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

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

Refer to: 06-0082GC

NOV 03 2015

CERTIFIED MAIL

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

RE: Request for Reconsideration
CHW 2000 DSH Dual Eligible Days CIRP Group
FYE: 2000 (Various)
PRRB Case No.: 06-0082GC

Dear Mr. Knight,

The Provider Reimbursement Review Board ("Board") has reviewed the documents related to the Request for Reconsideration of the Board's denial of the Providers' Request for Bifurcation of the dual eligible exhausted Part A and Part C days issues. The Board hereby grants the Request for Reconsideration and grants bifurcation of the two issues.

BACKGROUND

The Providers requested to establish this group appeal on October 4, 2005. On April 24, 2007, the group representative submitted the final position paper for the appeal, which included a listing of the dual eligible days categories the Providers were appealing. On December 26, 2012, the Board received a request from Toyon Associates, Inc., the group representative, entitled, "Request for Case Bifurcation, Expedited Judicial Review for Part A Dual Eligible Days and for a Consolidated Hearing for Dual Eligible Part C Days." The Board partially granted the request for bifurcation of the issues for Participants listed as 2, 5, and 7 on the Schedule of Providers. The Board established case number 15-2573GC for the Part C days issue for those three Providers, and denied the bifurcation request for the remaining Providers. The transfer request for Participant 1, California Hospital Medical Center (provider no. 05-0149, FYE 12/31/2000), was denied on June 30, 2006, because its individual appeal was closed prior to its transfer request. The Board also denied jurisdiction over Participant 10, Northridge Hospital – Sherman Way Campus (provider no. 05-0299, FYE 12/31/2000), and Participant 17, San Gabriel Valley Medical Center (provider no. 05-0132, FYE 9/30/2000). Toyon Associates, Inc. then submitted a July 17, 2015 Request for Reconsideration of Bifurcation Request on behalf of the Providers who had the Part C bifurcation denied.

REQUEST FOR RECONSIDERATION ARGUMENTS

The Providers argue that the Board should grant reconsideration and bifurcate the dual eligible

exhausted Part A and Part C days issues. The Providers argue that their intent at the time they filed the appeal of the dual eligible days issue was to appeal all categories of dual eligible days. They argue that the factual and historical context in which the Providers appealed the dual eligible days issue supports their assertion that their intent was to appeal all categories of dual eligible days. First, because the 1986 DSH rule allowed dual eligible days in the Medicaid fraction numerator when Medicaid paid for the days, such as when no Medicare payment was made because Part A benefits were exhausted. Second, the Providers argue that after CMS Ruling 97-2, CMS asserted that all dual eligible days must be excluded from the numerator of the Medicaid fraction based on the patient's status as a beneficiary. Furthermore, the Providers state that when they filed the group appeal, hospitals were contesting the exclusion of all dual eligible days that were not entitled to payment of benefits under Part A for any reason.

The Providers further argue that their intent to appeal the "whole dual-eligible issue" was expressed in the appeal and transfer language of the various Providers.[1] According to the Providers, the Board erred in assuming that the group issue statement was not intended to encompass the dual eligible days issue and in assuming that several Providers abandoned the dual eligible days issue. Finally, the Providers argue that the notice-pleading rules in effect when the group appeal was established did not require a specific description of the "exact nature of all aspects of the issue in dispute."[2]

BOARD'S DECISION

The Board hereby grants the Providers' Request for Reconsideration and grants bifurcation of the dual eligible exhausted Part A and Part C days issues for all of the Providers in case number 06-0082GC.

The Board agrees with the Providers that at the time the group appeal, individual appeals, and transfer requests were filed, the issue of whether a Medicaid patient that was "dually eligible" for 'Medicare' but no 'Medicare' payment was made should be included in the Medicaid DSH fraction, was not necessarily subdivided by Medicare Part A or Part C. The Federal court decisions that later ruled differently on the Medicaid/ Medicare Part A and the Medicaid/Medicare Part C dual eligibility had not yet been rendered, nor had the Board consistently bifurcated those issues or required bifurcation of those sub-issues. Consequently, the Board agrees that the Providers contentions that it was their intent to appeal the various categories of dual eligible days including both exhausted Part A and Part C days. The language of the issue statement filed in this group appeal may have been broad, and did not identify specific sub-categories of dual eligible days, however, the Providers' final position paper, submitted on April 24, 2007, specifically identified the various sub-categories of dual eligible days which the Providers are appealing including Part A exhausted and Part C.

Based on these factors, the Board finds that there are two issues pending in case number 06-0082GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] Therefore, the Board grants the Providers' request for reconsideration and bifurcates the dual eligible exhausted Part A and

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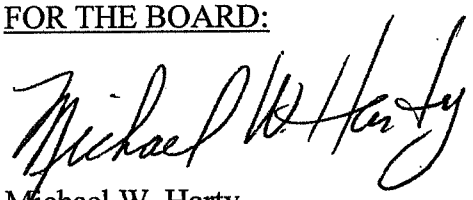
[1] Request for Reconsideration at 5 (July 16, 2015).
[2] *Id.* at 7.
[3] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

Part C days issues into separate group appeals. The remaining Providers Part C issue is incorporated into case number 15-2573GC, CHW 2000 DSH Part C Days CIRP Group, which the Board previously established for three of the Providers in case number 06-0082GC.[4] Please submit updated Schedule of Providers in case number 15-2573GC to the Board within 45 days. The remaining Providers in Case No. 06-0082GC are subject to CMS Ruling 1498-R, and you will receive notification of remand of those providers under separate cover.

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

cc: Darwin San Luis
Noridian Healthcare Solutions
Appeals Coordinator – Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

[4]For all providers but participants 1, 10 and 17, as those providers were previously dismissed from this appeal for various reasons. Those decisions have not been reconsidered.

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Refer to:

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CERTIFIED MAIL

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

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

RE: Duane Morris 02 National DSH Dual Eligible Group II, Case No. 06-0859G
Bifurcation of Dual Eligible/Part C Days and Remand of Dual Eligible Days

Dear Ms. Erde and Mr. Browning:

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. 16-0144G, Duane Morris 2002 National 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.

Pertinent Facts Regarding Bifurcation:

The Group Representative's Request for a Hearing, dated January 12, 2006, framed the group issue as follows:

> Is the [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]

The Representative attached a preliminary Schedule of Providers to the Request for a Hearing, naming providers St. Joseph Hospital (33-0108) ((Transfer from 06-0214) and Bannock Regional Medical Center (13-0028) (Transfer from 05-1679).[3]

The Final Position Paper, filed October 1, 2007, briefed Dual eligible non-covered days and Part C days.[4]

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[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] 06-0859G Group Request for Hearing at 2, Jan. 12, 2006.
[3] *See id.* at Schedule A.

There are ten participants on the Dual Eligible Days Schedule of Providers. All but two participants (Arnot Ogden Medical Center and St. Joseph Hospital Elmira) are also on the Part C Days Schedule.

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 of the Board's Rules, 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."[5] 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 2006 group appeal request.

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.

Although the eight providers 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 deems 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 to which the providers were

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[4] *See* 06-0859G Final Position Paper, Oct. 1, 2007. The Providers argued that EB days and Part C days were excluded from the Medicaid fraction and that, generally, Part C days were also excluded from the SSI fraction.

[5] 42 C.F.R. § 405.1837(a)(2) (2003).

transferring explicitly defined the issue under appeal as including the Part C days component. Because the Part C days group was created by bifurcating the issue from an existing optional group which was filed in 2006, the Part C days group is being deemed complete. Enclosed please find a Critical Due Dates letter.

Finally, the Board finds that all ten providers listed on the attached Dual Eligible Days Schedule of Providers in case number 06-0859G are subject to CMS Ruling 1498-R. Enclosed, please find the Board's Standard Remand of the Dual Eligible Days issue.

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: Standard Remand of Medicare Dual Eligible Days Under Ruling CMS-1498-R
Schedule of Providers
Critical Due Dates Letter for Optional Group

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services

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Refer to: 14-2168G, 14-2169GC, 14-2170GC, 14-2171GC,
14-2172GC, 14-2173GC, 14-2349GC, 14-2433GC, 14-2461GC

NOV 05 2015

Certified Mail

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

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

James Ward
Appeals Resolution Manager
Noridian Healthcare Solutions, LLC
P.O. Box 6722
Fargo, ND 58101-6722

Danene Hartley
Appeals Lead
National Government Services
MP: INA 101-AF-42
P.O. Box 6474
Indianapolis, IN 46206-6474

Kyle Browning
Appeals Manager
National Government Services
MP: INA102-AF-42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: QRS FFY 2014 2 Midnight Rule Group, PRRB Case No. 14-2168G
QRS Avera FFY 2014 2-Midnight CIRP Group, PRRB Case No. 14-2169GC
QRS JCL FFY 2014 2-Midnight CIRP Group, PRRB Case No. 14-2170GC
QRS Wheaton FFY 2014 2-Midnight Rule CIRP Group, PRRB Case No. 14-2171GC
QRS Scottsdale FFY 2014 2-Midnight CIRP Group, PRRB Case No. 14-2172GC
QRS Novant FFY 2014 2-Midnight CIRP Group, PRRB Case No. 14-2173GC
QRS WCHN FFY 2014 2-Midnight CIRP Group, PRRB Case No. 14-2349GC
QRS LMHS FFY 2014 2-Midnight CIRP Group, PRRB Case No. 14-2433GC
QRS Asante FFY 2014 2-Midnight CIRP Group, PRRB Case No. 14-2461GC

Determination Regarding Expedited Judicial Review of the 2-Midnight Issue

Dear Messrs. Ravindran, Lamprecht, Ward and Browning and Ms. Hartley:

The Provider Reimbursement Review Board (Board) has reviewed the parties' comments agreeing with the Board's proposed finding on its own motion that expedited judicial review (EJR) is appropriate for the issue under dispute. The Board's decision with respect to EJR is set forth below.

Issue Under Appeal

Whether the provision in the FY 2014 IPPS final rule that imposes a 0.2 percent decrease in the inpatient prospective payment system (IPPS) rates for all IPPS hospitals for each of the fiscal years (FYs) 2014-2018 is procedurally invalid, arbitrary and capricious and outside the statutory authority of the [Secretary the Department of Health and Human Services].[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 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

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[1] Providers' Hearing Requests establishing group appeals, Tab 2 (various dates).
[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).
[3] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[4] *Id.*

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]

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

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[5] *Id.*
[6] CMS Pub. 100-02, Chapter 6, § 20.6 and Chapter 1, § 10.
[7] 78 Fed. Reg. at 50,907-08.
[8] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[9] 78 Fed. Reg. at 50,908.

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 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

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

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 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

The Providers contend that the provision of the final rule imposing a 0.2 percent decrease in the IPPS rates was an agency action conducted "without observance of procedure required by law" and should be set aside. Pursuant to 5 U.S.C. § 706(2)(A), an agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" should be set aside. The Providers believe that 42 U.S.C. § 1395ww does not provide authority for the Secretary to institute an across-the-board payment cut in the IPPS payments.

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[15] *Id.*
[16] *Id.* at 50,945.
[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and the parties' comments regarding the proposed own motion EJR determination. 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 all of the remaining Providers in each group case referenced on page one timely filed their requests for hearing from the issuance of the August 19, 2013 Federal Register.[19,20] The amount in controversy in each case exceeds the $50,000 threshold necessary for a group appeal.[21] Consequently, the Board has determined that it has jurisdiction over the group appeals and the participants within the groups. 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 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

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.

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[19] *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).

[20] The Board previously dismissed one participant (Bristol Hospital, provider number 07-0029) from Case No. 14-2168G for lack of jurisdiction as noted on the Schedule of Providers. Since that provider is no longer participating within the group appeal, it is not subject to the Board's EJR findings above.

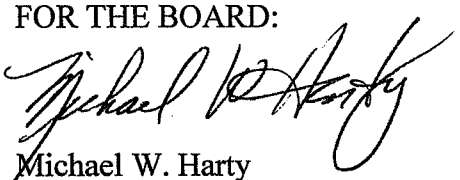
[21] *See* 42 C.F.R. § 405.1837(a)(3).

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 these cases. 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 these group 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

cc: Wilson C. Leong, Federal Specialized Services (w/Schedules of Providers)

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: 14-4180G

NOV 05 2015

Certified Mail

Daniel J. Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Avenue, NW
Washington, D.C. 20006-4706

RE: K&S 2011 SCH HSR Budget Neutrality Group
Provider Nos. Various
FYE 2011
PRRB Case No. 14-4180G
Expedited Judicial Review Determination

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' October 10, 2015 request for expedited judicial review (EJR) and the associated Schedule of Providers and jurisdictional documents (received October 13, 2015). The Board's decision with respect to the Providers' EJR request is set forth below.

