. Keyes, Executive Director, BCBSA (without enclosures)

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[17] 42 C.F.R. § 405.1889.
[18] *See* Individual Appeal Request Tabs 3-4.

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Phone: 410-786-2671
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Refer to: 14-2856

CERTIFIED MAIL

AUG 17 2015

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

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

RE: Jurisdictional Decision
Parkview Medical Center
Provider No.: 06-0020
FYE: 6/30/2010
PRRB Case No.: 14-2856

Dear Mr. Ravindran and Mr. Tisdale:

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

Parkview Medical Center was issued a Notice of Program Reimbursement ("NPR") for FYE 06/30/2010 on September 6, 2013. On March 5, 2014, the Provider filed an appeal request with the Board in which it appealed the following issues:

1. DSH/SSI Percentage (Provider Specific) – Recalculation of SSI% based upon the Provider's cost reporting period;
2. DSH/SSI Percentage (Systemic Errors);
3. DSH – Medicaid Fraction/Medicare Managed Care Part C Days;
4. DSH – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days;
5. DSH – SSI Fraction/Medicare Managed Care Part C Days;
6. DSH – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days;
7. Rural Floor Budget Neutrality Adjustment (RFBNA).

NOTE: The RFBNA issue has been withdrawn from the appeal.

The Medicare contractor challenged the Board's jurisdiction over the RFBNA issue on July 10, 2014. The Provider withdrew the RFBNA issue on March 2, 2015, therefore the challenge is moot.

On September 22, 2014, the Provider requested to transfer the following issues to group appeals:

Issue:	Number of case transferred to:
DSH SSI Percentage	14-1815G
DSH SSI Fraction Dual Eligible Days	14-1816G
DSH Medicaid Fraction Dual Eligible Days	14-1818G
DSH SSI Fraction Medicare Managed Care Part C Days	14-1820G
DSH Medicaid Fraction Medicare Managed Care Part C Days	14-1822GC

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 March 5, 2014 and dismisses the issue from case number 14-2856. 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. ... The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves 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 14-1815G. 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 14-2856 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 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

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

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 14-2856.

Since the SSI Percentage (Provider Specific) issue was the sole remaining issue in the individual appeal, case number 14-2856 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
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

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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Refer to: 10-1195GC

CERTIFIED MAIL

AUG 18 2015

Jeffery R. Reid
Sharp Healthcare
Finance
8695 Spectrum Center Boulevard
San Diego, CA 92123-1489

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

RE: Group Name: Sharp HC FFY 2002 DSH - Dual Eligible Days
FYE: 09/30/2002
PRRB Case No.: 10-1195GC

Dear Mr. Reid and Ms. Kalafut,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documentation submitted in the above-captioned case. The Board determined that (1) Sharp Memorial Hospital will be dismissed for lack of jurisdiction; (3) Sharp Chula Vista Medical Center will be remanded pursuant to CMS Ruling 1498-R; and, (3) Part C days will be dismissed from the appeal. The Board hereby closes this case.

Background

The hearing request for the establishment of the group appeal was filed with the Board on July 29, 2010. The issue statement read:

> Whether the days for patients not entitled to Medicare Part A such as Medicare Advantage and Medicare Exhausted Benefit should be included in the Medicaid percentage for the Disproportionate Share Hospital (DSH) Adjustment.[1]

The Group Representative included two providers on the Schedule of Providers: Sharp Chula Vista Medical Center (Provider No. 05-0222) and Sharp Memorial Hospital (Provider No. 05-0100). Both of these providers established individual appeals prior to the group appeal request. The Group Representative stated that the providers added the group issue on October 18, 2008,

[1] Group Appeal Request letter to Board, Jul. 29, 2010.

and then transferred the issue to the group appeal on July 27, 2010.[2]

Sharp Chula Vista Medical Center (Prov. No. 05-0222)

Sharp Chula Vista Medical Center ("Sharp Chula Vista") appealed from its September 26, 2006 Notice of Program Reimbursement ("NPR") on March 22, 2007. In its individual appeal request, Sharp Chula Vista appealed several issues, including "Issue 4: DSH Excluded Dual Eligible days."[3] Sharp Chula Vista described its position as follows:

> The provider claims that patients entitled to Medicare part [sic] A and Medicaid (dual eligible claims) that have not been included in the SSI entitled Medicare patient days should be examined to determine if they are entitled to SSI and included in the SSI percentage if determined to be SSI entitled. If the claims are not entitled to SSI but are eligible for Medicaid, regardless of whether or not they are entitled to Medicare Part A benefits during their hospital inpatient stay, they should be included in the Medicaid percentage of the DSH adjustment. In addition, claims where Medicare benefits are exhausted should be included in the Medicaid percentage if they are not SSI entitled. . . . .[4]

The Board established Case No. 07-1572 for Sharp Chula Vista's individual appeal.[5]

The Group Representative included an Add Request for Case No. 07-1572 in the Schedule of Providers.[6] This requested the following issue be added to the individual case: "Whether the California Department of Health Services reported all Title XIX Medi-Cal Eligible patients."[7]

The Transfer Request, submitted along with the documents to establish the group appeal, stated:

> The Provider requests to transfer the issue of Medicare [DSH] Dual Eligible Days to a Group Appeal from the above referenced individual appeal of the Provider to a group appeal [sic]. The issue to be transferred is Issue 4:
>
> Whether the Medicare Benefit Exhausted patient days eligible for Medi-Cal and the Medicare Advantage (MC+C) days should be included in the Medicare ratio, the Medicaid ratio, or excluded from the [DSH] Adjustment.[8]

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[2] *See* Schedule of Providers Tab 2, Jul. 29, 2010.
[3] Sharp Chula Vista's Individual Hearing Request at 3, Mar. 22, 2007.
[4] *Id.* at 7.
[5] *See* Schedule of Providers Tab 2F-1 ("April 6, 2007 Acknowledgement and Critical Due Dates letter").
[6] Schedule of Providers Tab 2G-1.
[7] *Id.* at 1.
[8] Schedule of Providers Tab 2G-2 at 1 ("July 27, 2010 Request to transfer an issue to Group Appeal letter")

Sharp Memorial Hospital (Prov. No. 05-0100)

Sharp Memorial Hospital ("Sharp Memorial") appealed its November 21, 2007 NPR to the Board on May 19, 2008.[9] Sharp Memorial appealed four issues, but it did not appeal dual eligible days or Part C days in its individual appeal.[10] The Board established Case No. 08-1937 for Sharp Memorial's individual appeal.[11]

The Group Representative attached an Add Request for Case No. 08-1937, which requested to add Title XIX days to its individual appeal.[12]

The Group Representative also included a Transfer Request, which requested that:

> The issue to be transferred is Issue 5
>
> Whether the Medicare Benefit Exhausted patient days eligible for Medi-Cal and the Medicare Advantage (MC+C) days should be included in the Medicaid ratio, the Medi-Caid [sic] ratio, or excluded from the [DSH] Adjustment.[13]

On April 30, 2012, the Group Representative sent its proof of filing its Preliminary Position Paper to the Board. The cover letter stated, "[t]he case has a component that may be governed by CMS Ruling 1498-R (Medicare Exhausted Benefit Days) but also has components that are not governed by CMS Ruling 1498-R (Medicare +C days, Medicare Part B only days)."[14]

Board's Determination

The Group Representative claims that dual eligible and Part C days were added by each provider on October 18, 2008, but the Board finds this to be inaccurate. Instead, the providers added Title XIX days to their respective individual appeals. There is no evidence that there were any other Add Requests submitted by the providers. Therefore, in order to have valid appeals of both dual eligible days and Part C days, the two providers must have appealed these issues in their individual appeal requests.

Sharp Memorial (Prov. No. 05-0100) did not include a dual eligible days or Part C days issue in its individual appeal request. Sharp Memorial's Transfer Request, filed on July 27, 2010,

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(emphasis omitted).
[9] Schedule of Providers Tab 2B-2.
[10] *Id.*
[11] Schedule of Providers Tab 2F-2 ("May 23, 2008 Acknowledgement and Critical Due Dates e-mail").
[12] *See* Schedule of Providers Tab 2G-2.
[13] Schedule of Providers Tab 2H-2 at 1 ("July 27, 2010 Request to transfer an issue to Group Appeal").
[14] Group Preliminary Position Paper letter at 1, Apr. 30, 2012.

requests to transfer Issue 5, which the Group Representative stated was a dual eligible exhausted benefits and Part C days issue. The Board finds that there was no "Issue 5" in Sharp Memorial's individual appeal, nor was there evidence offered that the issues of dual eligible days and Part C days were properly added.

The 2008 Board Rules state that, subject to the provisions of 42 C.F.R. § 405.1835(c), an issue may be added to an individual appeal by (a) timely filing a Model Form C, and (b) including all supporting documentation listed on such request.[15] 42 C.F.R. § 405.1835(c) (2008) provides:

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

The Board finds that Sharp Memorial's Transfer Request cannot be considered an Add Request of the dual eligible days and Part C days issues. Therefore, since Sharp Memorial never properly appealed or added these issues, the Board hereby dismisses this provider from the appeal.

Sharp Chula Vista did appeal dual eligible days in its individual appeal request (Issue 4); however, there was no mention of Part C days in its argument. Nonetheless, since dual eligible days were a part of its individual appeal request, this issue was properly included. Sharp Chula Vista requested to transfer the dual eligible days issue (Issue 4) on July 27, 2010. Therefore, the Board finds that it was properly appealed and transferred to the instant group appeal. The Board concludes that it has jurisdiction over Sharp Chula Vista's dual eligible days issue and will remand this issue under separate cover pursuant to CMS Ruling 1498-R.

As previously mentioned, Sharp Chula Vista's individual appeal request did not raise Part C days. Further, Sharp Chula Vista failed to properly add Part C days to its appeal. According to regulation, Sharp Chula Vista's Transfer Request is not timely, nor is it in the proper form of an Add Request as required by Board Rules. Moreover, the Transfer Request misrepresented the way Issue 4 was framed in Sharp Chula Vista's individual appeal request, and is not an

[15] Board Rule 11.1 at 8, Aug. 21, 2008.

acceptable "Add Request" of Part C days. The Part C days issue was never included in Case No. 07-1572 in order for the Board to honor Sharp Chula Vista's request to transfer Part C days. Therefore, the Board determines that Sharp Chula Vista does not have a valid appeal of Part C days.