Issue Under Appeal

> [T]he relief sought by the Providers is a reversal of CMS's [the Centers for Medicare & Medicaid Services] construction of a regulation, in which it requires the application of cumulative budget neutrality adjustments to the Providers respective HSRs [hospital specific rates].[1]

Background: Sole Community Hospital (SCH) Rebasing

Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110-275) provided an option for SCHs to rebase their HSR including data from their FY 2006 cost reports if this resulted in a payment increase. In cases where no payment increase resulted from using the HSR, the provider continued to be paid the higher of their FY 1982, FY 1987 or FY 1996 rate.[2]

The August 27, 2009 Federal Register, which published the final inpatient prospective payment system (IPPS) rule for 2010, explained that effective with cost reporting periods beginning prior to January 1, 2009, 42 U.S.C. § 1395ww(d)(5)(D)(i) provided that SCHs would be paid based on one of four statutorily specified rates which yielded the greatest aggregate payments. In this case, that was the updated HSR based on the FY 2006 costs per discharge.[3,4] The CMS Medicare Claims Processing Manual[5] instruction

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[1] Providers' October 10, 2015 EJR Request at 5.
[2] 42 U.S.C. § 1395ww(d)(5)(D)(i) was amended by section 6003(e) of Pub. L. No. 101-239 (OBRA 1989) and section 1395ww(b)(3)(I) (as added by section 405 of Pub. L. No. 106-113 (BBRA 1999) and further amended by section 213 of Pub. L. No. 106-554 (BIPA 2000) provides that SCHs are paid based on whichever of four statutorily specified rates yields the greatest aggregate payment to the hospital for the cost reporting period. 74 Fed. Reg. 43,754, 43,894 (Aug. 27, 2009).
[3] Providers' September 5, 2014 Hearing Request, Tab 2.

issued October 3, 2008 directed intermediaries to apply the 2007 budget neutrality factor to the providers' 2006 cost report data. Later, in the August 27, 2009 Federal Register, the Secretary expanded the fiscal years' budget neutrality adjustments applied to the SCH reimbursement to include the aggregate FYs 1993-2007 adjustments. She explained that the "instructions for implementing both the FY 1996 and FY 2006 SCH rebasing provisions direct the fiscal intermediary . . . to apply cumulative budget neutrality adjustment factors to account for DRG changes *since FY 1993* in determining an SCH's [HSR] based on . . . FYE 2006 cost data."[6] These instructions had been furnished in a Joint Signature Memorandum (JSM), JSM/TDL-09052 issued on November 17, 2008.

The Providers' Jurisdictional Documentation

The Providers are requesting that the Board reverse the application of the cumulative, prior year budget neutrality adjustment factor in the calculation of the Providers' 2006 base year HSR.[7] All of the Providers participating in the group appeal referenced an audit adjustment for protested amounts, as well as an adjustment to properly report SCH payments.

Decision of the Board

The Board finds that it lacks jurisdiction over the Providers in this group appeal because they failed to protest the application of the cumulative budget neutrality adjustment to the fiscal year under appeal as required by 42 C.F.R. § 405.1835(a)(1)(ii). Since jurisdiction over an appeal is a prerequisite to granting the request for EJR, the Providers' request for EJR is hereby denied. Since this is a group appeal, which may only consist of a single common issue, the Board hereby closes the case.

Although the Providers included adjustments related to protested amounts, they did not include Worksheet E, Part A and the narrative that explains what was specifically protested. As a result, the Board cannot determine if the Providers protested the application of the cumulative budget neutrality adjustment to their reimbursement. Board Rule 21 requires that providers submit documentation to evidence the issues protested on their cost reports. The Rule instructs providers to:

> Complete the Schedule of Providers that includes all providers in the group and provide the supporting documentation.
>
> **********
>
> D. Audit Adjustment Number
>
> 1. Schedule – **Column D** – Identify the audit adjustment or determination/ authority challenged.
>
> 2. Documentation –Tab D –

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[4] 74 Fed. Reg. 43,754, 43,894 (Aug. 27, 2009).
[5] CMS Manual (CMS Pub. 100-04), Transmittal 1610 (Change Request 6189).
[6] 74 Fed. Reg. at 43,895.
[7] Schedule of Providers and Jurisdictional Documents, Tab 1.B.

- Provider a copy of the matter appealed (e.g., audit adjustment report or other final determination.)

****

- For appeals of Self-Disallowed Items, you **MUST** submit a brief narrative identifying the authority that the Provider is challenging, and a copy of the cost report protested item page, if applicable. For cost report periods that end on or after December 31, 2008, the Provider must submit the evidence of protest. (*See* Rule 7.2 and 42 C.F.R. § 405.1835(a)(1)(ii)).

Further, effective with cost report periods ending on or after December 31, 2008, providers which sought reimbursement that the Medicare Contractor could not allow were required to file the matter under protest on their cost reports. This was codified in 42 C.F.R. § 405.1835, which states:

> (a) *Right to hearing on final contractor determination.* A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by a final contractor or Secretary determination if—
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—
>
> **********
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the contractor lacks discretion to award the reimbursement the provider seeks for the item(s)).

The cost reporting period at issue in this appeal involves fiscal year 2009.

At the outset, the Board notes that providers subject to IPPS ("IPPS providers") are required to file cost reports on an annual basis pursuant to 42 C.F.R. §§ 412.40 and 412.52. Further, in defining "determination" for purposes of appeal rights under 42 U.S.C. § 1395oo(a), CMS has specified in 42 C.F.R. § 405.1803 that the appeal rights of an IPPS provider flow from the intermediary's issuance of the NPR that is based upon the cost report filed by that provider. Thus, the Board concludes that the "report" discussed in 42 U.S.C. § 1395oo(a)(1)(B) is the cost report.

The Board notes that the cost report (including the procedures for filing a cost report under protest) is based on the provider's obligation to provide information that the Secretary requires to determine payment. In this regard, 42 U.S.C. § 1395g(a) specifies in pertinent part:

> (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, . . .

> except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

CMS has historically set forth the rules governing items filed under protest in the Provider Reimbursement Manual (PRM) (CMS Pub.15-2) § 115 *et seq.* and specified what information providers are required to furnish for items under protest in PRM 15-2 §§ 115.1 and 115.2:

> 115.1 Provider Disclosure of Protest.--When you file a cost report under protest, the disputed item and amount *for each issue* must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.
>
> 115.2 Method for Establishing Protested Amounts.--The effect of *each nonallowable cost report item is estimated* by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. In addition, *you must submit*, with the cost report, *copies of the working papers used to develop the estimated adjustments* in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).[8]

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." In promulgating this regulation, CMS included the following discussion in the preamble to the final rule published on May 23, 2008 ("2008 Final Rule")[9] to confirm that this regulation codified the PRM rules governing cost reports filed under protest:

> *Comment*: One commenter recommended that the text of section 115 *et seq.* of the PRM, Part II, be placed in the regulations. The commenter noted that these sections of the PRM have not changed since 1980. . . .
>
> *Response*: We are adopting the proposal, which is essentially a codification of the protested amount line procedures set forth in section 115 *et seq.* of the PRM, Part II.[10]

---

[8] (Emphasis added.)
[9] 73 Fed. Reg. 30,190 (May 23, 2008).
[10] *Id.* at 30,195. Similarly, the preamble to the 2008 Final Rule states the following regarding the documentation requirements for filing a cost report under protest: "We are attempting to strike a balance between, on the one hand, having provider present enough information so as to put the intermediaries on notice as to the actual or potential reimbursement disputes, and, on the other hand, not making it unduly burdensome for providers to file cost reports."

For purposes of IPPS providers, filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 30 of the cost report. In this regard, PRM 15-2 § 3630.1 (Line 30) requires that IPPS providers:

> Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process (See §115.2). Attach a schedule showing the details and the computations for this line.

The Board notes that 42 C.F.R. § 405.1803(d) (2008) governs implementation of decisions to award, part or in full, self-disallowed items filed under protest:

> (d) *Effect of certain final agency decisions and final court judgments: audits of self-disallowed and other items.*
>
> **********
>
> (3) CMS may require the intermediary to audit any item, including any self-disallowed item, at issue in an appeal or a civil action, before any revised intermediary determination or additional Medicare payment, recoupment, or offset may be determined for an item under paragraph (d)(2) of this section.

In the preamble to the 2008 Final Rule, CMS stated the following regarding the purpose of this regulatory provision:

> The final decision awarding reimbursement for a self-disallowed item may come from the Board, the Administrator, or a court. Although we believe that, in most instances, the administrative or judicial body that issues a decision would not specify a dollar figure for reimbursement, the proposal was intended to ensure that intermediaries, in fact, have the opportunity to determine the correct amount of reimbursement after an award is made. We believe that it would be inappropriate for the administrative or judicial body to award a specific amount for reimbursement without the benefit of an audit by the intermediary.[11]

Thus, the procedures and documentation required for filing an item under protest, and the audit of such items when they are awarded (in part or in full) following a successful appeal (as codified at 42 C.F.R. §§ 405.1835(a)(1)(ii) and 405.1803(d), respectively), are an integral part of the cost reporting process. In addition, 42 U.S.C. § 1395g(a) states that "no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider."

Id. The preamble further states: "We believe it is reasonable to require providers to notify their intermediaries, via their cost report submission, of all items for which they potentially may be claiming reimbursement." *Id.* at 30,198.

[11] *Id.* at 30,199.

In the instant case, there is no evidence of amounts claimed on Worksheet E, Part A, Line 30 of the cost reports at issue as required to protest the amount of the cumulative budget neutrality adjustment pursuant to § 405.1835(a)(1)(ii). As these cost reports involve a fiscal year that ends on or after December 31, 2008, self-disallowed items, such as the application of the cumulative budget neutrality adjustment, must have been filed under protest in order to have "complied with the rules and regulations of the Secretary relating to such [cost] report" and, thereby, established one of the elements for Board jurisdiction under 42 U.S.C. § 1395oo(a)(1)(B). Thus, as the Providers failed to protest the application of the cumulative budget neutrality adjustment at issue, and that is the sole issue involved in this appeal, the Board lacks jurisdiction over the appeal and must deny the request for EJR and close the case.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) 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)(1) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Byron Lamprecht, Wisconsin Physicians Service
Wilson C. Leong, Federal Specialized Services

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:

09-1865G, 10-0230GC,
15-0869G, 15-1815, 15-2816

NOV 05 2015

Certified Mail

Daniel J. Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Avenue, NW
Washington, D.C. 20006-4706

RE: SCH 2009-2010 Budget Neutrality Hospital-Specific Rate Group, Provider Nos. Various, FFYs 2009 and 2010, PRRB Case No. 09-1865G
Sisters of Mercy Health System 2010 Sole Community Hospital FY 2006 Rebase CIRP Group, Provider Nos. Various, FFY 2010, PRRB Case No. 10-0230GC
K & S 2012 SCH HSR Budget Neutrality Group, Provider Nos. Various, FFY 2012, PRRB Case No. 15-0869G
Newman Regional Health, Provider No. 17-0001, FYE 12/31/2010, PRRB Case No. 15-1815
Hays Medical Center, Provider No. 17-0013, FYE 6/30/2013, PRRB Case No. 15-2816
Expedited Judicial Review Determination

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the requests for expedited judicial review (EJR) dated October 9, 2015 (case numbers 09-1865G and 10-0230G); October 21, 2014 (case numbers 15-1815 and 15-2816); and October 22, 2015 (case number 15-0869G) received on October 13, 2010, October 22, 2015 and October 23, 2015, respectively. The decision with respect to the Providers' requests for EJR is set forth below.

Issue

Whether it is appropriate to apply a cumulative budget-neutrality factor to the base year hospital specific rate [(HSR)] for SCHs [sole community hospitals].[1]

Background: SCH Rebasing

An SCH is a hospital that is the sole source of inpatient hospital services reasonably available to Medicare beneficiaries by reason of its distance from other hospitals (i.e. more than 35

[1] *See, e.g.,* Providers' October 9, 2015 Request for Expedited Judicial Review in case numbers 09-1865G and 10-0230G at 1.

miles), travel conditions, or similar factors.[2] Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110-275) provided an option for SCHs to rebase their HSR including data from their FY 2006 cost reports if this resulted in a payment increase. In cases where no payment increase resulted from using the HSR, the provider continued to be paid the higher of their FY 1982, FY 1987 or FY 1996 rate.[3]

The August 27, 2009 Federal Register, which published the final inpatient prospective payment system (IPPS) rule for 2010, explained that effective with cost reporting periods beginning prior to January 1, 2009, 42 U.S.C. § 1395ww(d)(5)(D)(i) provided that SCHs would be paid based on one of four statutorily specified rates which yielded the greatest aggregate payments. In this case, that was the updated HSR based on the FY 2006 costs per discharge.[4] The CMS Medicare Claims Processing Manual[5] instruction issued October 3, 2008 directed intermediaries to apply the 2007 budget neutrality factor to the providers' 2006 cost report data. Later, in the August 27, 2009 Federal Register, the Secretary[6] expanded the fiscal years' budget neutrality adjustments applied to the SCH reimbursement to include the aggregate FYs 1993-2007 adjustments. She explained that the "instructions for implementing both the FY 1996 and FY 2006 SCH rebasing provisions direct the fiscal intermediary . . . to apply cumulative budget neutrality adjustment factors to account for DRG changes *since FY 1993* in determining an SCH's [HSR] based on . . . FYE 2006 cost data."[7] These instructions had been furnished in a Joint Signature Memorandum (JSM), JSM/TDL-09052 issued on November 17, 2008.