The Group Representative's request to bifurcate the dual eligible days issue is denied. Following the remand of Sharp Chula Vista's dual eligible days pursuant to CMS Ruling 1498-R, the group appeal will be closed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 1877.

Board Members
Michael W. Harty
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: Sharon L. Keyes, BCBSA (without enclosures)

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Refer to:

CERTIFIED MAIL

AUG 19 2015

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

RE: Jurisdictional Decision – on revised NPR appeals for
Baylor Medical Center - Garland (45-0280), FYE 12/31/1999 and
Baylor University Medical Center (45-0021), FYE 6/30/2002

As participants in QRS BHCS 1997- 9/30/2004 DSH Dual Eligible Days CIRP Group,
PRRB Case No.: 09-0540GC

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the jurisdictional documents in the above-referenced common issue related party (CIRP) group appeal which is subject to CMS Ruling 1498-R. The Board notes an impediment to jurisdiction over two of the participants in the group. The background and the Board's jurisdictional determination are set forth below.

Background

Baylor Medical Center - Garland (Participant 8)

The Provider was issued a revised Notice of Program Reimbursement (RNPR) on October 7, 2004. On March 24, 2005 the Provider filed an individual appeal of the RNPR to which the Board assigned case number 05-1231. In a letter dated November 26, 2007, the Provider added the Dual Eligible Days issue to its individual appeal and requested that it be transferred to the subject group appeal. The Representative did not provide copies of the audit adjustment pages of the RNPR, nor did it supply any of the other documentation required to support an adjustment to Dual Eligible Days on the RNPR.

Baylor University Medical Center (Participant 11)

The Provider was issued a RNPR on April 23, 2010. On October 19, 2010, the Provider filed a Model Form E – Request to Join An Existing Group Appeal: Direct Appeal From Final Determination. The Provider referenced audit adjustment #1 which is "To adjust Medicaid days and DSH % per audit findings." No other documentation was submitted in support of the adjustment.

Board's Decision

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

Although the Intermediary did not file a jurisdictional challenge, the Board nonetheless finds that it does not have jurisdiction over Baylor Medical Center – Garland's and Baylor University Medical Center's RNPR appeals. The applicable regulations explain that a revised NPR is considered a separate and distinct determination, and, depending on when the revised NPR was issued, the issue on appeal must have been either reviewed[1] or revised[2] as a prerequisite for Board jurisdiction. In this case, the documentation is not sufficient to document that Dual Eligible Days were either reviewed or revised for Participants 8 or 11.

Therefore, Baylor Medical Center – Garland (Participant 8) and Baylor University Medical Center (Participant 11) are hereby dismissed from case number 09-0541GC. 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.

Enclosed, please find a Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R for the remaining participants in the group.

Board Members Participating:
Michael W. Harty
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD
Michael W. Harty
Chairman

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[1] 42 C.F.R. § 405.1885, 1889 (2004); *see also HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding 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 *Emanuel Med. Ctr., Inc. v. Sebelius*, No. CV 12-1962 (GK), 2014 WL 1557524 (D.D.C. Apr. 17, 2014) (holding that an "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).

[2] 42 C.F.R. § 405.1885, 1889 (2008), "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" (emphasis added).

Enclosures:
42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Standard Remand of Medicare Dual Eligible Days Under CMS Ruling CMS-1498-R
Schedule of Providers

cc: Sharon L. Keyes, Executive Director, BCBSA (w/enclosures)
Bill Tisdale, Novitas Solutions, Inc. (w/enclosures)

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CERTIFIED MAIL AUG 21 2015

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

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

RE: **Coral Springs Medical Center**
Provider Number: 10-0276
FYE: 6/30/2007
Case Number: 09-0956

Dear Mr. Ravindran and Mr. Pike:

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

Pertinent Facts:

The Provider timely filed its individual appeal request on February 26, 2009, from an original Notice of Program Reimbursement (NPR) dated September 22, 2008. The Provider appealed the following issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – SSI Percentage (Systemic Errors)
3. DSH – Medicaid Eligible Florida Charity Care Days

On May 15, 2009, the Provider submitted a request to add the DSH – Medicaid Eligible Labor Room Days issue to its individual appeal and also submitted three separate requests to transfer the following issues:

1. DSH – Medicaid Eligible Florida Charity Care Days to Group Case No. 09-1770GC
2. Medicaid Eligible Labor Delivery Room Days to Group Case No. 09-1772GC.
3. DSH – SSI Percentage (Systemic Errors) to Group Case No. 09-1769GC.

Provider Reimbursement Review Board
PRRB Case No. 09-0956

In a letter dated August 3, 2010, the Board transferred the DSH–Labor Delivery Room Days from CIRP Group Case No. 09-1772GC back to this individual appeal, as the Provider was the only Provider in the CIRP Group appeal. The two issues remaining in this appeal are DSH–SSI (Provider Specific) and DSH–Labor Delivery Room Days issue, which is subject to remand under CMS Ruling 1498-R.

Board Determination:

DSH-SSI (Provider Specific):

The Board finds that it does not have jurisdiction over the SSI Realignment issue in this appeal, as this issue is premature. 42 C.F.R. §405.1835 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."

In this case, there was no final determination made by the Intermediary and the Provider has not yet decided whether it will request realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data.

DSH-Labor Delivery Room Days

The DSH-Labor Delivery Room Days issue is subject to remand under CMS Ruling 1498-R. The remand of the Labor Delivery Room Days issue will be handled under separate cover.

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
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:
Michael W. Harty
Chairman

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

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AUG 21 2015

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RE: HRS FFY 2014 2 Midnight Rule Group Appeal,
PRRB Case No. 14-2165G
HRS Prime Healthcare FFY 2014 2 Midnight CIRP Group Appeal,
PRRB Case No. 14-2166GC
HRS ProMedica Health System FFY 2014 2 Midnight CIRP Group Appeal,
PRRB Case No.14-2167GC
HRS SCHS FFY 2014 2 Midnight CIRP Group Appeal,
PRRB Case No. 14-2304GC
HRS ECHN FFY 2014 Two Midnight CIRP Group Appeal,
PRRB Case No. 14-2451GC
HRS Lafayette General Health FFY 2014 2-Midnight CIRP Group Appeal,
PRRB Case No. 15-2999GC

Dear Ms. Goron:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 22, 2015 and July 29, 2015 requests for expedited judicial review (received July 24, 2015 and July 31, 2015, respectively).[1] The decision of the Board with respect to the EJRs is set forth below.

Issue

In these cases, the Providers are challenging the validity of the Secretary's 0.2 percent reduction to the Inpatient Prospective Payment System (IPPS) rates. The issue contained in the hearing requests and requests for EJR is:

> Whether the provision in the Fiscal Year 2014 Inpatient Prospective Payment System ("IPPS") Final Rule ("Final Rule") that imposes that imposes a .2 percent decrease in the IPPS rates for all IPPS hospitals for each of FYs 2014 - 2018 is procedurally invalid, arbitrary and capricious, and outside the statutory authority of the Centers for Medicare & Medicaid Services ("CMS").[2]

[1] The EJR request for case number 15-2999GC was dated July 29, 2015. The EJR requests for the remaining cases were dated July 22, 2014.
[2] Providers' Hearing Requests, various dates, Ex. 2.

Statutory and Regulatory Background

In the final IPPS rule for Federal fiscal year (FFY) 2014, the Secretary of Health and Human Services (Secretary) indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (OPPS) rule[3] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services. In recent years, the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours increased from approximately 3 percent in 2006 to 8 percent in 2011. This raised a concern about the financial impact on Medicare beneficiaries who may incur greater financial liability than they would if they were admitted to the hospital as inpatients.[4]

The Secretary noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied because the Medicare review contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[5]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary. The timely filing restrictions for Part B billing were not changed (claims must be filed within one year from the date of service).[6]

Medicare Part A

In addition, the Secretary reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. The Medicare Benefit Policy Manual[7] states that the typical decision to admit a beneficiary as an inpatient should be made within 24 to 48 hours after observation care and that an overnight stay may be a factor in the admission decision.

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[3] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[4] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[5] *Id.*
[6] *Id.*
[7] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.

Physicians should use the 24-hour or overnight period as a benchmark, i.e., patients who are expected to need care for 24 hours or overnight should be admitted. Generally, a beneficiary is considered an inpatient if formally admitted with the expectation that he or she will remain in the hospital overnight, regardless of whether there is a later transfer or discharge resulting in no overnight patient stay. Only rarely and in exceptional cases do reasonable and necessary observation services span more than 48 hours. Length of stay is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[8]

In the FFY 2014 IPPS proposed rule,[9] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[10]

Medicare Part B

In the final IPPS rule, the Secretary noted there had been an increasing number of hospitals appealing Part A inpatient claim denials in which it was determined the inpatient admissions were not reasonable or necessary. These claims received partial favorable treatment by the Medicare Appeals Council or Administrative Law Judges (ALJs). In those cases, the Medicare review contractor determinations that the inpatient admission was not reasonable or necessary was upheld, however, the Medicare Appeals Council and ALJ decisions ordered payment of the services as if they were rendered in an outpatient or observation level of care. These decisions effectively required Medicare to issue payment for all Part B services that would have been payable had the patient been treated as an outpatient (rather than an inpatient). In addition, payments were made regardless of whether or not the subsequent hospital claims were within the applicable time limit for filing Part B claims. The Secretary pointed out that this was contrary to longstanding polices that permitted billing for only a limited list of Part B inpatient services and required that the services be billed within specific timeframes.[11]

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[12] (the Ruling) which established a standard process for effectuating the decisions granting Part B coverage. Among other things, where the administrative adjudicator had issued an order for payment under Medicare Part B, the request for Part B payment would not be rejected if more than one year had elapsed (the time period for filing Part B claims), if the

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[8] 78 Fed. Reg. at 50,907-08.
[9] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[10] 78 Fed. Reg. 50,908.
[11] *Id.*
[12] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.

Part A claim had been submitted timely. The Ruling was to remain in effect until the effective date of regulations that finalized "Medicare Program; Part B Billing in Hospitals." In the August 19, 2013 Federal Register, the Secretary revised the Part B inpatient payment policy to allow payment of all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient, except for those services that specifically require outpatient status.[13] The 1-year deadline for filing claims remained unchanged and the Secretary stated that she was not creating an exception to this requirement (as found in 42 C.F.R. §§ 424.44(b)(1)-(4)) even though the contractor claims review and appeal process could exceed the 1-year filing period.[14]

The 2-Midnight Rule

In the final IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule included instructions that provided a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designates services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects the beneficiary to require a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided and is based on the judgment of the physician and the physician order (the physician must certify that the inpatient services were medically necessary).[16] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[17]

The Secretary's actuaries estimated that the 2-midnight rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient from the approximately 11 million encounters paid under IPPS. This shift of 40,000

[13] 78 Fed. Reg. at 50,909.
[14] *Id.* at 50,927.
[15] *Id.* at 50,944.
[16] *Id.*
[17] *Id.* at 50,945.

net encounters represents an increase of approximately 1.2 percent in the number of shorter stay hospital inpatient encounters paid under IPPS. This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay hospital inpatient encounters to hospital outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these hospital outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters. In light of the impact of the 2-midnight rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-midnight policy. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19]

Providers' Request for EJR

The Providers believe EJR is appropriate because the Board lacks the power to reverse the 0.2 percent reduction. The Providers note that in the final IPPS rule, published in the August 19, 2013 Federal Register, the Secretary instituted the 2-midnight policy whereby a hospital stay would be deemed to be inpatient-appropriate if the ordering physician reasonably expects the patient to be in the hospital at least 2 midnights. The Providers believe that if a patient is in the hospital past 2 midnights, CMS contractors will presume that the stay is an appropriate inpatient stay and [be less likely] to audit the hospitals records. Conversely, the Providers contend that one-night stays are per se not inpatient-appropriate unless the patient received a procedure on the "inpatient-only" list of procedures. Further, the Providers point out that the Secretary estimates her 2-midnight policy would increase IPPS operating and capital expenditures by approximately $220 million. In order to offset this amount, the Secretary, applied a 0.2 percent reduction to the operating IPPS standardized amount, the hospital specific rates, the Puerto Rico-specific standardized amount, and a 0.2 percent reduction for capital IPPS, using her authority in 42 U.S.C. §§ 1395ww(d)(5)(I)(1) and 1395ww(g).

The Providers believe the 0.2 percent reduction is susceptible to challenge on the following grounds:

> The decision to impose a $220 million (more correctly, the 0.2 percent reduction) is arbitrary and capricious because:
>
> (1) It relies on faulty assumptions and is not adequately explained;
>
> (2) It does not adequately take into account the payment reductions made by the Part B inpatient policy; and

[18] *Id.* at 50,952-53.
[19] *Id.* at 50,990.

> (3) It does not provide any mechanisms for making adjustments to, or reversing the effects of the payment cut if the [Secretary's] estimate is incorrect.

Faulty Assumptions

The final IPPS rule states that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, resulting in a net gain of 40,000 inpatient stays. The Providers maintain that the final rule does not give much detail regarding how the estimate of a net gain of 40,000 inpatient stays was calculated, other than the Secretary's actuaries based their estimate on FY 2011 claims data. The final rule does not explain the number of claims that were examined or how the data was used. Instead it states that:

> In determining the estimate of the number of encounters that would shift from outpatient to inpatient, our actuaries examined outpatient claims for observation or a major procedure. Claims not containing observation or a major procedure were excluded. The number of claims spanning 2 or more midnights based on the dates of service that were expected to become inpatient was approximately 400,000. This estimate did not include any assumption about outpatient encounters shorter than 2 midnights potentially becoming inpatient encounters.
>
> In determining the estimate of the number of encounters that would shift from inpatient to outpatient, our actuaries examined inpatient claims containing a surgical MS–DRG. Claims containing medical MS–DRGs were excluded. The number of claims spanning less than 2 midnights based on the length of stay that were expected to become outpatient, after excluding encounters that resulted in death or transfers, was approximately 360,000.[20]

The Providers believe that this indicates that the Secretary is assuming that any claims for which the time in the hospital spanned 2 or more midnights would become inpatient claims under the 2-midnight policy and any claims for which the time in the hospital did not span 2 midnights would be outpatient claims. These assumptions were not justified by the Secretary.

In particular, the Providers assert these assumptions will not prove to be valid in light of the Medicare "Part B Inpatient" policy announced in the August 19, 2013 final IPPS rule.[21] This rule provides that if a hospital bills an encounter as an inpatient stay, and the Recovery Audit Contractor (RAC) or other Medicare contractor subsequently determines that the inpatient stay

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[20] 78 Fed. Reg. at 50,953.
[21] *See generally* 78 Fed. Reg. at 50,914-38.

was not reasonable and necessary and that the beneficiary should have been treated on an outpatient basis instead, the hospital may rebill for services under Part B, but must do so within 12 months of the date of service. As a practical matter, following reopening by a RAC or other contractor, hospitals will never, or almost never, be able to rebill under Part B because the reopenings almost always occur more than 12 months after the patient is discharged. The Providers are concerned that short stays, including stays spanning 2 midnights, will denied under Medicare Part A and they will be unable to rebill under Part B within the 12-month window for filing claims. As a result, they may initially bill some of the stays exceeding 2 midnights under Part B. In addition, even if the patient was admitted and the stay was expected to span 2 midnights, the claim may be billed under Part B due to lack of documentation to support billing under Part A. Further, certain stays lasting less than 2 midnights will be billed under Part A. Some of these stays will be allowed under audit (or not audited and paid), but others will denied because the physician's assumption that the patient stay would exceed 2 midnights was not reasonable or sufficiently documented.

In addition, the Providers contend that there may be other fault assumptions upon which the Secretary relied but cannot be identified due to lack of sufficient details in the final IPPS rule about the estimation. For example, the Providers do not know if the actuaries included claims denied on reopening and what adjustments, if any, were made where FY 2011 claims were still within the 3-year reopening period. The Providers do not know if the Secretary assumed that the same rate of allowance/denials that occurred in previous years under different policies for inpatient admissions and rebilling under Part B would apply, or if some other rate was used.

Reductions Made as the Result of Part B Inpatient Policy

The Providers assert that even if the 2-midnight policy does result in an increase in Part A payments of $220 million per year, the Secretary projects that the closely related Inpatient Part B policy reduces Medicare payments by almost a billion dollars a year. However, there is no increase in payment to take into account with the reduced Part B payments (estimated at $4.8 billion in Part B inpatient expenditures or $4.6 billion over 5 years).[22] The Providers believe the Secretary should also increase Part B rates to account for this decrease in payments, but the Secretary indicated that the reduction in Part B payments would be offset by the cost of ALJ decisions and CMS Ruling 1455-R, which allows appeals outside the timely filing period. The combined impact of the Part B inpatient billing policy, appeals decisions and CMS Ruling 1455-R would be approximately $1.260 billion over calendar years 2013 to 2017.[23] The Providers find this calculation odd because the Ruling applies only for denials of service furnished before October 1, 2013. The Providers note that the Secretary does not include an explanation regarding the number of existing appeals to which the Ruling would apply, or the number of determinations

[22] 78 Fed. Reg. 16,632, 16,633 (Mar. 13, 2013) (we estimate the final [Part B Inpatient] policy will result in an approximately $4.8 billion decrease in Medicare program expenditures over 5 years) and 78 Fed. Reg. at 50,507 (Aug. 19, 2013) (with respect to the Part B Hospital Inpatient Payment Policy following the denial of Part A claims and subsequent billing to Part B, we estimate that the final Medicare expenditures will be reduced by $4.6 billion over 5 years).
[23] 78 Fed. Reg. at 50,954.

that would allow Providers to rebill. The Providers assert that the Part B policy is saving Medicare $4.6 billion over the next 5 years that it otherwise would have spent regardless of the effect of alleged offsets.

No Mechanism for Making Adjustments to, or Reversing the Effects of, Payments if the Estimate is Incorrect

The Providers believe that the estimate of an additional $220 million of IPPS expenditures is highly speculative because the Secretary acknowledged that the estimate is subject to a variety of factors. The Secretary noted that the actual costs or savings would depend substantially on unanticipated changes in hospital behavior and changes in inpatient and outpatient utilization.

The Providers believe that the Board lacks the authority to declare the 0.2 percent decrease in IPPS rates invalid, consequently EJR is appropriate.

Decision of the Board

The Board has reviewed the Providers' EJR requests, Schedules of Providers and jurisdictional documents. With respect to jurisdiction, the Board concludes that each of the Providers in the cases referenced above timely filed their requests for hearing from the issuance of the August 19, 2013 Federal Register.[24] The amount in controversy in each case exceeds the $50,000 threshold necessary for a group appeal.[25] The Board, therefore, has determined that it has jurisdiction over the appeals. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS is appropriate; consequently, EJR is appropriate for the issue under dispute in these cases.

The Board finds that:

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

2) based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount, there are no findings of fact for resolution by the Board;

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

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[24] *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year-end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *District of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare and Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

[25] *See* 42 C.F.R. § 405.1837(a)(3).

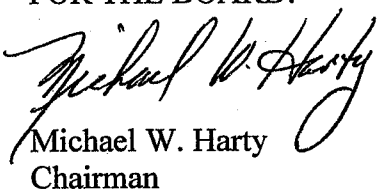
4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, is valid.