Position of the Parties

The Providers assert that the regulations governing payments to SCHs require specific steps to calculate a hospital's HSR, and do not account for the application of a cumulative budget neutrality adjustment.[8] The Providers believe that while 42 C.F.R. § 412.78 is silent with respect to the application of the prior years' budget neutrality facts to rebase the HSR, the Secretary adopted a definitive policy in the 2010 IPPS rule to apply prior years' cumulative budget neutrality adjustments to the 2006 HSR.[9]

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[2] *See* 42 U.S.C. § 1395ww(d)(5)(D)(iii).
[3] 42 U.S.C. § 1395ww(d)(5)(D)(i) was amended by section 6003(e) of Pub. L. No. 101-239 (OBRA 1989) and section 1395ww(b)(3)(I) (as added by section 405 of Pub. L. No. 106-113 (BBRA 1999) and further amended by section 213 of Pub. L. No. 106-554 (BIPA 2000) provides that SCHs are paid based on whichever of four statutorily specified rates yields the greatest aggregate payment to the hospital for the cost reporting period. 74 Fed. Reg. 43,754, 43,894 (Aug. 27, 2009).
[4] 74 Fed. Reg. 43,754, 43,894 (Aug. 27, 2009).
[5] CMS Manual (CMS Pub. 100-04), Transmittal 1610 (Change Request 6189).
[6] of the Department of Health and Human Services.
[7] 74 Fed. Reg. at 43,895.
[8] Providers' October 10, 2015 EJR Request at 2 referencing 42 C.F.R. § 412.78.
[9] 74 Fed. Reg. at 43,895-97.

The Providers point out that the Board is bound by the Secretary's policy set forth in the Federal Register with respect to the cumulative budget neutrality adjustment. Consequently, the Board lacks the authority to grant the relief sought, and the Providers assert EJR is appropriate.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(c) permits the Board to consider 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 the Providers timely filed their requests for hearing and the amount in controversy exceeds the $10,000 threshold necessary for individual appeals and the $50,000 threshold necessary for group appeals.[10] Consequently, the Board has determined that it has jurisdiction over the appeals. This issue involves a challenge to the validity of a rate published in the Federal Register and its implementation in the Notice of Re-Basing[11] or Notice of Program Reimbursement (NPR).[12] Further, the Board finds that it lacks the authority to decide the legal question of whether the application of the cumulative budget neutrality adjustment to the Providers' reimbursement rates is proper; 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 years and the Providers are entitled to a hearing before the Board;

2) based upon the Providers' assertions regarding the application of the cumulative budget neutrality adjustment, there are no findings of fact for resolution by the Board; and

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

Accordingly, the Board finds that the application of the cumulative budget neutrality issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review for the issue and the subject years. The Providers have 60 days from the

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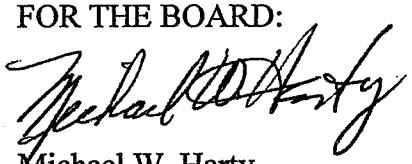
[10] *See* 42 C.F.R. §§ 405.1835(a)(2), 405.1837(a)(3) and 412.79(g).
[11] Case numbers 09-1865G and 10-0230GC were filed from Notices of Re-Basing.
[12] Case numbers 15-0869G, 15-1815 and 15-2816 were filed from NPRs and the application of the budget neutrality adjustment was included on each Provider's cost report as a protested amount as required by 42 C.F.R. § 405.1835(a)(1)(ii).

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 Anderson, 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 for Case Numbers 09-1865G, 10-0230GC, 15-0869G

cc: Byron Lamprecht, WPS (w/Schedules of Providers)
Bill Tisdale, Novitas (w/Schedules of Providers)
Wilson C. Leong, Federal Specialized Services (w/Schedules of Providers)

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: 14-2168G

Certified Mail

NOV 05 2015

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

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

RE: # 3 Bristol Hospital as a participant in the
QRS FFY 2014 2-Midnight Rule Group
Provider No. 07-0029
FFY 2014
PRRB Case No. 14-2168G

Dear Messrs. Ravindran and Lamprecht:

The Provider Reimbursement Review Board (Board) has reviewed the Schedule of Providers and associated jurisdictional documents in the above referenced group appeal. The Board's jurisdictional determination with respect to Bristol Hospital (provider number 07-0029) is set forth below.

Background

The Provider's appeal was received[1] in the Board's offices on February 19, 2014, 184 days after the publication of the August 19, 2013 Federal Register.[2] The issue under appeal is

> Whether the provision in the Fiscal Year 2014 Inpatient Prospective Payment System ("IPPS") Final Rule ("Final Rule") 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 Secretary].[3]

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[1] The date of receipt is presumed to be the date of delivery. 42 C.F.R. § 405.1801(a)(2)(i) (2008). A provider has the right to a Board hearing if the date of receipt of the provider's hearing request is not later than 180 days after the date of receipt of the intermediary's/Medicare Administrative Contractor's (MAC's) or Secretary's determination. 42 C.F.R. § 405.1835(a)(3)(ii)(2008). *But see* 42 U.S.C. § 1395oo(a)(3) which requires an appeal be filed "within 180 days of the Secretary's notice." The publication of the Inpatient Prospective Payment System Rules in the Federal Register constitutes the Secretary's notice of the rates for the upcoming Federal fiscal year.

[2] *Wash. 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 *Dist. 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).

[3] Providers' Hearing Request establishing the group appeal, Exhibit 2 (dated January 28, 2014).

Decision of the Board

The Board finds that Bristol Hospital's appeal was not timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which requires an appeal be filed "*within 180 days after notice of the . . .Secretary's final determination*" (emphasis added). This appeal was received in the Board's offices 184 days after the issuance of the August 19, 2013 Federal Register giving notice of the inpatient prospective payment rates for Federal fiscal year (FFY) 2014.

The Federal Register notice is the Secretary's final notice of the IPPS rates for each FFY. The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[4] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[5] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, sections 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[6] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[7] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
>
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, CMS publishes the schedules of the Prospective Payment System (PPS) rates (including the 2 midnight rule/the 0.2 percent reduction to IPPS) in the Federal Register pursuant to the requirements of 42

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[4] *See* 42 C.F.R. § 405.1867.
[5] of the Department of Health and Human Services.
[6] 42 U.S.C. § 1306(a).
[7] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act (FOIA).

C.F.R. § 412.8(b)(2). This regulation was created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[8]

With regard to the notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it (emphasis added).

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office (GPO) promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[9] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[10] Consequently, the Provider is deemed to have notice of the 0.2 percent reduction to IPPS on the date the Federal Register was published and made available online.

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[11]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act (APA)) are clear on their face: the date of publication of the Federal Register is the date the Providers are deemed to have notice of the IPPS rules including the 2 midnight rule/the 0.2 percent reduction to IPPS. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

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[8] *See also* 42 C.F.R. Part 401, Subpart B.
[9] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[10] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.
[11] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or August 19, 2013.

The regulation at 42 C.F.R. § 405.1801(d)(3) allows that if the last day of the filing period falls on a weekend day or Federal holiday, then the deadline for filing is extended to the next business day. Here, the 180th day for appealing the August 19, 2013 Federal Register notice fell on Saturday, February 15, 2014. Monday, February 17 was Presidents' Day, a Federal holiday. Thus, the next business day was Tuesday February 18, 2014. However, the Provider's hearing request was not received until one day later on February 19, 2014.[12] Even taking into account the 3-day extension of time for filing because of the weekend and holiday, the Provider's appeal was still not timely filed.

Consequently, the Board concludes that it does not have jurisdiction over the Provider's untimely appeal and hereby dismisses Bristol Hospital from Case No. 14-2168G.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

Enclosures: 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875, 405.1877

cc: Wilson C. Leong, Federal Specialized Services

[12] *See* Schedule of Providers. Tab 3B. The Model Form E (Request to Join an Exiting Group Appeal) was dated and certified as having been sent by nationally recognized courier on February 18, 2014 and the attached United Parcel Service tracking receipt confirms delivery on February 19, 2014.

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: 14-2687G

NOV 06 2015

Certified Mail

Daniel J. Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Avenue, NW
Washington, D.C. 20006-4706

RE: Southwest Medical Center
Provider Nos. 17-0068
FYE 12/31/2010
PRRB Case No. 14-2687
Expedited Judicial Review Determination

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's October 28, 2015 request for expedited judicial review (EJR) and the associated Schedule of Providers and jurisdictional documents (received October 29, 2015). The Board's decision with respect to the Provider's EJR request is set forth below.

Issue Under Appeal

> [T]he relief sought by the Provider is a reversal of CMS's [the Centers for Medicare & Medicaid Services] construction of a regulation, in which it requires the application of cumulative budget neutrality adjustments to the Provider's HSRs [hospital specific rates].[1]

Background: Sole Community Hospital (SCH) Rebasing

Section 122 of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110-275) provided an option for SCHs to rebase their HSR including data from their FY 2006 cost reports if this resulted in a payment increase. In cases where no payment increase resulted from using the HSR, the provider continued to be paid the higher of their FY 1982, FY 1987 or FY 1996 rate.[2]

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[1] Provider's October 28, 2015 EJR Request at 6.

[2] 42 U.S.C. § 1395ww(d)(5)(D)(i) was amended by section 6003(e) of Pub. L. No. 101-239 (OBRA 1989) and section 1395ww(b)(3)(I) (as added by section 405 of Pub. L. No. 106-113 (BBRA 1999) and further amended by section 213 of Pub. L. No. 106-554 (BIPA 2000) provides that SCHs are paid based on whichever of four statutorily specified rates yields the greatest aggregate payment to the hospital for the cost reporting period. 74 Fed. Reg. 43,754, 43,894 (Aug. 27, 2009).

The August 27, 2009 Federal Register, which published the final inpatient prospective payment system (IPPS) rule for 2010, explained that effective with cost reporting periods beginning prior to January 1, 2009, 42 U.S.C. § 1395ww(d)(5)(D)(i) provided that SCHs would be paid based on one of four statutorily specified rates which yielded the greatest aggregate payments. In this case, that was the updated HSR based on the FY 2006 costs per discharge.[3, 4] The CMS Medicare Claims Processing Manual[5] instruction issued October 3, 2008 directed intermediaries to apply the 2007 budget neutrality factor to the providers' 2006 cost report data. Later, in the August 27, 2009 Federal Register, the Secretary expanded the fiscal years' budget neutrality adjustments applied to the SCH reimbursement to include the aggregate FYs 1993-2007 adjustments. She explained that the "instructions for implementing both the FY 1996 and FY 2006 SCH rebasing provisions direct the fiscal intermediary . . . to apply cumulative budget neutrality adjustment factors to account for DRG changes *since FY 1993* in determining an SCH's [HSR] based on . . . FYE 2006 cost data."[6] These instructions had been furnished in a Joint Signature Memorandum (JSM), JSM/TDL-09052 issued on November 17, 2008.

The Providers' Jurisdictional Documentation

The Provider is requesting that the Board reverse the application of the cumulative, prior year budget neutrality adjustment factor in the calculation of the Provider's 2006 base year HSR.[7] The Provider referenced audit adjustment 21,[8] which adjusted the SCH payment. The Provider argues that since the HSR does not appear on the cost report, there is no audit adjustment. However, the absence of an audit adjustment reflecting an adjustment to the HSR cannot deprive the Board of jurisdiction. The Provider believes that the adjustment to the SCH is sufficient for Board jurisdiction.

Decision of the Board

The Board finds that it lacks jurisdiction over the Provider because it failed to protest the application of the cumulative budget neutrality adjustment to the fiscal year under appeal as required by 42 C.F.R. § 405.1835(a)(1)(ii). Since jurisdiction over an appeal is a prerequisite to granting the request for EJR, the Provider's request for EJR is hereby denied. Since this is the only issue under appeal in this case, the Board hereby closes case number 14-2687.