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

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

FOR THE BOARD:



Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1); Schedules of Providers

cc: Donna Kalafut, Noridian Healthcare Solutions (w/Schedules of Providers)
Judith E. Cummings, CGS Administrators (w/Schedules of Providers)
Kyle Browning, NGS (w/Schedules of Providers)
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Refer to: 05-2281

AUG 21 2015

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RE: Blumberg-Ribner 2001 Dual Eligible Days Group
PRRB Case No. 05-2281G

Dear Mr. Ribner and Mr. Browning:

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdictional documentation submitted in the above captioned case. The Board's jurisdiction decision regarding Provider 2 (Hershey Medical Center, Prov. No. 33-0259, FYE 12/31/2001) and Provider 7 (Saint Joseph's Medical Center, Prov. No. 33-0006 and FYE 12/31/2001) is set forth below.

Background

The group appeal was established on September 23, 2005. On July 15, 2013 the group representative requested Expedited Judicial Review (EJR) on behalf of the Providers. On August 13, 2013, the Board sent a development letter requesting that Participants 2 and 7 submit additional documentation related to these Providers' appeals from revised Notices of Program Reimbursement (NPR). The Board did not receive a response to the letter and on April 22, 2014 the Board denied the Providers request for EJR. Participants 5 and 9, Mercy Medical Center, Prov. No. 33-0259, FYE 12/31/2001 and Scripps Memorial Hospital – Chula Vista, Prov. No. 05-0270, FYE 9/30/2001, were transferred to Common Issue Related Party group appeals.

Hershey Medical Center (Prov. No. 33-0259, FYE 12/31/2001)

Hershey Medical Center, listed as Participant 2 on the Schedule of Providers, was issued its original NPR on September 17, 2003 and its revised NPR February 11, 2005. Participant 2 filed an appeal request from the original NPR on February 2, 2004. Participant 2 did not include Dual Eligible days issue in its original NPR appeal but requested to add the dual eligible days issue to its individual appeal and transfer the issue to this group on January 17, 2006. Participant 2 did not provide the request for hearing from the revised NPR.

Saint Joseph's Medical Center (Prov. No. 33-000, FYE 12/31/2001)

Saint Joseph's Medical Center, listed as Participant 7 on the Schedule of Providers, was issued an original NPR on September 16, 2001 and a revised NPR on January 17, 2006. Participant 7 appealed from the original NPR on March 14, 2005 and from the revised NPR on July 10, 2006. Participant 7 added the issue to the original NPR and transferred the issue to the group appeal on February 1, 2006.

The Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2005), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date the notice of the intermediary'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 (2006) 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 emotion 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, effective October 1, 2002, through May 22, 2008, stated:

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

In *HCA Health Services 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.

In this appeal, Participant 2 and 7 are appealing from both original and revised NPRs for the same fiscal year end. The Board has jurisdiction over the original NPRs pursuant to *Bethesda.*[1] However, the Board does not have jurisdiction over the appeals from revised NPRs because neither revised NPR specifically adjusted dual eligible days as required by the regulations for Board jurisdiction.

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[1] *Bethesda Hospital Ass'n v. Bowen,* 485 U.S. 399 (1988).

The Board hereby dismisses the revised NPR appeals for both Participant 2 and Participant 7. However, these Providers remain pending in case number 05-2281G because the Board has jurisdiction over the Providers' original NPR appeals.

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:
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Clayton J. Nix, Esq.
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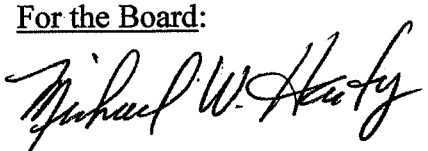
For the Board:



Michael W. Harty
Chairman

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

Cc: Sharon L. Keyes, BSBCA

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Refer to: 10-1047GC

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CERTIFIED MAIL

Toyon Associates, Inc.
Thomas P. Knight, President
1800 Sutter Street, Suite 600
Concord, CA 94520

National Government Services
Danene Hartley, Appeals Lead
MP INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206

RE: Essentia Health System 2006 DSH SSI MMA Section 951 CIRP Group
Prov. Nos.: 24-0002 and 24-0019
FYE: 6/30/2006
PRRB Case No.: 10-0147GC

Dear Mr. Knight and Ms. Hartley,

The Provider Reimbursement Review Board (Board) has reviewed the documents in the above-mentioned appeal. The Board finds that this appeal is moot based on the Centers for Medicare & Medicaid Services' (CMS) decision not to release SSI data for SSI percentages that will be, or already have been, recalculated.

Background

On November 19, 2009 the Providers filed this group appeal with the issue stated as "Whether CMS has arranged to furnish all data necessary for hospitals to compute the number of patient days used in computing the disproportionate patient percentage in accordance with Section 951 of the Medicare Modernization Act."

These Common Issue Related Party (CIRP) Providers also filed an appeal with the Board in which they appealed the DSH SSI Ratio issue. On October 23, 2013, PRRB case number 09-1671GC, the Essentia Health System 2006 SSI Ratio CIRP Group, was remanded to the Medicare contractor for recalculation of its SSI ratio pursuant to CMS Ruling 1498-R.

The Board requested that the Group Representative submit comments as to whether the issue raised in the DSH SSI Ratio appeal addressed a separate legal issue from the issue raised in the DSH SSI MMA Section 951 appeal. The Providers responded that the DSH SSI MMA appeal challenged the release of data that would allow the Providers to calculate their SSI ratio, while the DSH SSI Ratio appeal challenged the errors in the actual calculation made by CMS.

Board's Decision

The Board finds that while the DSH SSI MMA Section 951 appeal and the DSH SSI Ratio appeal contain separate legal issues, the remand of the DSH SSI Ratio appeal renders this DSH SSI MMA Section 951 appeal moot.

Section 951 of the Medicare Modernization Act instructs the Secretary of Health and Human Services to provide the data CMS used in calculating SSI ratios. The statute reads, in part:

> [T]he Secretary shall arrange to furnish . . . 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.

While the Providers might be entitled to the SSI ratio data under MMA § 951, CMS has since issued a notice in MLN Matters entitled, "The Supplemental Security Income (SSI) Ratios for Fiscal Year (FY) 2006 through FY 2009 for Inpatient Prospective Payment System (IPPS) Hospitals . . ."[1] This document explains that CMS has posted SSI Ratios for FYs 2006-2009 on the CMS website and that the SSI ratios include Medicare Advantage days and are calculated in accordance with CMS Ruling 1498-R. CMS also stated in this MLN Matters:

> Providers who are interested in obtaining the data used to calculate their FY 2006 – FY 2009 SSI ratios are encouraged to submit a Letter of Request . . . If you submitted a request when CMS was not accepting requests because these data were not available, you must submit a new request.
>
> ***
>
> Since CMS has published revised SSI Ratios, the previous requests for these cost report years are no longer valid.[2]

The Providers in this group appeal are also participants in case number 09-1671GC, which has been remanded to the Medicare contractor pursuant to CMS Ruling 1498-R. All of the Providers, therefore, will receive revised SSI Ratios, and as indicated in the MLN Matters, the previous requests for data for the relevant FY are no longer valid. Furthermore, the MLN Matters also indicates that CMS will not provide data for the old SSI Ratios, which is what the Providers in this appeal, case number 10-0147GC, are requesting. Therefore, because the Providers will receive new SSI ratios as a result of the remand of case number 09-1671GC, this appeal is moot. The Board hereby dismisses case number 10-0147GC.

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.

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[1] Medicare Learning Network Matters No. SE1225, *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1225.pdf.
[2] *Id.* at 2, 3.

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

For the Board:

Michael W. Harty
Chairman

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

cc: Sharon L. Keyes, BCBSA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 14-0247

AUG 25 2015

CERTIFIED MAIL

Quality Reimbursement Services, Inc.
James C. Ravindran, President
150 N. Santa Anita Avenue
Arcadia, CA 91006

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

RE: Parkview Medical Center
Provider No. 06-0020
FYE 06/30/2009
Case No. 14-0247

Dear Mr. Ravindran and Mr. Tisdale:

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

Background

The Medicare Contractor issued a Notice of Program Reimbursement (NPR) for FYE 06/30/2009 on April 24, 2013. On October 18, 2013, the Provider submitted an appeal request to the Board, appealing seven issues including SSI Percentage Provider Specific and SSI Percentage Systemic Errors. On June 19, 2014, the Provider transferred 5 of those issues to relevant mandatory CIRP groups, leaving the Rural Floor Budget Neutrality Adjustment issue and the SSI Provider Specific issue pending. The Provider withdrew the Rural Floor Budget Neutrality Adjustment Issue on February 27, 2015. The SSI Provider Specific issue is the only issue remaining in the appeal.

Board's Decision

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue, as the issue is premature. The SSI Provider Specific issue is a combined issue addressing SSI Systemic Errors percentage and SSI Realignment arguments. The Board finds that to the extent the Provider is arguing that the SSI Percentage is understated, and in need of the underlying data to determine what is or is not included; the issue is the same as the systemic issue in SSI Percentage Systemic Errors, which has been transferred to a group appeal. The basis of each SSI percentage issue is that the Provider does not have the underlying data, and cannot determine if the percentage is understated.

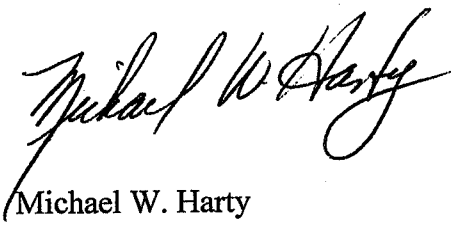
The other part of the SSI Provider specific issue is SSI Realignment. The Board finds that it does

not have jurisdiction over the Provider's appeal of SSI realignment. A Provider has a right to a Board hearing for specific issues covered by a final contractor determination.[1] In this case, the issue is premature because the Medicare Contractor has not yet issued a final determination and the Provider has not yet decided whether it will request realignment. Realignment is a remedy the Provider may pursue if it is dissatisfied with MEDPAR SSI data. Therefore, the SSI realignment issue is premature and the Board hereby dismisses the issue from this appeal. The case is hereby closed because the SSI Provider Specific Issue is the last remaining issue in Case No. 14-0247.