Although the Provider included adjustments to the SCH calculation which increased reimbursement, there was no protest of the application of the cumulative budget neutrality adjustment to the 2006 base year HSR calculation as required by 42 C.F.R § 405.1835(a)(1)(i). Providers were on notice that the Secretary was applying the cumulative budget neutrality adjustment to the 2006 base year rate as the result of the publication of the August 27, 2009

[3] Provider's February 27, 2014 Hearing Request, Tab 3.
[4] 74 Fed. Reg. 43,754, 43,894 (Aug. 27, 2009).
[5] CMS Manual (CMS Pub. 100-04), Transmittal 1610 (Change Request 6189).
[6] 74 Fed. Reg. at 43,895.
[7] Provider's February 27, 2014 Hearing Request, Tab 3
[8] Provider's October 28, 2015 EJR at 5.

> furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

CMS has historically set forth the rules governing items filed under protest in the Provider Reimbursement Manual (PRM) (CMS Pub.15-2) § 115 *et seq.* and specified what information providers are required to furnish for items under protest in PRM 15-2 §§ 115.1 and 115.2:

> 115.1 Provider Disclosure of Protest.--When you file a cost report under protest, the disputed item and amount *for each issue* must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.
>
> 115.2 Method for Establishing Protested Amounts.--The effect of *each nonallowable cost report item is estimated* by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. In addition, *you must submit*, with the cost report, *copies of the working papers used to develop the estimated adjustments* in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).[9]

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest." In promulgating this regulation, CMS included the following discussion in the preamble to the final rule published on May 23, 2008 ("2008 Final Rule")[10] to confirm that this regulation codified the PRM rules governing cost reports filed under protest:

> *Comment*: One commenter recommended that the text of section 115 *et seq.* of the PRM, Part II, be placed in the regulations. The commenter noted that these sections of the PRM have not changed since 1980. . . .

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[9] (Emphasis added.)
[10] 73 Fed. Reg. 30,190 (May 23, 2008).

> *Response*: We are adopting the proposal, which is essentially a codification of the protested amount line procedures set forth in section 115 *et seq*. of the PRM, Part II.[11]

For purposes of IPPS providers, filing a cost report under protest is achieved by entering such costs on Worksheet E, Part A, Line 30 of the cost report. In this regard, PRM 15-2 § 3630.1 (Line 30) requires that IPPS providers:

> Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process (See §115.2). Attach a schedule showing the details and the computations for this line.

The Board notes that 42 C.F.R. § 405.1803(d) (2008) governs implementation of decisions to award, part or in full, self-disallowed items filed under protest:

> (d) *Effect of certain final agency decisions and final court judgments: audits of self-disallowed and other items.*
>
> **********
>
> (3) CMS may require the intermediary to audit any item, including any self-disallowed item, at issue in an appeal or a civil action, before any revised intermediary determination or additional Medicare payment, recoupment, or offset may be determined for an item under paragraph (d)(2) of this section.

In the preamble to the 2008 Final Rule, CMS stated the following regarding the purpose of this regulatory provision:

> The final decision awarding reimbursement for a self-disallowed item may come from the Board, the Administrator, or a court. Although we believe that, in most instances, the administrative or judicial body that issues a decision would not specify a dollar figure for reimbursement, the proposal was intended to ensure that intermediaries, in fact, have the opportunity to determine the correct amount of reimbursement after an award is made. We believe that it would be

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[11] *Id.* at 30,195. Similarly, the preamble to the 2008 Final Rule states the following regarding the documentation requirements for filing a cost report under protest: "We are attempting to strike a balance between, on the one hand, having provider present enough information so as to put the intermediaries on notice as to the actual or potential reimbursement disputes, and, on the other hand, not making it unduly burdensome for providers to file cost reports." *Id.* The preamble further states: "We believe it is reasonable to require providers to notify their intermediaries, via their cost report submission, of all items for which they potentially may be claiming reimbursement." *Id.* at 30,198.

> inappropriate for the administrative or judicial body to award a specific amount for reimbursement without the benefit of an audit by the intermediary.[12]

Thus, the procedures and documentation required for filing an item under protest, and the audit of such items when they are awarded (in part or in full) following a successful appeal (as codified at 42 C.F.R. §§ 405.1835(a)(1)(ii) and 405.1803(d), respectively), are an integral part of the cost reporting process. In addition, 42 U.S.C. § 1395g(a) states that "no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider."

As this cost reports involves a fiscal year that ends on or after December 31, 2008, self-disallowed items, such as the application of the cumulative budget neutrality adjustment, must have been filed under protest in order to have "complied with the rules and regulations of the Secretary relating to such [cost] report" and, thereby, established one of the elements for Board jurisdiction under 42 U.S.C. § 1395oo(a)(1)(B). Thus, as the Provider failed to protest the application of the cumulative budget neutrality adjustment at issue, and that is the sole issue involved in this appeal, the Board lacks jurisdiction over the appeal and must deny the request for EJR and close case number 14-2687.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) 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)(1) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Byron Lamprecht, Wisconsin Physicians Service
Wilson C. Leong, Federal Specialized Services

[12] *Id.* at 30,199.

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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

NOV 06 2015

Nina Adatia Marsden, Esq.
Hooper, Lundy & Bookman
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

RE: Hooper Lundy & Bookman FFY 2015 Two Midnight
0.2 Percent IPPS Payment Reduction Groups
Case Numbers: 15-1102GC, 15-1107GC, 15-1109GC,
15-1113GC, 15-1114GC, 15-1115GC, 15-1116GC, 15-1117GC,
15-1120GC, 15-1121GC, 15-1122GC, 15-1176GC, 15-1177GC,
15-1178GC, 15-1181GC, 15-1182G, and 15-1183GC
Expedited Judicial Review Decision

Dear Ms. Marsden:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' October 27, 2015 request for expedited judicial review (EJR) (received October 28, 2015). The Board's decision is set forth below.

Background

Issue Under Appeal

The Providers[1] note that in the final inpatient prospective payment system (IPPS) rule for Federal fiscal year (FFY) 2015 the Centers for Medicare & Medicaid Services (CMS) failed to eliminate the 0.2% reduction to IPPS payments to offset the expected increase in national inpatient reimbursement due to the implementation of the two-midnight policy. Based on this, the Providers filed these appeals to challenge the payment reduction in 2015 on the following grounds:

(1) The Secretary[2] improperly exercised the authority purportedly granted . . . under 42 U.S.C. § 1395ww(d)(5)(I)(i);

(2) The Secretary improperly reduced the IPPS and hospital specific payments, including operating, capital and any other aspect of IPPS payments that was affected by the 0.2% reduction, and all the components therein, to IPPS hospitals,

[1] *See e.g.* Providers' January 28, 2015 Hearing Request in case number 15-1183GC at 3.
[2] of the Department of Health and Human Services.

sole community and Medicare dependent hospitals, including the Providers , for all inpatient stays for FFY 2015 by 0.2% in light of the Secretary's implementation of the "two-midnight" policy; and

(3) The Secretary should have imposed a positive rather than a negative adjustment under 42 U.S.C. § 1395ww(d)(5)(I)(i), because the two-midnight policy actually reduces IPPS.

Statutory and Regulatory Background

In the final IPPS rule for 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]

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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.*

Medicare Part A

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

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[7] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.
[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.*

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 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]

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[12] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[13] 78 Fed. Reg. at 50,909.
[14] *Id.* at 50,927.
[15] *Id.* at 50,944.
[16] *Id.*
[17] *Id.* at 50,945.

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 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] In the final IPPS rule for 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 period.[20]

Providers' Position

The Providers explain that the FFY 2014 IPPS Final Rule[21] the Secretary adopted a new policy that presumes (a) inpatient admissions are appropriate if the beneficiary's inpatient hospital stay extends past two midnights and (b) stays shorter than two midnights, that do not involve services designated as "inpatient only," are "generally inappropriate for payment under Part A" as inpatient services (and should be provided as outpatient services) unless there is clear physician documentation in the medical record supporting the physician's order and expectation that the beneficiary would require care spanning at least two midnights (even though this ultimately did not occur). This is referred to as the "two-midnight" policy.

The Secretary assumed in the 2014 Final Rule that this new policy would result in a net shift of 40,000 encounters from outpatient departments to inpatient care, and surmised that this would cause IPPS expenditures to increase by approximately $220 million for FFY 2014. Based on this assumption, the Secretary took the allegedly extremely rare step of using her special statutory

[18] *Id.* at 50,952-53.
[19] *Id.* at 50,990.
[20] 79 Fed. Reg. 49,854,50,382-83 (Aug. 22, 2014).
[21] 78 Fed. Reg. at 50,506.

"exceptions and adjustments" authority to reduce the standardized amount and the hospital-specific payment rate for all IPPS payments. This included, but was not limited to both operating and capital payments[22] and all components therein, by 0.2% for FFY 2014 and thereafter to offset the expected annual $220 million increase in national inpatient reimbursement under IPPS.

After reviewing the FFY 2014 IPPS proposed and final rules and the comments submitted in response to the 2014 proposed rule, the Providers determined that (1) there is no support for CMS to use this special statutory authority for an across the board adjustment to IPPS rates and hospital specific rates, including operating capital and any other aspect of the IPPS payments that are affected by the 0.2% reduction; (2) the adjustment conflicts with the other statutory authority; and (3) the adjustment's promulgation does not comply with the requirements of the Administrative Procedure Act (APA), 5 U.S.C. §§ 551 *et seq.* and 706 *et seq.*, and other authorities.

Consequently, the Providers filed these appeals challenging the adjustment on the grounds that it (1) exceeds and conflicts with the statutory authority in Title XVIII of the Social Security Act and (2) 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 under the APA and other authorities. In the FFY 2015 Proposed Rule,[23] the Secretary failed to eliminate or even address the 0.2% reduction. In response to the 2015 proposed rule, the Providers allege a number of comments were submitted requesting that the Secretary withdraw the reduction, especially in light of the lack of any data supporting the reduction. However, in the 2015 Final Rule CMS did not address these comments or the 0.2% reduction for FFY 2015.

The Providers believe that EJR is appropriate because:

(1) The Secretary lacks the Authority to apply the 0.2% reduction because it violates Medicare statutes and regulations.

(2) The 0.2% reduction violates that APA and Medicare Act because the Secretary's actions for both 2014 and 2015 violates the APA (5 U.S.C. § 553) and the Medicare Statute (42 U.S.C. § 1395hh), is arbitrary, capricious and not based on substantial evidence and is otherwise and abuse of the Secretary's discretion.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider whether it lacks the authority to decide a

[22] For capital payments, the Secretary referred to "broad authority" under 42 U.S.C. § 1395ww(g). For the reasons stated in their EJR requests, the Providers dispute the Secretary's authority under this provision as well.
[23] 79 Fed. Reg. 27,978 (May 15, 2014)

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) and 405.1837(a). The Board concludes that the Providers timely filed their requests for hearing from the issuance of the August 22, 2014 Federal Register[24] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[25] Consequently, the Board has determined that it has jurisdiction over Providers' appeals. This issue involves a challenge to the application of the 0.02 percent reduction, for which the promulgation background is found in the proposed and final rules published in the Federal Register. 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 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

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' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

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[24] *Washington Hospital Center v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ([A] year end cost report is not a report necessary in order for the Secretary to make PPS payments, and the appeals provisions 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 Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (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).

Review of the jurisdictional determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) 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
Schedule of Providers

cc: Wilson C. Leong, Federal Specialized Services (w/Schedules of Providers)
Darwin San Luis, Noridian Healthcare Solutions (w/Schedules of Providers)
Danene Hartley, National Government Services (w/Schedules of Providers)
Bill Tisdale, Novitas Solutions (w/Schedules of Providers)
Judith Cummings, CGS Administrators (w/Schedules of Providers)
Beth Wills, Cahaba GBA c/o National Government Services (w/Schedules of Providers)
Byron Lamprecht, Wisconsin Physicians Service (w/Schedules of Providers)

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

NOV 0 6 2015

Nina Adatia Marsden, Esq.
Hooper, Lundy & Bookman
1875 Century Park East, Suite 1600
Los Angeles, CA 90067-2517

RE: CHS FFY 2015 Two Midnights 0.2% IPPS Payment Reduction Group
Provider Nos. Various
FFY 2015
PRRB Case No. 15-1175GC
Expedited Judicial Review Decision

Dear Ms. Marsden:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' October 27, 2015 request for expedited judicial review (EJR) (received October 28, 2015). The Board's decision is set forth below.