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
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

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

[1] 42 C.F.R. 405.1835.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to:

CERTIFIED MAIL

AUG 26 2015

Select Medical Corporation
Wade Snyder
Reimbursement Director
4714 Old Gettysburg Road
Mechanicsburg, PA 17055

RE: Select Medical Corp 2011-2012 SSI Fraction Medicare Part C Days CIRP
PRRB Case No. 15-2737GC

Dear Mr. Snyder:

The Provider Reimbursement Review Board (the Board) is in receipt of your request for a group appeal which was filed on June 10, 2015. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Select Medical Corp 2011-2012 SSI Fraction Medicare Part C Days CIRP group appeal was filed on June 10, 2015 with 5 participants (that all have pending individual appeals.) There was no supporting documentation submitted for the participants in the group (NPRs, audit adjustment pages, copy of individual appeal showing issue was appealed) nor did the Representative file transfer requests from the individual appeals.

The group was established and assigned case number 15-2737GC. An email acknowledgement letter was issued on June 11, 2015.

On June 17, 2015 the Group Representative emailed Board staff to advise that one of the provider numbers on the Model Form G submitted with the appeal request contained a typographical error. In the same letter, the Group Representative indicated that it wanted to withdraw the individual appeals filed on behalf of two of the participants (case numbers 14-3677 and 14-3692) if the MAC agreed to their jurisdiction as part of the group.

On June 24, 2015, the Board emailed the Group Representative regarding the deficiencies of the group appeal request. The Board advised that copies of the final determination, appeal request showing the issue was included, audit adjustment pages and Model Form D's (Transfer Requests) were missing. The Board advised that "absent a transfer request . . . and the appropriate supporting documentation to effectuate a transfer . . . , these groups have been formed with no participating providers. Therefore, the groups do not meet the requirements of Board Rule 12.5 as to minimum number of providers to form a group." The Representative was advised that it must submit a Transfer Request for at least the initial providers identified in the group or the group would be dismissed.

The Group Representative acknowledged receipt of the Board's Request for Additional Information by email on June 24, 2015.

To date there is no record of the Transfer Requests or the additional supporting documentation requested by the Board.

Board Determination:

After reviewing the facts in the case, the Board finds that the group appeal does not meet the filing requirements.

42 C.F.R § 405.1837(c) specifically requires the Provider to include a copy of the Intermediary determination under appeal with the timely group 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 group, Select Medical is filing a group appeal that does not meet the regulatory requirements.

Board Rule 12.1 also addresses documentation required when filing a group:

> To file a group appeal: (1) complete Model Form B – Request for Group Appeal, and (2) include all supporting documentation listed on the request. If the group is formed by a transfer from an existing individual appeal, complete Model Form D – Transfer and Model Form B.

Rule 14 further explains the acknowledgement of the group:

> The Group Representative and the Lead Intermediary selected by the Group Representative will receive an Acknowledgement via email from the Board indicating that the group appeal has been received and the case number assigned. If the Providers' 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 deficient.

Because the group appeal request was not filed in conformance with 42 C.F.R § 405.1835 and the Board Rules, the Board dismisses the group 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:
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson

For the Board:

Clayton J. Nix, Esq.
Board Member

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

cc: Bruce Snyder, Novitas Solutions, Inc.
Sharon L. Keyes, Executive Director, BC BS Association

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Refer To: 13-2142

AUG 27 2015

CERTIFIED MAIL

Bricker & Eckler LLP
James F. Flynn, Esq.
100 South Third Street
Columbus, OH 43215

CGS Administrators
Judith E. Cummings, Accounting Manager
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: PRRB Case No. 13-2142
Riverside Methodist Hospital
FYE 6/30/2008
Prov. No. 36-0006

Dear Mr. Flynn and Ms. Cummings:

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

Background

On April 26, 2013, Riverside Methodist Hospital (provider no. 36-0006, FYE 6/30/2008), filed an appeal with the following issue: "The resolution of issues raised by the provider on appeal regarding adjustments made in previous years is reasonably believed to affect the amount of program reimbursement that the provider should receive in this appealed year."

On May 12, 2014 the Medicare Contractor submitted a jurisdictional challenge based upon the lack of specificity, a failure to provide adjustments relating to the issue, and a failure to identify the amount in controversy. The Provider did not respond to this jurisdictional challenge.

Board's Decision

The Board finds that it does not have jurisdiction over Riverside Methodist Hospital because the Provider failed to specify what issues were being appealed or the amount in controversy and failed to submit an audit adjustment report.

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 (1) it is dissatisfied with the final determination of the Medicare Contractor, (2) the amount in controversy is $10,000 or more (or $50,000 for a group), and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

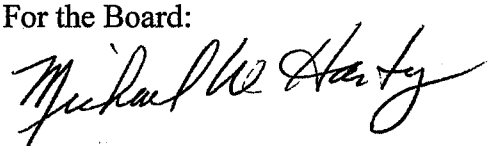
Further guidance and requirements for filing an appeal with the Board are outlined in the PRRB Rules (updated July 1, 2009). PRRB Rule 6.3 states: "An individual appeal request must have a total amount in controversy of at least $10,000. For each issue, provide a calculation or support demonstrating the amount in controversy." PRRB Rule 7 states: "For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction." If filing an appeal from a Notice of Program Reimbursement (NPR), Rule 7.1 requires a provider to give a concise statement describing the adjustment, including the adjustment number, why the adjustment is incorrect, and how the payment should be determined differently. Rule 8.1 (Framing Issues for Adjustments Involving Multiple Components, General) further provides that in order to "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 Rule 7."

The Provider failed to comply with PRRB Rules 6.3, 7.1, and 8.1. The Provider failed to provide audit adjustment reports or a calculation of the amount in controversy. The Provider further failed to provide a description as to how the payment should have been calculated. The Provider's issue statement lacked specificity. From the issue statement the Board was unable to make basic determinations such as whether the issue related to DSH, IME/GME, or other factors. The issue statement also failed to separate issues or describe sub-issues. The Board hereby dismisses case number 13-2142 due to a failure of the Provider to follow PRRB Rules, which required a specific issue statement, a calculation for the amount in controversy, and the attachment of supporting documentation.

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:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

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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Refer to: 08-2011GC

AUG 27 2015

CERTIFIED MAIL

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

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

RE: Blumberg Ribner 1998 SSI Percentage Group
PRRB Case No. 08-2011GC

Dear Mr. Blumberg and Ms. Kalafut:

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdictional documentation submitted in the above captioned case. The Board's jurisdiction decision regarding St. Joseph's Hospital Health Center (Prov. No. 33-0140, FYE 12/31/1998) is set forth below.

Pertinent Facts

On May 28, 2002 Saint Joseph's Hospital Health Center (Participant 3 on the Schedule of Providers) was issued a Notice of Program Reimbursement (NPR) for Fiscal Year End (FYE) 12/31/1998. Subsequently, on March 10, 2005, the Provider revised a revised NPR for the same FYE.

On March 10, 2005, the Board received the Provider's appeal request from its revised NPR which listed the following issues:

1) Disproportionate Share Payment (DSH) (Medicaid Percentage)
2) DSH SSI Proxy
3) Inpatient Part B Ancillary Charges

On May 23, 2008 the Board received a request to establish this group appeal, which included a request to add Provider 3 to the group appeal.

Board's Decision

Although Saint Joseph's Hospital Health Center included its original NPR date on the Schedule of Providers, the Provider has actually appealed from its revised NPR in this group.[1] The Board finds that it does not have jurisdiction over the Provider's revised NPR appeal because the SSI percentage was not specifically adjusted.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2004), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

[1] Saint Joseph's Hospital filed an appeal request from its original NPR on October 18, 2002. The Board assigned case number 03-0059 to the appeal and it was withdrawn on April 18, 2003. The Board assigned case number 05-1058 to the appeal filed from the revised NPR, which was in an open status at the time of the group formation.

dissatisfied with the final determination of the Medicare contractor, 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 the notice of the intermediary'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 (2006) provides, in relevant part:

> A determination of [a Medicare contractor] ... may be reopened with respect to findings on matters at issue in such determination or decision, by such [Medicare contractor] ..., either on motion of such [Medicare contractor] ...or on the emotion 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, effective October 1, 2002, through May 22, 2008, stated:

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

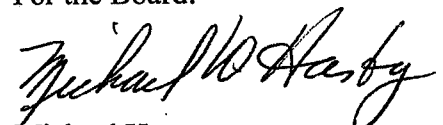
In *HCA Health Services v. Shalala,* 27 F.3d 614 (D.C. Cir. 1994), the Court held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited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

Based on the documents before the Board, Participant 3 appealed from a revised NPR that did not specifically adjust the SSI percentage. The Provider stated in its appeal request that it self-disallowed the SSI percentage; this does not meet the jurisdictional requirements of 42 C.F.R. §§ 405.1885 and 405.1889. The Board hereby dismisses Provider 3, St. Joseph's Hospital Health Center (Prov. No. 33-0140, FYE 12/31/1998) from case number 08-2011GC.

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:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Anderson, Esq.
Charlotte F. Benson, CPA
Jack Ahern, MBA

For the Board:



Michael Harty
Chairman

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

Cc: Sharon L. Keyes, BSBCA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Refer to: 04-1874G

CERTIFIED MAIL AUG 28 2015

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

Kyle Browning
Appeals Lead
National Government Services
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH DE Days Bifurcation to (1) Part A Non-Covered/Exhausted Benefits Days and (2) Part C Days**
PRRB Case No.: 04-1874G
FYE: 2001

Dear Ms. Erde:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. The Part C days issue will be adjudicated in Case No. 15-3223G, Duane Morris 01 Part C Days Group.[1] If the Board finds jurisdiction over providers appealing Part A Non-Covered and Exhausted Benefit days, those providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal, established in 2004, framed the issue as follows:

> Is the [Medicare Administrative Contractor's] exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either whose Medicare Part A benefits were exhausted or who received Part C benefits correct?[2]

[1] This letter will serve as the Acknowledgement Letter normally sent via e-mail. The parties will be informed of new position paper deadlines in a Notice of Hearing.
[2] Group Request for Hearing at 1, Jul. 13, 2004.

The list of providers for Case No. 04-1874G is in the table below.

Provider Number	Provider Name	Original Case Number	Request for Bifurcation?
36-0008	Southern Ohio	04-1220 (closed 10.20.09)	Yes, both Dual Elig. and Part C
39-0137	Wyoming Valley	04-1009 (closed 04.28.08)	Yes, both Dual Elig. and Part C
33-0108	St. Joseph	05-0418 (closed 03.31.05)	No, Dual Elig. Schedule only
33-0226	Unity	05-0407 (closed 05.19.05)	Yes, both Dual Elig. and Part C
33-0078	Sisters of Charity	Direct Add	Yes, both Dual Elig. and Part C
39-0168	Butler Memorial	05-0991 (closed 06.21.05)	Yes, both Dual Elig. and Part C
33-0066	St. Clare's	05-0707 (closed 07.14.09)	Yes, both Dual Elig. and Part C
33-0222	Saratoga	05-1174 (closed 06.28.05)	Yes, both Dual Elig. and Part C
33-0229	Brooks Memorial	05-0919 (closed 06.28.05)	Yes, both Dual Elig. and Part C

The group's Final Position Paper briefed both Dual Eligible Exhausted Benefits days and Part C days.[3]

On June 3, 2013, the Provider Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[4] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[5] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[6] However, not every provider was listed on both the Exhausted Benefits and Part C days' Schedules of Providers.

Board Determination on Bifurcation

The Board has granted the bifurcation request regarding the Dual Eligible issue into two groups:

(1) Dual Eligible Exhausted Benefits days
(2) Part C days

The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS

[3] *See* Final Position Paper, Feb. 1, 2006.
[4] *See* Case Management Plan Letter, Jun. 3, 2013.
[5] *See* Bifurcation Letter, Aug. 30, 2013.
[6] *Id.* at 1.

Rulings."[7] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). However, the Board has decided to treat the "multi-component" issue as a valid appeal because of the way "Dual Eligible days" were defined in the 2004 group appeal request. The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

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.

Regarding appeals from revised Notice of Program Reimbursements ("RNPR"), the applicable regulations explain that a RNPR is considered a separate and distinct determination, and, depending on when the RNPR was issued, the issue on appeal must have been either reviewed[8] or revised[9] as a prerequisite for Board jurisdiction. The 2002 Board Rules also provide:

> 3. Revised NPR - The Board accepts jurisdiction over appeals from a [RNPR] where the issue(s) in dispute were specifically adjusted by that [RNPR]. The Board typically follows the courts by limiting the scope of such an appeal to only the revised issue(s).[10]

The Board finds that Butler (Prov. No. 39-0168) failed to meet jurisdictional requirements and must be dismissed from both the Dual Eligible Exhausted Benefits days and the Part C days appeals. Butler appealed from its November 18, 2004 RNPR. Butler's documentation shows that it requested an additional 422 eligible days in its Reopening Request; however, none of those days were for dual eligible patients.[11] In fact, Butler stated that all days with a Medicare verifier were removed " . . . so as not to claim as Medicaid eligible a day that was secondary to Medicare Part A."[12] Therefore, the Board finds that the Dual Eligible days at

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[7] 42 C.F.R. § 405.1837(a)(2) (2003).
[8] 42 C.F.R. § 405.1885, 1889; *see also HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding that when a Medicare contractor 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).
[9] 42 C.F.R. § 405.1889 (2004), "When a revision is made in a determination or decision . . . after such determination or decisions has ben reopened as provided in §405.1885, 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."
[10] Board Rule B.I.a.3 at 3, Mar. 1, 2002 (citation omitted).
[11] Butler's Reopening Request at 1, May 14, 2004 *attached at* Schedule of Providers Tab 2D.
[12] *Id.* at 2.

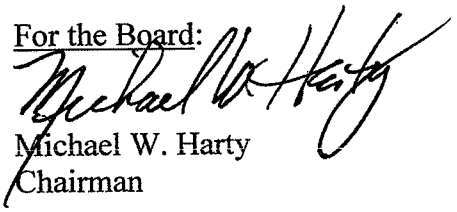
issue in Butler's appeal could not have been specifically adjusted in its RNPR. The Board further finds that Butler cannot document that Part C days were revised as part of the RNPR.[13] The Board concludes that it lacks jurisdiction over Butler's appeal, and Butler is hereby dismissed.

Additionally, the Board finds that, although five of the providers requesting bifurcation of the Part C days issue (Brooks Memorial (Prov. No. 33-0229), Unity (Prov. No. 33-0226), Saratoga (Prov. No. 33-0222), Wyoming Valley (Prov. No. 39-0137) and St. Clare's (Prov. No. 33-0066)) did not originally raise the sub-issue of Part C days in their original appeals, the request to transfer the issue occurred prior to the 2008 regulation change, which limited the ability to add issues to an open appeal. Prior to the regulatory change, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Therefore, the Board will deem the "transfer" of the Dual Eligible Exhausted and Part C days issue, as an "add/transfer" of the Dual Eligible Part C days issue. The Board finds that the group appeal that the providers were transferring to explicitly defined the issue under appeal as including the Part C days component.

The Board finds that the remaining two providers who requested an appeal of Part C days are jurisdictionally valid. Sisters of Charity (Prov. No. 33-0078) was a "direct add" to the group appeal, meaning that Sisters of Charity's issue statement was the same as the group's issue statement. Therefore, Sisters of Charity had a proper appeal of the Dual Eligible days and Part C days issues. Southern Ohio (Prov. No. 36-0008) did not raise Dual Eligible or Part C days in its individual appeal; however, Southern Ohio was one of the providers used to establish the instant group appeal on July 13, 2004. The Board has decided to treat Southern Ohio's joining this appeal as an "add/transfer" of the Dual Eligible days and Part C days issue to its individual appeal. The Part C days appeal for these seven providers will continue in Case No. 15-3223G.

Finally, the Board finds that Southern Ohio (Prov. No 36-0008), Wyoming Valley (Prov. No. 39-0137), St. Joseph (Prov. No. 33-0108), Unity (Prov. No. 33-0226), Sisters of Charity (Prov. No. 33-0078), St. Clare's (Prov. No. 33-0066), Saratoga (Prov. No. 33-0222), and Brooks Memorial (Prov. No. 33-0229) all have jurisdictionally valid appeals of Dual Eligible Exhausted Benefits days. Brooks Memorial, Saratoga, St. Clare's, St. Joseph, and Unity timely appealed Dual Eligible days in their respective individual appeal requests. Wyoming Valley did not raise Dual Eligible days in its original appeal request; however, on December 17, 2004, it requested to add/transfer Dual Eligible days. Further, for the reasons aforementioned, Sisters of Charity and Southern Ohio have valid Dual Eligible Exhausted Benefits days appeals. All eight providers will be remanded under separate cover pursuant to CMS Ruling 1498-R.

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

[13] *See* Butler's Reopening Workpapers *attached at* Schedule of Providers Tab 2D.

cc: Sharon L. Keyes, BCBSA

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

AUG 28 2015

HealthEast Care System
David Knowlan
1700 University Avenue
St. Paul, MN 55104

RE: HealthEast 2010 DSH SSI Systemic Errors CIRP Group, Case No. 12-0298GC

Dear Mr. Knowlan:

The Provider Reimbursement Review Board (the Board) has reviewed the HealthEast 2010 DSH SSI Systemic Errors CIRP Group, which appears to be subject to remand pursuant to CMS Ruling 1498-R. Upon review, the Board notes that there are two participants that were added to the group that filed subsequent to the issuance of the Ruling. The pertinent facts and the Board's determination are set forth below.

PERTINENT FACTS:

The HealthEast 2010 DSH SSI Systemic Errors CIRP Group appeal was filed on March 30, 2012. The original participant used to form the group appeal, HealthEast Woodwinds (24-0213) filed from a Notice of Program Reimbursement (NPR) dated October 18, 2010.

On September 30, 2013, HealthEast added two participants to the group. The NPRs in dispute for these providers were issued in 2013, after the issuance of CMS Ruling 1498-R (Ruling) which revised the published SSI Percentages.[1]

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 NPR.

CMS Ruling 1498-R – Pre-Ruling/Post-Ruling SSI Proxy Issues:

As noted in the facts above, the HealthEast 2010 DSH SSI Systemic Errors CIRP Group was established with a Provider that appealed from an NPR that was issued prior to CMS Ruling 1498-R. The other participants that were subsequently added to the group filed from NPRs that were issued after the effective date of the Ruling. Because the Ruling affected the

[1] CMS Ruling 1498-R became effective on April 28, 2010.

published SSI Percentages, the issue in dispute for the Provider that appealed prior to the Ruling is subject to remand to the Medicare Administrative Contractor (MAC) for a recalculated SSI ratio pursuant to the Ruling. However, the participants that filed post-Ruling have received the updated SSI ratios and are not subject to a remand. Therefore, the pre-Ruling SSI issue is different than the SSI issue currently being raised by the participants that filed after the Ruling.

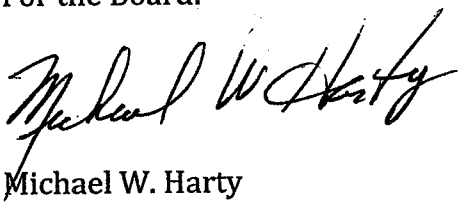
Consequently, the Board is bifurcating case no. 12-0298GC to separate the final determinations in dispute. Enclosed, please find a Notification of Bifurcated CIRP Group assigning case no. 15-3241GC to the post-Ruling participants. Case no. 12-0298GC will remain pending for the participant that received its NPR prior to the issuance of the Ruling. The Board is transferring HealthEast St. Joseph's (24-0063) and HealthEast St. John's (24-0210) to the newly bifurcated group, case no. 15-3241GC.

The Board notes that the last addition of participants to the group was submitted in September 2013. Please advise the Board, within 30 days of the date of this letter, which Providers in the chain are still awaiting receipt of their NPRs. If the group is complete, you must so advise the Board in writing within the same time frame.

The Parties will receive correspondence regarding the applicability of CMS Ruling 1498-R in case no. 12-0298GC under separate cover shortly.