Background

Issue Under Appeal

The Providers note that in the final Federal fiscal year end (FYE) 2015 Final Inpatient Prospective System Payment (IPPS) rule,[1] the Secretary[2] failed to eliminate the 0.2% reduction to all IPPS payments to offset the expected increase in national reimbursement under IPPS due to implementation of the two-midnight policy, thereby carrying the reduction forward to 2015. Based on the foregoing the Providers filed this appeal to challenge the application of the payment reduction in FFY 2015 on the following grounds:

(1) The Secretary improperly exercised the authority purportedly granted to her under 42 U.S.C. § 1395ww(d)(5)(I)(i);

(2) The Secretary improperly reduced the IPPS and hospital specific payments, including operating, capital and any other aspect of IPPS payments that was affected by the 0.2% reduction and all the components therein, to IPPS hospitals, sole community and Medicare dependent hospitals, including the Providers, for all inpatient stays for FFY 2015 by 0.2% in

[1] 79 Fed. Reg. 49,853 (August 22, 2014).
[2] of the Department of Health and Human Services.

light of the Secretary's implementation of the "two-midnight" policy; and

(3) The Secretary should have imposed a positive rather than a negative adjustment under 42 U.S.C. § 1395ww(d)(5)(I)(i), because the two-midnight policy actually reduces IPPS expenditures.[3]

Statutory and Regulatory Background

In the final IPPS rule for 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[4] 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.[5]

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.[6]

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).[7]

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[3] Providers' January 28, 2015 Hearing Request at 3.
[4] 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).
[5] 78 Fed. Reg. 50,496, 50,907 (Aug. 19, 2013).
[6] *Id.*
[7] *Id.*

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[8] 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.[9]

In the FFY 2014 IPPS proposed rule,[10] 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).[11]

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.[12]

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[8] CMS Pub. 100-02, Chapter 6, §20.6 and Chapter 1, §10.
[9] 78 Fed. Reg. at 50,907-08.
[10] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[11] 78 Fed. Reg. 50,908.
[12] *Id.*

As a result of the number of these administrative adjudications, the CMS Administrator issued Ruling CMS-1455-P[13] (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.[14] 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.[15]

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.[16]

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).[17] The Secretary maintains that she has consistently provided physicians with a time-based admission framework to effectuate appropriate inpatient hospital admission decisions.[18]

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[13] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[14] 78 Fed. Reg. at 50,909.
[15] *Id.* at 50,927.
[16] *Id.* at 50,944.
[17] *Id.*
[18] *Id.* at 50,945.

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 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.[19] 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.[20] In the final IPPS rule for 2015, the Secretary did not reverse the 0.2 percent reduction to the standardized amount made in 2014, and, therefore, continued to apply the contested reduction for the FFY 2015 period.[21]

Providers' Position

The Providers explain that the FFY 2014 IPPS Final Rule[22] the Secretary adopted a new policy that presumes (a) inpatient admissions are appropriate if the beneficiary's inpatient hospital stay extends past two midnights and (b) stays shorter than two midnights, that do not involve services designated as "inpatient only," are "generally inappropriate for payment under Part A" as inpatient services (and should be provided as outpatient services) unless there is clear physician documentation in the medical record supporting the physician's order and expectation that the beneficiary would require care spanning at least two midnights (even though this ultimately did not occur). This is referred to as the "two-midnight" policy.

The Secretary assumed in the 2014 Final Rule that this new policy would result in a net shift of 40,000 encounters from outpatient departments to inpatient care, and surmised that this would cause IPPS expenditures to increase by approximately $220 million for FFY 2014. Based on this assumption, the Secretary took the allegedly extremely rare step of using her special statutory "exceptions and adjustments" authority to reduce the standardized amount and the hospital-

[19] *Id.* at 50,952-53.
[20] *Id.* at 50,990.
[21] 79 Fed. Reg. 49,854,50,382-83 (Aug. 22, 2014).
[22] 78 Fed. Reg. at 50,506.

specific payment rate for all IPPS payments. This included, but was not limited to both operating and capital payments[23] and all components therein, by 0.2% for FFY 2014 and thereafter to offset the expected annual $220 million increase in national inpatient reimbursement under IPPS.

After reviewing the FFY 2014 IPPS proposed and final rules and the comments submitted in response to the 2014 proposed rule, the Providers determined that (1) there is no support for CMS to use this special statutory authority for an across the board adjustment to IPPS rates and hospital specific rates, including operating capital and any other aspect of the IPPS payments that are affected by the 0.2% reduction; (2) the adjustment conflicts with the other statutory authority; and (3) the adjustment's promulgation does not comply with the requirements of the Administrative Procedure Act (APA), 5 U.S.C. §§ 551 *et seq.* and 706 *et seq.*, and other authorities.

Consequently, the Providers filed these appeals challenging the adjustment on the grounds that it (1) exceeds and conflicts with the statutory authority in Title XVIII of the Social Security Act and (2) 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 under the APA and other authorities. In the FFY 2015 Proposed Rule,[24] the Secretary failed to eliminate or even address the 0.2% reduction. In response to the 2015 proposed rule, the Providers allege a number of comments were submitted requesting that the Secretary withdraw the reduction, especially in light of the lack of any data supporting the reduction. However, in the 2015 Final Rule CMS did not address these comments or the 0.2% reduction for FFY 2015.

The Providers believe that EJR is appropriate because:

(1) The Secretary lacks the Authority to apply the 0.2% reduction because it violates Medicare statutes and regulations.

(2) The 0.2% reduction violates that APA and Medicare Act because the Secretary's actions for both 2014 and 2015 violates the APA (5 U.S.C. § 553) and the Medicare Statute (42 U.S.C. § 1395hh), is arbitrary, capricious and not based on substantial evidence and is otherwise and abuse of the Secretary's discretion.

Decision of the Board

The Board has reviewed the Providers' requests for hearing and EJR. The regulation at 42 C.F.R. § 405.1842(a) permits the Board to consider 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

[23] For capital payments, the Secretary referred to "broad authority" under 42 U.S.C. § 1395ww(g). For the reasons stated in their EJR requests, the Providers dispute the Secretary's authority under this provision as well.
[24] 79 Fed. Reg. 27,978 (May 15, 2014)

conduct a hearing under the provisions of 42 C.F.R. §§ 405.1840(a) and 405.1837(a). The Board finds that is does not have jurisdiction over the nine Providers listed below:

#135 Chester Regional Medical Center (provider number 42-0019)
#136 Springs Memorial Hospital (provider number 42-0036)
#137 Gaffney Medical Center (provider number 42-0043)
#138 Marlboro Park Hospital (provider number 42-0054)
#139 Marion County Medical Center (provider number 42-0055)
#140 Chesterfield General Hospital (provider number 42-0062)
#141 May Black Health System (provider number 42-0083)
#142 Carolinas Hospital System (provider number 42-0091)
#143 Henderson County Community Hospital (provider number 44-0008)

These Providers were not included on the original Schedule of Providers submitted with the original hearing request nor were they timely added to the group appeal in separate correspondence. They were first included on the Schedule of Providers included with the EJR request. Since the Providers listed above did not file their appeals within 180 days of the issuance of the Federal Register,[25] the final determination giving rise to this appeal, the Board hereby dismisses the Providers from case number 15-1175GC.

With respect to jurisdiction over the remaining Providers, the Board concludes that the Providers timely filed their request for hearing from the issuance of the August 22, 2014 Federal Register and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[26] Consequently, the Board has determined that it has jurisdiction over the remaining Providers' appeal. This issue involves a challenge to the application of the 0.02 percent reduction, for which the promulgation background is found in the proposed and final rules published in the Federal Register. 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 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[27];

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[25] *Washington Hospital Center v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ([A] year end cost report is not a report necessary in order for the Secretary to make PPS payments, and the appeals provisions 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 Hospital Association Wage Index Group Appeal* (HCFA Adm. Dec. January 15, 1993), *Medicare & Medicaid Guide* (CCH) ¶ 41,025 (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

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

[27] Excluding the nine Providers dismissed above for lack of a timely appeal.

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.

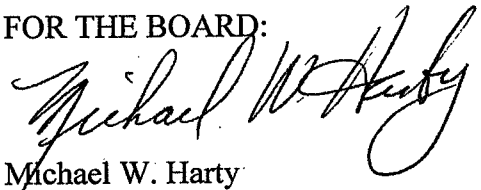
Accordingly, the Board finds that the 0.2 percent reduction issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for expedited judicial review for the issue and the subject year. The Providers have 60 days from the receipt of this decision to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

Review of the jurisdictional determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) 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
Schedule of Providers

cc: Byron Lamprecht, Wisconsin Physicians Service (w/Schedule of Providers)
Wilson C. Leong, Federal Specialized Services (w/Schedule of Providers)

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

NOV 06 2015

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

RE: Trinity Regional Health System – Bettendorf, Provider No. 16-0104, FYE 12/31/2010, PRRB Case No. 14-3906

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal in response to the Medicare Contractor's challenge to jurisdiction over two of the issues. The pertinent facts with regard to these issues and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The Representative, Blumberg Ribner, Inc., filed an appeal for the subject Provider on August 7, 2014 from an original NPR dated February 10, 2014. The Board assigned case number 14-3906 and acknowledged the appeal in an email dated August 8, 2014.

On July 1, 2015, the Medicare Contractor (MAC)[1] has objected to the Board's jurisdiction over the Medicaid Dual Eligible Patient Days issue because the MAC did not make an adjustment to the cost report with respect to the Provider's Medicaid days used to calculate the DSH adjustment, nor did the Provider claim the matter as a protested item on its cost report.

The Provider did not submit a responsive jurisdictional brief, but did request the transfer of the following issues to group appeals:

- HMO Part C Days – Medicaid Fraction to case no. 15-2577GC
- HMO Part C Days – Medicare Fraction to case no. 15-2576GC
- Dual Eligible- Medicare Fraction to case no. 15-2578GC
- Dual Eligible- Medicaid Fraction to case no. 15-2579GC
- SSI Percentage to case no. 15-2575GC

[1] The term MAC, formerly known as Intermediary is used interchangeably in this document as the regulations describe the Medicare contractor who performs audits of cost reports as "intermediary."

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 final determination.

Medicare Fraction Dual Eligible Days

The Board denies the Provider's request to transfer the Medicare Fraction Dual Eligible Days issue to case number 15-2578GC as the issue was not raised in the initial appeal, nor was it timely added to the case. The issue description in the appeal request for the Medicare/Medicaid Dual Eligible Patient Days included the following language:

> "The Provider contends that the Medicaid fraction has not been calculated in accordance with Medicare regulations and Manual provisions as described in 42 CFR Section 412.106. Further, the Provider contends that the Medicare/Medicaid dual eligible patient days have not been properly included in the DSH calculation. Specifically, the Medicaid Fraction should include any inpatient day where the patient is both Medicaid Eligible and Medicare is the Secondary Payer (MSP) or those inpatient days where the patient is Medicaid Eligible and his Medicare benefits are exhausted (Exhausted Days). [2]

This issue statement is exclusively appealing the Medicaid Fraction, not the Medicare Fraction.[3]

Medicaid Fraction Dual Eligible Days

The Board finds that it lacks jurisdiction over the Medicaid Dual Eligible Patient Days issue. The Provider failed to claim this issues as a protested amount on its cost report as required by 42 C.F.R. § 405.1835(a)(1)(ii).

Failure to Claim a Matter as a Protested Amount

This appeal was filed based on the provisions of 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835(a)(1) which permit providers to file appeals with the Board "no later than 180 days after the date of receipt by the provider of the intermediary [MAC] or Secretary determination." In this regard, 42 U.S.C. § 1395oo(a) states in relevant part:

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[2] (Emphasis added.)

[3] See Issue 2 from Provider's August 6, 2014 appeal request which is related to the SSI Percentage. The statement of the issue indicates that the Percentage is understated, but is not raised in the context of Dual Eligible Days in the SSI ratio.

> (a) [ ] any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title and which has submitted such reports within such time as the Secretary may require in order to make payment under such section may *obtain a hearing* with respect to such payment by the Board, if—
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> (1) such provider—
>
> (A)(ii) is dissatisfied with the final determination of the Secretary as to the amount of payment under subsection (b) or (d) of section 1395ww of this title,
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> *********
>
> (3) such provider files a request for a hearing within 180 days after notice of the intermediary's final determination under paragraph (1)(A)(ii), 180 days after notice of the Secretary's final determination, or with respect to appeals pursuant to appeals pursuant to paragraph (1)(B) or (C), within 180 days after notice of such determination would have been received if such determination had been made on a timely basis.[3]

Similarly, 42 C.F.R. § 405.1835(a) (2008) states in pertinent part:

> (a) **Criteria.** A provider . . . has a *right to a Board hearing*, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, *only if*—
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> (1) *The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for specific item(s) at issue, by* either—
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> (i) Including a claim for specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, *self-disallowing the*

[3] (Emphasis added.)

> *specific item(s) by following the applicable procedures for filing a cost report under protest,* where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).[4]

This confirms that the general right to hearing at the beginning of the 42 C.F.R. § 405.1835(a) necessarily encompasses claims for both reasonable cost reimbursement and reimbursement under IPPS. The general right to hearing in the new subsection (a) relates to "an intermediary or Secretary *determination.*"[5] The definition of "determination" as used therein is defined in 42 C.F.R. § 405.1801. Significantly, the § 405.1801 definition of "determination" has included determinations for both reasonable cost reimbursement and reimbursement under IPPS since September 1983 when the Centers for Medicare & Medicaid Services (CMS) revised its regulations to implement IPPS.[6] Indeed, the Board's review of the regulatory history of § 405.1835 suggests that the May 23, 2008 changes simply update and expand the § 405.1835 right to hearing to include any IPPS reimbursement issues that are part of the normal cost report audit, settlement and appeals process as reflected by the historical application of such process.