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

For the Board:



Michael W. Harty
Chairman

Enclosure: Notification of Bifurcated SSI CIRP Group

cc: Danene Hartley, National Government Services, Inc. (w/enclosure)
Sharon L. Keyes, Executive Director, BC BS Association (w/enclosure)

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Refer to: 04-1872G

CERTIFIED MAIL AUG 28 2015

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

Kyle Browning
Appeals Lead
National Government Services
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH DE Days Bifurcation to (1) Part A Non-Covered/Exhausted Benefits Days and (2) Part C Days**
PRRB Case No.: 04-1872G
FYE: 2000

Dear Ms. Erde:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. The Part C days issue will be adjudicated in Case No. 15-3222G, the Duane Morris 00 Nat'l DSH Part C Days group.[1] If the Board finds jurisdiction over providers appealing Part A Non-Covered and Exhausted Benefit days, those providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal, established in 2004, framed the issue as follows:

> Is the [Medicare Administrative Contractor's] exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either whose Medicare Part A benefits were exhausted or who received Part C benefits correct?[2]

[1] This letter will serve as the Acknowledgement Letter normally sent via e-mail. The parties will be informed of new position paper deadlines in a Notice of Hearing.
[2] Group Request for Hearing, Jul. 13, 2004.

The list of providers for Case No. 04-1872G is in the table below.

Provider Number	Provider Name	Original Case Number	Request for Bifurcation?
33-0108	St. Joseph	04-2248 (closed 05.31.06)	No, Dual Elig. Schedule only
33-0229	Brooks	05-0462 (closed 05.07.08)	Yes, both Dual Elig. and Part C
33-0226	Unity	05-0044 (closed 05.25.05)	Yes, both Dual Elig. and Part C
33-0078	Sisters of Charity	Direct Add	Yes, both Dual Elig. and Part C
23-0147	Detroit Mercy	04-1101 (closed 08.18.09)	Yes, both Dual Elig. and Part C

On June 3, 2013, the Provider Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[3] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[4] McKay wrote that it determined that "... each of the group appeals ... challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[5] However, not every provider was listed on both the Exhausted Benefits and Part C days' Schedules of Providers.

Board Determination on Bifurcation

The Board has granted the bifurcation request regarding the Dual Eligible issue into two groups:

(1) Dual Eligible Exhausted Benefits days
(2) Part C days

The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS Rulings."[6] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). However, the Board has

[3] *See* Case Management Plan Letter, Jun. 3, 2013.
[4] *See* Bifurcation Letter, Aug. 30, 2013.
[5] *Id.* at 1.
[6] 42 C.F.R. § 405.1837(a)(2) (2003).

decided to treat the "multi-component" issue as a valid appeal because of the way "Dual Eligible days" were defined in the 2004 group appeal request. The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

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 Board finds that, although three of the providers requesting bifurcation of the Part C days issue (Brooks (Prov. No. 33-0229), Unity (Prov. No. 33-0226), and Detroit Mercy (Prov. No. 23-0147)) did not originally raise the sub-issue of Part C days in their original appeals, the request to transfer the issue occurred prior to the 2008 regulation change, which limited the ability to add issues to an open appeal. Prior to the regulatory change, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Therefore, the Board will deem the "transfer" of the "Dual Eligible days component" a transfer of Dual Eligible Exhausted Benefits days and an "add/transfer" of the Dual Eligible Part C days issue. The Board finds that the group appeal that the providers were transferring to explicitly defined the issue under appeal as including the Part C days component. Further, Sisters of Charity (Prov. No. 33-0078) was a "direct add" to the group appeal, meaning that Sisters of Charity's issue statement was the same as the group's issue statement. Therefore, Sisters of Charity also had a proper appeal of the Part C days issue. The Part C days appeal will continue in Case No. 15-3222G.

Finally, the Board finds that all five providers in Case No. 04-1872G filed timely individual appeals of Dual Eligible Exhausted Benefits days; and, were properly transferred to this group appeal. All five providers, St. Joseph (Prov. No. 33-0108), Brooks (Prov. No. 33-0229), Unity (Prov. No. 33-0226), Sisters of Charity (Prov. No. 33-0078) and Detroit Mercy (Prov. No. 23-0147), will be remanded under separate cover pursuant to CMS Ruling 1498-R.

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, BCBSA

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Refer to: 04-1875G

CERTIFIED MAIL AUG 28 2015

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

Kyle Browning
Appeals Lead
National Government Services
MP: INA102 - AF42
P. O. Box 6474
Indianapolis, IN 46206-6474

Re: **Duane Morris/McKay Consulting DSH DE Days Bifurcation to (1) Part A Non-Covered/Exhausted Benefits Days and (2) Part C Days**
PRRB Case No.: 04-1875G
FYE: 2002

Dear Ms. Erde:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal regarding the bifurcation of Dual Eligible days into (1) Exhausted Benefits days and (2) Part C days. The Board determined that, for providers deemed eligible (see below), it will grant the bifurcation request. The Part C days issue will be adjudicated in Case No. 15-3224G, Duane Morris 02 Part C Days Group.[1] If the Board finds jurisdiction over providers appealing Part A Non-Covered and Exhausted Benefit days, those providers will be remanded pursuant to CMS Ruling 1498-R.

Background

The instant group appeal, established in 2004, framed the issue as follows:

> Is the [Medicare Administrative Contractor's] exclusion from the Medicaid percentage of all days of care rendered to dually eligible patients who were eligible for reimbursement under the State's Medicaid plan and either whose Medicare Part A benefits were exhausted or who received Part C benefits correct?[2]

[1] This letter will serve as the Acknowledgement Letter normally sent via e-mail. The parties will be informed of new position paper deadlines in a Notice of Hearing.
[2] Group Request for Hearing at 2, Jul. 13, 2004.

The initial appeal request included two providers, St. John's (Prov. No. 14-0053)[3] and Washington Hospital (Prov. No. 39-0042). Subsequent to the establishment of the instant case, other providers transferred into this group appeal. The Final Position Paper for the group appeal addressed Dual Eligible Non-Covered, or Exhausted Benefits, days and Part C days.[4]

On June 3, 2013, the Provider Representative, Duane Morris, submitted a Case Management Plan for the "McKay Consulting Appeals," including the instant case, which adopted new deadlines for the Schedule of Providers.[5] On August 30, 2013, the Board received the Schedule of Providers from McKay Consulting ("McKay") for both Part C days and "Dual Eligible," or Exhausted Benefits, days, along with a letter addressing the bifurcation of the Dual Eligible days issue.[6] McKay wrote that it determined that ". . . each of the group appeals . . . challenges the exclusion of both non-covered and Medicare part [*sic*] C dual eligible patients from the numerator of the DSH Medicaid fraction."[7] However, not every provider was listed on both the Exhausted Benefits and Part C days' Schedules of Providers.

The list of providers for Case No. 04-1875G is in the table below.

Provider Number	Provider Name	Original Case Number	Request for Bifurcation?
39-0168	Butler Memorial	05-0994 (closed 06.13.05)	Yes, both Dual Elig. and Part C
36-0096	East Liverpool	05-1035 (closed 09.25.12)	Yes, both Dual Elig. and Part C
01-0113	Mobile Infirmary	04-2189 (closed 12.11.07)	Yes, both Dual Elig. and Part C
39-0042	Washington	04-0139 (closed 05.31.05); original provider in group	No, Dual Elig. Schedule only

Board Determination on Bifurcation

The Board has granted the bifurcation request regarding the Dual Eligible issue into two groups:

(1) Dual Eligible Exhausted Benefits days
(2) Part C days

The Board's decision rests on the framing of the group issue and the regulations and Board Rules applicable at the time the group appeal was filed.

Prior to the 2008 revisions, the regulations required that, for a group appeal, "[t]he matters at issue involve a common question of fact or interpretation of law, regulations, or CMS

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[3] St. John's was transferred to Case No. 13-2467GC and will not be addressed here.
[4] *See* Final Position Paper, Feb. 1, 2006. The group argued that exhausted benefits and Part C days were excluded from the Medicaid fraction and that, generally, Part C days were also excluded from the SSI fraction.
[5] *See* Case Management Plan Letter, Jun. 3, 2013.
[6] *See* Bifurcation Letter, Aug. 30, 2013.
[7] *Id.* at 1.

Rulings."[8] Here, the group "matter at issue" is described as Dual Eligible days. The group clearly defines Dual Eligible days as "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C. Seemingly, the group appealed multiple issues, since the group's definition of Dual Eligible days is viewed as two separate issues by the Board (i.e. Exhausted Benefits days and Part C days). However, the Board has decided to treat the "multi-component" issue as a valid appeal because of the way "Dual Eligible days" were defined in the 2004 group appeal request. The Board concludes that it will grant the bifurcation of Dual Eligible days, as long as all other jurisdictional requirements are met.

Board Determination on Jurisdiction

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.

Regarding appeals from revised Notice of Program Reimbursements ("RNPR"), the applicable regulations explain that a RNPR is considered a separate and distinct determination, and, depending on when the RNPR was issued, the issue on appeal must have been either reviewed[9] or revised[10] as a prerequisite for Board jurisdiction. The 2002 Board Rules also provide:

> 3. Revised NPR - The Board accepts jurisdiction over appeals from a [RNPR] where the issue(s) in dispute were specifically adjusted by that [RNPR]. The Board typically follows the courts by limiting the scope of such an appeal to only the revised issue(s).[11]

The Board finds that Butler (Prov. No. 39-0168) failed to meet jurisdictional requirements and must be dismissed from both the Dual Eligible Exhausted Benefits days and the Part C days appeals. Butler appealed from its December 15, 2004 RNPR. Butler's individual appeal request appealed DSH (1) Supplemental Security Income and (2) Dual Eligible days.[12] However, for Dual Eligible days, the appeal referenced an RNPR adjustment to generic Medicaid Eligible days. Butler identified that it requested an additional 413 eligible days, none of which were for dual eligible patients.[13] Therefore, the Board finds that the Dual Eligible days

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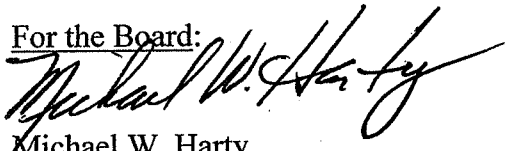
[8] 42 C.F.R. § 405.1837(a)(2) (2003).
[9] 42 C.F.R. § 405.1885, 1889; *see also HCA Health Services v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994) (holding that when a Medicare contractor reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening).
[10] 42 C.F.R. § 405.1889 (2004), "When a revision is made in a determination or decision . . . after such determination or decisions has ben reopened as provided in §405.1885, 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."
[11] Board Rule B.I.a.3 at 3, Mar. 1, 2002 (citation omitted).
[12] Butler's Individual Appeal Request at 1, Mar. 10, 2005.
[13] *See* Schedule of Providers Tab 1D at 4, Aug. 30, 2013.

at issue in Butler's appeal could not have been specifically adjusted in its RNPR, as those days were not part of the requested 413 days. The Board concludes that it lacks jurisdiction over Butler's appeal from its RNPR and is hereby dismissed from the appeals.