Providers subject to IPPS ("IPPS providers") are required to file cost reports on an annual basis pursuant to 42 C.F.R. §§ 412.40 and 412.52. Further, in defining "determination" for purposes of appeal rights under 42 U.S.C. § 1395oo(a), CMS has specified in 42 C.F.R. § 405.1803 that the appeal rights of an IPPS provider flow from the intermediary's issuance of the NPR that is based upon the cost report filed by that provider. Thus, the "report" discussed in § 1395oo(a)(1)(B) is the cost report.

In similar cases, the Board has noted that the cost report submission procedures (including the procedures for filing a cost report under protest) are based on the provider's obligation to provide information that the Secretary requires to determine payment. In this regard, 42 U.S.C. § 1395g(a) specifies in pertinent part:

> (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it . . . ; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this

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[4] (Emphasis added.)

[5] (Emphasis added.)

[6] *See* 42 C.F.R. § 405.1835 (editions dated Oct. 1, 1983, Oct. 1, 2007, Oct. 1, 2010).

> part for the period with respect to which the amounts are being paid or any prior period.

CMS has historically set forth the rules governing items filed under protest in the Provider Reimbursement Manual (PRM) (CMS Pub. 15-2) § 115 *et seq.* and specified what information providers are required to furnish for items under protest in PRM 15-2 §§ 115.1 and 115.2:

> 115.1 **Provider Disclosure of Protest**.--When you file a cost report under protest, the disputed item and amount *for each issue* must be specifically identified in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.
>
> 115.2 **Method for Establishing Protested Amounts**.-- The effect of *each nonallowable cost report item is estimated* by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. In addition, *you must submit*, with the cost report, *copies of the working papers used to develop the estimated adjustments* in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).[7]

Effective with cost report periods that end on or after December 31, 2008, CMS amended the regulations governing cost report appeals to incorporate PRM 15-2 § 115 *et seq.* into the regulations at 42 C.F.R. § 405.1835(a)(1)(ii) (2008) by specifying that, where a provider seeks payments that it believes may not be allowable or may not be in accordance with Medicare policy, the provider must claim the items as self-disallowed costs "by following the applicable procedures for filing a cost report under protest."

In the preamble to the final rule published on May 23, 2008 ("2008 Final Rule"),[8] the Secretary explained that he believed that requirement to follow the procedures for filing cost reports under protest was appropriate under the decision in *Bethesda Hospital*

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[7] (Emphasis added.)
[8] 73 Fed. Reg. 30190 (May 23, 2008).

Association v. Bowen.[9] In *Bethesda*, the providers were dissatisfied with malpractice reimbursement and did not file a claim for the additional reimbursement on their cost report nor did they file a statement with the cost report challenging the validity of the regulation. Hence, there was no final determination with respect to malpractice costs. The Court rejected the Secretary's argument that 42 U.S.C. § 1395oo(a)(1)(A)(i), which requires dissatisfaction with a final determination of the intermediary, "necessarily incorporates an exhaustion requirement." The Court found that this "strained interpretation" of the statutory dissatisfaction requirement was inconsistent with the express language of the statute.[10] However, the Court agreed, that under § 1395oo(a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition of the Board's jurisdiction, but held that "it is clear, however, that the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the intermediary.... Thus, [the providers in *Bethesda*] stand on different ground than do providers who bypass clearly prescribed exhaustion requirements or who fail to request from the intermediary reimbursement for costs to which they are entitled under the applicable rules. While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the intermediary, those circumstances are not presented here."[11] The Secretary noted that the Court recognized that an exhaustion requirement could be imposed by regulation, and that a provider who fails to claim all costs to which it is entitled may fail to meet the jurisdictional prerequisite of dissatisfaction.[12] In light of the ability to enact such regulations, 42 C.F.R. § 405.1835(a)(1)(ii) was promulgated, requiring providers to claim all items for which they seek additional reimbursement.

The Secretary went on to state that "[a]lthough there may be nothing in the statute indicating that dissatisfaction must be expressed with respect to "each claim," there also is nothing in the statute indicating that the Secretary cannot interpret the dissatisfaction requirement in this manner."[13] The final determination, which here is the NPR, is not just the total amount of program reimbursement. Rather, it is composed of many individual calculations representing the various items for which a provider seeks payment. Providers generally challenge discrete reimbursement items. Thus, dissatisfaction with total reimbursement is based on dissatisfaction with items that result in total reimbursement. Consequently the Secretary believes it is reasonable under 42 U.S.C. § 1395oo(a) to require dissatisfaction be shown with respect to each issue being appealed.[14] In light of this and the requirements of the regulation, the challenge to the treatment of Medicaid Dual Eligible

---

[9] 485 U.S. 399 (1988).
[10] 73 Fed. Reg. at 30196 citing *Bethesda* at 404.
[11] *Id.* at 404-405.
[12] *Id.*
[13] 73 Fed. Reg. at 30197.
[14] *Id.*

Days must be claimed as protested items and the Provider failed to comply with this requirement.

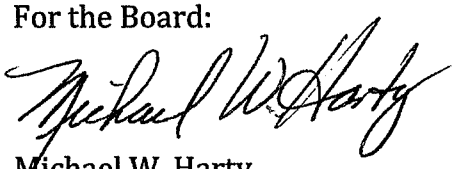
As the cost report under appeal involves a fiscal year that ends on or after December 31, 2008, self-disallowed items such as the Dual Eligible days in the Medicaid fraction of the DSH calculation at issue must have been filed under protest in order to have "complied with the rules and regulations of the Secretary relating to such [cost] report" and, thereby, established one of the elements for Board jurisdiction under 42 U.S.C. § 1395oo(a)(1). Thus, the Board finds that it does have jurisdiction over Dual Eligible Days in the numerator of the Medicaid fraction for fiscal year 2010 because the Provider failed to protest the issue and, therefore, did not comply with the regulation. The Board dismisses the Medicare Fraction Dual Eligible Days issue and denies the transfer of this issue to case number 15-2579GC.

Since all other issues have been transferred to groups, the individual appeal is hereby 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 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 .1877

cc: Byron Lamprecht, Wisconsin Physicians Service
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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

NOV 06 2015

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

RE: QRS 1996 DSH Medicaid Proxy Group II, PRRB Case No. 08-2664G
Specifically: Valley Presbyterian Hospital (05-0126) as a participant

Dear Mr. Ravindran:

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

Pertinent Facts:

On August 19, 2008 the Board received the Representative's request for the QRS 1996 DSH/ Medicaid Proxy Group II. The group appeal was formed with two participants:

- Nyack Hospital (33-0104) for FYE 12/31/1996 – transferred the issue from case no. 07-2579 and
- Valley Presbyterian (05-0126) for FYE 12/31/1996- transferred the issue from case no. 06-2413.

Both participants filed their individual appeals from revised Notices of Program Reimbursement (RNPRs).

Valley Presbyterian Hospital (Participant 1)

The Medicare Contractor issued a RNPR for this Provider on June 13, 2006. The RNPR indicates the cost report was reopened for Medicare Disproportionate Share Adjustment (DSH).[1]

The Provider's individual appeal, dated September 26, 2006, identified the issue in dispute as Medicaid Percentage (General Assistance & Labor Room Days). The Provider referenced adjustment R2-001 which was an adjustment to "Medi-Cal elig. Days based on the review of provider documents."[2]

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[1] Schedule of Providers at Tab 1A.
[2] Id. At Tab 1D.

On August 15, 2008, the Provider added the Medicare SSI Percentage, Medicaid Eligible Patient Days and Medicare/Medicaid Dual Eligible Patient Days issues to its individual appeal. The Provider referenced adjustments R2-001 and R2-002 for each added issue. R2-002 is an adjustment for the allowable DSH percentage.

On March 8, 2012, within the Provider's individual appeal (Case No. 06-2413), the Board asked the Provider to submit supporting documentation to determine if the issues raised were jurisdictionally valid and properly transferred to groups. The Provider responded on two occasions but the documentation was returned on July 9, 2012 because the information contained protected health information and again on November 20, 2012 because the documents referenced another Provider, other than Valley Presbyterian Hospital. Ultimately the Provider failed to submit the requested documentation prior to the closure of the individual case on March 24, 2015.

Nyack Hospital (Participant 2)

On April 30, 2012, the Board denied jurisdiction over the Medicaid eligible days issue in Nyack Hospital's individual appeal. (Although the issue was dismissed from the individual appeal, the Board did not address the denial of the transfer of this issue to the subject group in the letter denying jurisdiction).

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 final determination.

After reviewing the facts in this case, the Board denies jurisdiction over Valley Presbyterian Hospital's appeal of the Medicaid Eligible Days issue which it appealed from the RNPR. Although audit adjustment R2-001 was an adjustment for Medi-Cal eligible days, the Board is unable to determine what days were specifically reviewed and adjusted within the RNPR or whether the days currently in dispute were a product of that review or represent a new subset of days not previously presented to the Medicare Contractor.[3] As the Board previously requested supporting documentation on this matter, to which the Provider failed to respond, the Board finds that it does not have jurisdiction over this Provider.

Since Valley Presbyterian Hospital is hereby dismissed from the group and the Board previously denied jurisdiction over Nyack Hospital in 2012, there are no remaining participants in the group. Consequently, the Board hereby closes case number 08-2664G.

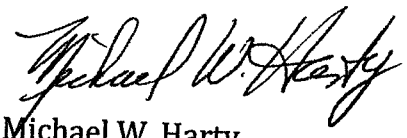
---

[3] The Board also notes that the adjustment in the RNPR was to add days. As a result, there should be no dissatisfaction with regard to the adjustment made in the RNPR.

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

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

For the Board:



Michael W. Harty
Chairman

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

cc: Kyle Browning, National Government Services
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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

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

Refer to: 09-0196GC

CERTIFIED MAIL

NOV 13 2015

Keith D. Barber, Esq.
Hall, Render, Killian, Heath & Lyman
One American Square
Suite 2000, P.O. Box 82064
Indianapolis, IN 46282

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

Re: Group: Ascension Health 1998-9/30/2004 DSH Dual Eligible Group
PRRB Case No.: 09-0196GC

Dear Mr. Barber and Mr. Lamprecht:

The hearing request for the establishment of the Ascension Health Dual Eligible Days Group appeal was filed with the Provider Reimbursement Review Board ("Board") on October 20, 2008. This provider group appealed the following issue:

> The [Medicare Contractor's] failure to include all dual eligible days (Medicare/Medicaid dually eligible days) as Medicaid eligible days, whether paid or unpaid, or otherwise to be used in the calculation of Medicare's disproportionate share hospital (DSH) eligibility and payment adjustments pursuant to 42 U.S.C. § 1395ww(d)(5)(F), including any impact such would have on capital DSH, was improper. The [Medicare Contractor] failed to include these dual eligible days in either the Medicare or Medicaid proxy.[1]

The Group Representative added multiple fiscal year ends to the group. The case was reviewed and on July 1, 2014, the Board sent a letter to bifurcate fiscal years 10/01/2004-2005 to a Medicare fraction dual eligible days and a Medicaid fraction dual eligible days group. The Board allowed fiscal year ends 1998-09/30/2004 to remain in the instant case.

This case is governed by CMS Ruling 1498-R, which provides for a remand of

[1] Group Appeal Request Tab 2, Oct. 20, 2008.

dual eligible days for cost reports with discharges prior to 10/01/2004. The remand will be sent under separate cover; however, not all of the providers in the group will be remanded. The Board reviewed the jurisdictional documentation submitted by the Group Representative and found it lacks jurisdiction over some of the providers in the group, as described below.

Board Determination

Revised Notice of Program Reimbursement

The regulations provide an opportunity for a provider to appeal from a revised Notice of Program Reimbursement ("RNPR"); however, different appeal rights apply. Pursuant to 42 C.F.R. § 405.1889 (2008):

> (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.

Two providers, Detroit Riverview Hospital (Participant 1) and St. John North Shores (Participant 25) appealed from RNPRs. Neither provider documented that there was a specific revision to dual eligible days. Detroit Riverview Hospital (Participant 1) only documented that DSH% and HMO (State paid) days were revised; St. John North Shores (Participant 25) documented that LIP days were adjusted. Therefore, the Board finds that the documentation provided does not support that revisions to dual eligible days were

made in the providers' RNPRs. The Board hereby dismisses Detroit Riverview Hospital (Participant 1) and St. John North Shores (Participant 25) from this appeal.

Missing Final Determination

Board Rules require a copy of a provider's final determination. The Commentary to Board Rule 20.2 provides:

> . . . it is the responsibility of the Group Representative to gather these [various elements of documentation to demonstrate jurisdiction] . . . for each Provider to be included in the group, even when such documentation may be on file with the Board in another appeal (e.g., the underlying individual appeal, another group appeal). Failure to submit the requisite documentation for one of the Providers may result in the dismissal of that Provider from the group.[2]

St. John Northeast Community Hospital (Participant 9) failed to include its final determination in the Schedule of Providers. Rather, a note stated, "[t]his Hospital closed in 2004. The System is currently trying to locate this 6/30/01 NPR. The System has contacted WPS to retain a copy of the NPR."[3] St. John Northeast Community Hospital (Participant 9) never submitted a copy of its NPR to the Board. The Board hereby dismisses St. John Northeast Community Hospital (Participant 9) from this appeal.

Issue Not Properly Added

Seton Health System (Participant 2) did not appeal dual eligible days in its original hearing request. Further, Seton Health System (Participant 2) never added dual eligible days to its individual appeal, Case No. 04-0820. Instead, Seton Health System (Participant 2) filed a request to be added to a different dual eligible days group appeal (Case No. 04-0728G) on October 19, 2004. In its request, Seton Health System (Participant 2) cited its individual case number. Subsequently, Seton Health System (Participant 2) requested to transfer from the dual eligible days group appeal to the instant case. The Board finds that Seton Health System's (Participant 2) appeal is

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[2] Board Rule 20.2 Commentary at 17, Mar. 1, 2013.
[3] *See* Schedule of Providers Vol. 1 Tab 9A, Aug. 15, 2014.

jurisdictionally valid. The Board finds that the initial transfer request to a dual eligible days group can be considered an add/transfer request of the dual eligible days issue since this transaction occurred prior to the 2008 rule changes. Therefore, Seton Health System (Participant 2) will remain in this case.

Genesys Regional Medical Center (Participant 11 and Participant 20) also failed to appeal, or subsequently add, the issue of dual eligible days. On September 14, 2009, Genesys Regional Medical Center (Participant 11 and Participant 20) requested to transfer "SSI Days, DSH Dual Eligible Days, and L&D DSH issues" to group appeals.[4] At this time, the post-2008 Board Rules applied and, in order to properly add an issue to an existing appeal request, the provider must have filed a timely Model Form C with supporting documentation (and in accordance with 42 C.F.R. § 405.1835(c), the 60-day deadline).[5] Here, Genesys Regional Medical Center (Participant 11 and Participant 20) failed to properly add dual eligible days to its appeals. Further, the Group Representative failed to include evidence of transferring dual eligible days for Genesys Regional Medical (Participant 11).[6] The Board, therefore, dismisses Genesys Regional Medical Center (Participant 11 and Participant 20).

Seton Health System (Participant 22) filed an individual appeal request on March 19, 2007. The Group Representative failed to include any evidence that the dual eligible days issue was transferred out of Seton Health System's (Participant 22) individual appeal. The only transfer documented was a "Request to Transfer Provider from Optional Group Appeal to Mandatory Group Appeal."[7] Board Rules require that the Group Representative include the jurisdictional documentation as part of the Schedule of Providers.[8] The Board finds that it lacks jurisdiction over Seton Health System (Participant 22), since the Group Representative did not provide proof of the transfer.

Saint John Macomb Hospital (Participant 24) submitted a copy if its Model Form E, dated December 23, 2009, which is a Request to Join an Existing Group Appeal:

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[4] *See* Schedule of Providers Vol. 2 Tab 11G.
[5] *See* Board Rule 11 at 8, Aug. 21, 2008.
[6] *See* Schedule of Providers Vol. 2 Tab 11G; *see also* Board Rules Appendix at 55 [Model Form D Certifications], Aug. 21, 2008. It should also be noted that the Board sent correspondence to the Group Representative explaining that several transfer requests were missing Provider Representative signatures and that the Group Representative was to submit proper requests for previous transfers submitted and any future transfer requests.
[7] Schedule of Providers Vol. 3 Tab 22G.
[8] *See* Board Rule 21G at 15, Aug. 21, 2008.

Direct Appeal from Final Determination.[9] The Model Form E requests to appeal DSH SSI Days and join the Ascension Health 2006 SSI Days Group.[10] The Group Representative provided no evidence that Saint John Macomb Hospital (Participant 24) appealed dual eligible days; there is no documentation that dual eligible days were timely appealed or added. Therefore, the Board dismisses Saint John Macomb Hospital (Participant 24) from this appeal.

The Board determines that it lacks jurisdiction over seven providers in Case No. 09-0196GC: Detroit Riverview Hospital (Participant 1), St. John North Shores (Participant 25), St. John Northeast Community Hospital (Participant 9), Genesys Regional Medical Center (Participant 11), Genesys Regional Medical Center (Participant 20), Seton Health System (Participant 22), and Saint John Macomb Hospital (Participant 24). The Board hereby dismisses Participants 1, 25, 9, 11, 20, and 24 from this group appeal. A remand of the remaining providers will be detailed under separate cover. 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 upon final disposition of this appeal.

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: Wilson C. Leong, Esq., CPA, Federal Specialized Services (without enclosures)

[9] Schedule of Providers Vol. 3 Tab 24B.
[10] *Id.*

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

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

Refer to: 06-1764

CERTIFIED MAIL NOV 17 2015

Venus Marin-Bautista
Director of Reimbursement
Huntington Memorial Hospital
100 West California Blvd
Pasadena, CA 91105-3010

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

Re: Provider: Huntington Memorial Hospital
Provider No.: 05-0438
FYE: 12/31/2001
PRRB Case No.: 06-1764

Dear Ms. Marin-Bautista and Mr. Lowe:

The Provider, Huntington Memorial Hospital ("Huntington"), appealed the amount of its Medicare reimbursement calculated by the Medicare Administrative Contractor, Cahaba Safeguard Administrators, LLC ("Cahaba"). The Provider Reimbursement Review Board ("Board") concludes that it lacks jurisdiction over Huntington's appeal because Huntington abandoned the issue of Miscellaneous Income Offset in its appeal, and the other issues were withdrawn at Huntington's request. The Board hereby dismisses the case.

Background

Huntington's Notice of Reimbursement ("NPR") for fiscal year end December 31, 2001 was issued on November 21, 2005. Huntington timely appealed the following two issues to the Board on May 17, 2006:

(1) Whether the Medicare Contractor properly excluded Medi-Cal one-day stay, Medi-Cal days for the Patients' Medicare Part A effective date after the service dates and overlapped days for DSH% calculation [Medicaid Eligible days]; and,
(2) Whether the Medicare Contractor properly determined the SSI%.[1]

Upon receipt of Huntington's appeal, the Board sent its Acknowledgement and Critical Due Dates letter. The letter provided that Huntington's preliminary position paper was due by September 1, 2006.[2] The Board received proof that Huntington submitted its preliminary

[1] Huntington Individual Appeal Request at 3, May 17, 2006.
[2] Acknowledgement and Critical Due Dates letter, May 26, 2006.

position paper timely. Huntington only briefed the Medicaid Eligible days issue because it requested to transfer the SSI% issue to Case No. 95-2120G. Huntington submitted it final position paper on December 18, 2006. Again, only the Medicaid Eligible days issue was briefed.

In October 2007, Huntington requested to add and transfer the Rural Floor Budget Neutrality Adjustment ("RFBNA") issue.[3] Then, on August 21, 2008, Huntington sent in an additional Add Request for the following issues:

(1) Crossover Unbilled Inpatient Bad Debt;
(2) Crossover Unbilled Outpatient Bad Debt;
(3) Miscellaneous Income Offset;
(4) Excess Cost from Prior Year; and,
(5) Prior Year Revenue Add-on.[4]

Huntington requested that both of the Bad Debt issues be transferred to Case Nos. 98-0212G and 97-2983G, respectively.[5]

On August 10, 2012, the Board sent its Notice of Hearing, which contained an Alert 3 Reminder. The Reminder stated, " . . . if issues added after [August 21, 2008] pursuant to 73 FR 30240 (60 days) . . . but after position paper deadlines have already expired, supplemental position papers that comply with the requirements of Rule 25 for the added issue are due as follows:" the Provider's supplemental position paper is due 120 days prior to the hearing date, the Medicare contractor's response is due 60 days prior to the hearing date, and the Provider's optional rebuttal is due 30 days prior to the hearing date. The Notice of Hearing set the hearing date as April 18, 2013. The hearing was rescheduled to October 29, 2013 at the request of the parties, and was later rescheduled by the Board to January 27, 2014.

The hearing never took place. Instead, the parties entered into an Administrative Resolution ("AR") on or around January 23, 2014. The AR resolved all but one issue.

Cahaba filed a Jurisdictional Challenge with the Board on January 13, 2014.[6] The Jurisdictional Challenge noted that the AR resolved the following issues:

(1) Medicaid Eligible days;
(2) Excess Cost from Prior Year; and,
(3) Prior Year Revenue Add-on.[7]

Cahaba stated that the only issue that remains to be resolved is Miscellaneous Income Offset; however, Cahaba challenged the Board's jurisdiction on the grounds that no adjustment was

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[3] First Add Request at 1, Oct. 17, 2007.
[4] Second Add Request at 1, Aug. 21, 2008.
[5] *Id.*
[6] Jurisdictional Challenge at 3, Jan. 13, 2014.
[7] *See* Administrative Resolution, Jan. 23, 2014.

made.[8] Cahaba argued that:

> In adding this issue to the appeal, the provider referenced Adjustment 26 and described the issue as "The provider discovered that Cafeteria revenue and Vending machines revenue were incorrectly offset to Dietary cost center and it was **omitted** during the audit" (emphasis added). Without a determination, the Provider has nothing to appeal and the criteria for the right to a hearing has not been met.[9]

Cahaba further argued that *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) did not apply since Huntington was not barred from claiming reimbursement of Dietary or Cafeteria costs reduced by Miscellaneous Income.[10] Cahaba also argued that *Loma Linda University Medical Center v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007) did not apply since Huntington did not make an "inadvertent omission," but was aware that Dietary costs were reduced by Miscellaneous Income on its as-submitted cost report.[11] Cahaba requests that the Board decline jurisdiction over the remaining issue since Cahaba never made a determination as to Miscellaneous Income Offset.

On January 27, 2014, Huntington filed a response to the Jurisdictional Challenge. It argued that *Loma Linda* does apply because the offset should have been against the "Cafeteria" instead of the "Dietary" cost center. Therefore, the incorrect application of the offset was an "inadvertent omission."

Board Determination

The Board determined that it does not have jurisdiction over the remaining issue of Miscellaneous Income Offset. Huntington failed to brief Miscellaneous Income Offset in a supplemental position paper as required.[12] Board Alert 3 ("Added Issue Deadlines") provides:

> **The following are deadlines applicable only to CASES PENDING BEFORE AUGUST 21, 2008, AND HAVE AN ISSUE ADDED ON OR AFTER AUGUST 21, 2008.**
>
> In cases filed prior to August 21, 2008, if issues are added after that date pursuant to 73 FR 30240 (60 days after implementation of the Regulations, or, as applicable, 60 days after expiration of the 180 day appeal deadline) but **after position paper deadlines have already expired**, a supplemental position paper that complies with

[8] *See* Jurisdictional Challenge.
[9] *Id.* at 3-4.
[10] *Id.* at 4.
[11] *Id.*
[12] Since the Board is dismissing Miscellaneous Income Offset on a procedural basis, it need not address Cahaba's argument that no adjustment was made.

the requirements of Rule 25 for the added issue is due as follows:

- Provider's supplemental position paper – 120 days prior to hearing.
- [Medicare contractor's] response – 60 days prior to hearing.
- Provider's rebuttal [optional] – 30 days prior to hearing.

Exception: If you have a hearing date scheduled on or before March 1, 2009, contact the [Medicare contractor] to work out a position paper schedule for the added issue. If no agreement can be reached, contact your Board Advisor. The position paper must meet Rule 25 requirements.[13]

Board Rule 25 sets forth the requirements for filing preliminary position papers with the Board.[14]

Alert 3 applies in this case since Huntington's appeal was pending before August 21, 2008 and had issues added on August 21, 2008. The Board issued three separate Notices of Hearing to Huntington, all providing the Alert 3 Reminder for briefing any issues added after the deadlines for position papers had passed. Here, Huntington was required to file a supplemental position paper on the Miscellaneous Income Offset issue at least 120 days prior to the hearing date. Using the last scheduled hearing date of January 27, 2014, Huntington's supplemental paper would have been due by September 30, 2013.[15]

Board Rule 41.2 provides that the Board " . . . may also dismiss a case on its own motion (1) if it has a reasonable basis to believe that the issues have been fully settled or abandoned, (2) upon failure of the Provider to comply with Board procedures . . . ."[16] Here, Huntington failed to comply with Board procedures when it failed to file a supplemental position paper on Miscellaneous Income Offset. Therefore, the Board finds that the issue was abandoned.