Additionally, the Board finds that, although the other two providers (East Liverpool (Prov. No. 36-0096) and Mobile Infirmary (Prov. No. 01-0113)) requesting bifurcation of the Part C days issue did not originally raise the sub-issue of Part C days in their original appeals, the request to transfer the issue occurred prior to the 2008 regulation change, which limited the ability to add issues to an open appeal. Prior to the regulatory change, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Therefore, the Board will deem the "transfer" of the Dual Eligible days issue as an "add/transfer" of the Part C days issue. The Board finds that the group that the providers were transferring to explicitly defined the issue under appeal as including the Part C days component. The Part C days appeal will continue in Case No. 15-3224G.

Finally, the Board finds that the remaining three providers in Case No. 04-1875G filed timely individual appeals of Dual Eligible days and were properly transferred to this group appeal. All three providers, East Liverpool (Prov. No. 36-0096), Mobile Infirmary (Prov. No. 01-0113) and Washington (Prov. No. 39-0042), will be remanded under separate cover pursuant to CMS Ruling 1498-R.

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, BCBSA

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

Refer to:

CERTIFIED MAIL

AUG 31 2015

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

RE: QRS UW 1989, 1998, 1991-1993, 1995 1998 Medicine Medicare DSH SSI% CIRP Group
Provider Nos.: Various
PRRB Case No.: 09-0222GC

Dear Mr. Ravindran:

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

Board Determination:

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

The Board finds that it does not have jurisdiction over Harborview Medical Center (50-0064) for FYEs 6/30/1989, 6/30/1991, 6/30/1992 and 6/30/1993.

For FYEs 6/30/1989 and 6/30/1991, Harborview Medical Center did not submit proof that the SSI Percentage issue was included in its individual appeal request, nor is there evidence that the Provider separately added the issue to its individual appeals. In addition, the Provider did not submit evidence that the SSI issue was properly transferred to case number 95-1407G (the first group to which it allegedly transferred prior to ultimately transferring to the subject group appeal) for FYEs 6/30/1989, 6/30/1991, 6/30/1992 and 6/30/1993.

The Board issued Rules which went into effect on August 21, 2008, limiting the ability to add issues. After this date, the Providers must have specifically added the issue to their individual appeals prior to requesting a transfer to the group appeal.

Because case number 09-0222G was filed on November 3, 2008, after the issuance of the August 2008 Rules, and because there is no evidence demonstrating the SSI Percentage issue was part of the individual appeals for FYEs 1989 and 1991 the Board dismisses

Harborview Medical Center from the group (participants 1 and 4). Further, because Harborview Medical Center did not submit evidence showing the trail of transfers of the SSI Percentage issue from its individual appeals for FYEs 1992 and 1993 to case number 95-1407G, the Board dismisses Harborview Medical Center from the group for these FYEs as well (participants 6 and 8).

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.

Enclosed, please find a Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R.

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

FOR THE BOARD

Michael W. Harty
Chairman

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

cc: Sharon L. Keyes, Executive Director, BCBSA (w/enclosures)

Noridian Healthcare Solutions WA/AK (w/enclosures)
Lee Crooks
6505 216th Street SW, Suite 205
Mountlake Terrace, WA 98043

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AUG 31 2015

CERTIFIED MAIL

Quality Reimbursement Services, Inc.
James Ravindran, President
150 N. Santa Anita Ave., Suite 570A
Arcadia, CA 91006

Novitas Solutions, Inc.
Bill Tisdale
Union Trust Building
501 Grant St., Suite 600
Pittsburgh, PA 15219

RE: QRS BHCS 97-00, 04-05 DSH SSI Percentage Group
PRRB Case No. 09-0539GC

Dear Mr. Ravindran and Mr. Tisdale:

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

Background

On December 31, 2008 the Board received a request to establish this group appeal. One of the participants in the group appeal is Baylor All Saints Medical Center (45-0137) for FYE 12/31/2005. This participant did not provide its Notice of Program Reimbursement (NPR) or its hearing request in the supporting documentation supplied with the Schedule of Providers.

Board's Decision

The Board finds that it does not have jurisdiction over Baylor All Saints Medical Center for FYE 12/31/2005.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (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 the notice of the intermediary's determination was mailed to the provider.

Further guidance and requirements for filing an appeal with the Board are outlined in the PRRB Rules (July 1, 2009). PRRB 16.1 requires a Provider to include "a copy of the relevant NPR or revised NPR" and "documentation showing that the issue being transferred is currently part of the individual appeal from which it is to be transferred."

Due to Baylor All Saints Medical Center's failure to provide the hearing request, the Board cannot determine if the SSI Percentage issue was included in its individual appeal prior to the Provider's transfer request to join this group appeal. Without this information, the Board is unable to determine if Baylor All Saints Medical Center filed a jurisdictionally valid appeal of the SSI Percentage issue. Therefore, the Board dismisses Baylor All Saints Medical Center for FYE 12/31/2005 from the group.

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.

Enclosed, please find the Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R for the remaining participants in the group.

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

For the Board:

Michael W. Harty
Chairman

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

cc: Sharon L. Keyes, BSBCA (w/enclosures)

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AUG 31 2015

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RE: Reed Smith 2001-2004 SSI Group
PRRB Case No. 08-2059

Dear Mr. Rotella and Ms. Cummings:

The Provider Reimbursement Review Board (the Board) has reviewed the jurisdictional documentation submitted in the above captioned case and finds that it lacks jurisdiction over a number of participants in the group. The pertinent facts with regard to these Providers and the Board's jurisdiction decision are set forth below.

Pertinent Facts

Participant 1, Cabell Huntington Hospital, Prov. No. 51-0055, FYE 9/30/2001:

This Provider received a Notice of Program Reimbursement (NPR) on 9/27/2005. According to the Schedule of Providers, the Provider filed an individual appeal on 3/20/2006. The documentation submitted for this participant behind tab 1B, however is the cover page of the Provider's Final Position Paper. Based on the documentation submitted, the Board is unable to determine whether the Provider properly appealed the SSI Percentage issue prior to transferring it to the group on 3/25/2009.

Participant 27, St. Claire Regional Medical Center, Prov. No. 18-0018, FYE 6/30/2002:

This Provider 27 received an NPR on 8/19/2004 and filed an appeal request on 2/10/2005. Based on a review of the appeal request, the Provider did not appeal the SSI Percentage issue in the original appeal request, nor does it have proof that the issue was properly added to the individual appeal prior to transferring it to the group on 3/6/2009.

Participant 31, St. Elizabeth Medical Center, Prov. No. 18-0035, FYE 12/31/2003:

This Provider received an NPR on 8/22/2005 and filed an appeal request on 2/15/2006. Participant 31 did not include the SSI Percentage issue in its original appeal nor does it have proof that the issue was properly added to the individual appeal prior to transferring it to the group on 12/28/2009.

***Participant 33,* St. Francis Hospital and Medical Center, Prov. No. 07-0002, FYE 9/30/1998:**

This Provider received an NPR on 5/25/2004 and submitted an appeal request on 9/6/2006. The Provider did not include the issue in the original appeal request nor does it have proof that the issue was properly added to the individual appeal prior to transferring it to the group on 5/8/2009.

Board Decision

The Board finds that it does not have jurisdiction over Participants 1, 27, 31, and 33.

Pursuant to 42 U.S.C. §1395oo(a) and 42 C.F.R. §§405.1835-405.1840(2006), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if (1) it is dissatisfied with the final determination of the MAC, (2) the amount in controversy is $10,000 or more (or $50,000 for a group), and (3) the request for a hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Further guidance and requirements for filing an appeal with the Board are outlined in the PRRB Rules (July 1, 2009). PRRB Rule 16.1 requires a provider who is transferring an issue from an individual appeal to a group appeal to provide documentation that the issue being transferred is "currently apart of the individual appeal from which it is being transferred."

Regulation 42 C.F.R. §405.1835(c) provides that an issue may be added to the original appeal request "no later than 60 days after the expiration of the 180-day period" following the Provider's receipt of its NPR.

After reviewing the jurisdictional documentation submitted with the Schedule of Providers the Board finds that Cabell Huntington Hospital for FYE 2001 (participant 1) did not provide proof that the SSI Percentage issue was properly appealed prior to transferring to the group.

In addition, the Board finds that the following Providers did not include the SSI Percentage issue in their original appeal requests and failed to add the issue prior to transferring into the group:

Provider Name	Provider No.	FYE	Ptcp #
St. Claire Regional Medical Center	18-0018	06/30/2002	27
St. Elizabeth Medical Center	18-0035	12/31/2003	31
St Francis Hospital and Medical Center	07-0002	09/30/1998	33

Therefore, the Board hereby dismisses these four participants from case number 08-2059G.

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.

Enclosed, please find the Board's Standard Remand of the SSI fraction under CMS Ruling CMS-1498-R for the remaining participants in the group.

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

For the Board:

Michael W. Harty
Chairman

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

cc: Sharon L. Keyes, BSBCA (w/enclosure)