The Board concludes that it lacks jurisdiction over the Miscellaneous Income Offset issue. Since no other issues remain in this case,[17] the Board hereby closes this 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.

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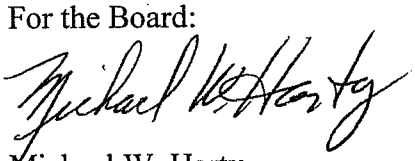
[13] Board Alert 3 ("Added Issue Deadlines"), Oct. 3, 2008, *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Board/PRRBReview/PRRB_Alerts.html (last visited Aug. 4, 2015) (emphasis in original).
[14] *See* Board Rule 25 at 20-22, Aug. 21, 2008.
[15] Actual date is September 29, 2013; however, since that was a Sunday, the due date is the next business day.
[16] Board Rule 41.2 at 36.
[17] The other issues were withdrawn pursuant to Huntington's request since an AR was reached. Therefore, the Board does not reach the issue of jurisdiction regarding those issues.

Board Members Participating:
Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson
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: Wilson C. Leong, Esq., CPA, Federal Specialized Services (without enclosures)

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

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

Refer to: 14-2620

NOV 17 2015

CERTIFIED MAIL

HealthCare Reimbursement Services
Corinna Goron, President
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

Novitas Solutions, Inc.
Bill Tisdale
Director, Provider Audit-JH
Union Trust Building
501Grant Street # 600
Pittsburgh, PA 15219

RE: Jurisdictional Decision – W.O. Moss Medical Center
Provider No.: 19-0161
FYE: 06/30/2010
PRRB Case No.: 14-2620

Dear Ms. Goron and Mr. Tisdale:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. The Board finds that W.O. Moss timely filed its appeal. The decision of the Board is set forth below.

Medicare Contractor's Contention

On October 27, 2014, the Medicare Contractor filed a jurisdictional challenge contending W.O. Moss Medical Center Medicare appeal was not timely filed and therefore, the Board does not have jurisdiction over the appeal. The Medicare Contractor states the NPR was issued on August 22, 2013, and argues the Provider filed its appeal request 186 days after the Provider received the NPR. As such, the Provider has failed to meet the timeliness requirement

Provider's Contentions

On November 19, 2014, the Provider filed a jurisdictional response and contended that its appeal was timely filed. The Provider states pursuant to the Board Rule 4.3, "the date of receipt of a final determination is presumed to be five days after the date of issuance and is a conclusive presumption and therefore, non-rebuttable." The Provider maintains that the 185 day deadline fell on Sunday, February 23, 2014.Therefore, in accordance with 42 C.F.R. § 405.1801(a),(d), its appeal was due at the Board on the next business day, Monday, February 24, 2014. Since the appeal was received by the Board on February 24, 2014, the appeal was timely.

Board's Decision

The Board finds that it does have jurisdiction over W.O. Moss Medical Center because it timely filed its appeal.

Pursuant to 42 C.F.R. § 405.1835(a)(3)(i) and PRRB Rules, an appeal must be filed with the Board no later than 180 days after the date of receipt of the final determination.[1] On August 22, 2013, W.O. Moss Medical Center's Notice of Program Reimbursement ("NPR") was issued and deemed to have been received by the Provider on August 27, 2013. The appeal request was delivered by UPS (United Parcel Service) and received by the Board on Monday, February 24, 2014. The date of filing was 181 days after the presumed receipt of the final determination.

Pursuant to 42 C.F.R. § 405.1801(d)(3), "If the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday . . . or a day on which the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days."

Since the filing deadline fell on a weekend (Sunday February 23, 2014), the due date is extended to the next business day (Monday, February 24, 2014). Therefore, W.O. Moss Medical Center did timely file its appeal. Case number 14-2620 remains open and pending before the Board.

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 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: Federal Specialized Series
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

[1] 42 C.F.R. §§ 405.1835 (a)(3) states in part, "the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination."

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

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

Refer to: 06-0083GC

NOV 17 2015

CERTIFIED MAIL

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

Noridian Healthcare Solutions
Darwin San Luis
Appeals Coordinator – Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation – CHW 2001 DSH Dual Eligible Days CIRP Group
Provider No.: Various
FYE: Various
PRRB Case No.: 06-0083GC

Dear Mr. Knight and Mr. San Luis,

The Provider Reimbursement Review Board (Board) has reviewed the above-referenced appeal in response to the Providers' Request for Case Bifurcation. The Board hereby grants the Providers' request for case bifurcation of the dual eligible and Part C/HMO[1] days issues. The decision of the Board with regard to jurisdiction and the bifurcation request is set forth below.

BACKGROUND

Formation of Group

On October 7, 2005, the Board received the Providers' initial request for the establishment of a group appeal for the CHW 2001 DSH Dual Eligible Days CIRP Group. On April 24, 2007, the group representative submitted the final position paper for the appeal, which included a listing of the dual eligible days categories the Providers were appealing. On December 26, 2012, the Board received this request from Toyon Associates, Inc., the group representative, entitled, "Request for Case Bifurcation, Expedited Judicial Review for Part A Dual Eligible Days and for a Consolidated Hearing for Dual Eligible Part C Days."

Jurisdictional Position of Participating Providers

Participant 8 included an original Notice of Program Reimbursement (NPR) with the handwritten date 2/20/04. There is no other date on the NPR. The Provider's appeal request indicates that it

[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

is appealing from a **Revised** NPR dated February 20, 2004. The Provider included an audit adjustment report that was run on September 15, 2003.

Participant 30 submitted an original NPR that does not include the date it was issued. The Provider's appeal request indicates that it is appealing from an original NPR dated March 3, 2004. The Provider submitted an audit adjustment report that was run on February 23, 2004.

Participant 34 is appealing from a revised NPR dated February 26, 2009. The Provider submitted an audit adjustment report that shows an adjustment to DSH, but did not submit any documents to establish that dual eligible days were specifically revised as part of the DSH adjustment.

PROVIDERS' REQUEST FOR BIFURCATION

On December 21, 2012, the Providers' Representative, Toyon Associates, Inc., submitted a request that the Board bifurcate a number of dual eligible day group appeals that were pending before the Board. Toyon argues that the dual eligible day group appeals in fact cover two issues: Part C days and other Part A dual-eligible non-covered patient days. Toyon explains that in light of CMS Ruling 1498-R, the Part C days at issue need to be in separate appeals from the other Part A dual eligible non-covered patient days at issue, because the Part C days are not subject to the remand.

BOARD'S DECISION

JURISDICTIONAL DETERMINATIONS

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 ($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 Board finds that it does not have jurisdiction over Participant 8, because it did not submit sufficient documentation for the Board to be able to determine whether it filed a jurisdictionally valid appeal. Based on the documents that the Provider submitted, it is unclear from which final determination the Provider is appealing. Without this documentation, the Board is not able to make a determination as to timeliness of the Provider's appeal or as to the Provider's dissatisfaction, as required by 42 C.F.R. § 405.1835. Accordingly, Participant 8, Marian Medical Center (6/30/2001), is hereby dismissed from this appeal.

The Board finds that it does not have jurisdiction over Participant 30 because it did not submit sufficient documentation for the Board to be able to determine whether it filed a jurisdictionally valid appeal. Based on the documents that the Provider submitted, it is unclear from which final determination the Provider is appealing. Without this documentation, the Board is not able to make a determination as to timeliness of the Provider's appeal or as to the Provider's

dissatisfaction, as required by 42 C.F.R. § 405.1835. Accordingly, Participant 30, St. Mary Medical Center – Long Beach (6/30/2001), is hereby dismissed from this appeal.

The Board finds that it does not have jurisdiction over Participant 34 because it appealed from a revised NPR that did not specifically adjust dual eligible days. The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885(a)(1) (2008) provides in relevant part:

> 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), or 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).

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889 (2008):

> (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 . . .
> (b) (1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
> (b) (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Here, Participant 34 is appealing from an audit adjustment report that adjusted DSH. However, the Provider did not submit any documentation to establish that dual eligible days were adjusted as part of the DSH adjustment. Therefore, pursuant to 42 C.F.R. § 405.1889, dual eligible days are beyond the scope of the appeal of the Provider's revised determination.[2] Accordingly, Participant 34, St. Bernadine Medical Center (12/31/2001), is hereby dismissed from this appeal.

BIFURCATION OF THE DUAL ELIGIBLE DAYS ISSUE

The Board hereby grants the Providers' request for bifurcation of the dual eligible exhausted Part A and Part C days issues for all of the Providers in case number 06-0083GC, except for those participants dismissed for jurisdictional reasons above.

The Board acknowledges that at the time the group appeal, individual appeals, and transfer requests were filed, the issue of whether a Medicaid patient that was "dually eligible" for

[2] *See also HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 615 (D.C. Cir. 1994) (holding that a provider's appeal of that reopening is limited to the specific issues revisited on reopening).

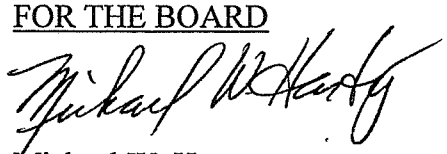
Medicare was not necessarily subdivided by Medicare Part A or Part C. Federal courts later ruled differently on the dual eligibility related to Part A and Part C days, thereby requiring bifurcation of these issues. In this case, the Board finds that the group appeal request included a broad issue statement that encompassed both Part A non-covered days and Part C days and the Providers' position paper, submitted on April 24, 2007, specifically identified the various sub-categories of dual eligible days that the Providers are appealing, including Part A and Part C.

Based on these factors, the Board finds that there are two issues pending in case number 06-0083GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[3] Therefore, the Board bifurcates the dual eligible exhausted Part A and Part C days issues into separate group appeals. The Providers' Part C issue (apart from Participants 8, 30, and 34, which the Board has dismissed) is now in case number 16-0208GC, CHW 2001 DSH Part C Days CIRP Group. The remaining Providers in Case No. 06-0083GC are subject to CMS Ruling 1498-R, and you will receive notification of remand of those providers under separate cover.

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

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
Schedule of Providers dated June 19, 2012
Acknowledgement and Critical Due Dates Notice for case number 16-0208GC

cc: Wilson C. Leong, Esq., CPA
Federal Specialized Services
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4508

[3] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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

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

Refer to:

06-0180

NOV 17 2015

CERTIFIED MAIL

Price, Fass & Co., LLP
Susan Starr
Vice President
1480 Moraga Road, #378
Moraga, CA 94556

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

RE: Mercy San Juan Hospital
Provider No: 05-0516
FYE: 03/31/1997
PRRB Case No.: 06-0180

Dear Ms. Starr and Mr. Lowe,

The Medicare Contractor in this appeal, Cahaba Safeguard Administrators, LLC, has challenged the Provider Reimbursement Review Board's (hereinafter "Board") jurisdiction to hear the last remaining issue in the appeal for Disproportionate Share Hospital (hereinafter "DSH") Medicaid eligible days.

Background

Mercy San Juan Hospital (hereinafter "Mercy Hospital") was issued a revised Notice of Program Reimbursement (RNPR) for FYE 03/31/1997 on May 13, 2005. On November 4, 2005, Mercy Hospital timely filed an appeal with the Board from the RNPR. In response to the Medicare Contractor's jurisdictional challenge, Mercy Hospital has filed a Response to the Jurisdictional Challenge.

Medicare Contractor's Contentions

The Medicare Contractor contends that Mercy Hospital submitted a listing of 15,295 eligible days for audit per their reopening request, and that the Medicare Contractor completed the audit and issued the RNPR on May 13, 2005. The Medicare Contractor states the Hospital is now asking for review of an additional listing of 1,061 eligible days as part of this appeal, and that this new listing was not part of the audit which resulted in the RNPR. The Medicare Contractor asserts that based upon 42 C.F.R. § 405.1889(b), it is clear that only issues raised/disallowances made concerning the original listing of 15,295 days audited may be appealed. It also asserts that no final determination has been made regarding the new listing of 1,061 days.

Mercy Hospital's Contentions

Mercy Hospital explains that it received the original NPR on November 1, 1998, which included only paid Medicaid days used in the Medicaid fraction of the Medicare DSH payment adjustment and some Medicaid HMO days. The Hospital then engaged a consulting firm to assist in following HCFA Ruling 97-2 (issued in February, 1997) which required hospitals to furnish documentation regarding all patients days claimed, and also disallowed days which could not be verified by the State. Mercy Hospital claims its consultant then had to wait until the State of California developed a process to allow hospitals to obtain eligibility data for all patients, and that between the time of the amended reopening request (August, 2002) and the appeal request (November, 2005), the State of California overhauled its DSH eligibility re-verification process.

Mercy Hospital says that it took nearly three years for the Medicare Contractor to review the reopening request, and it concedes it "requested 15,295 total Medicaid days"[1] prior to the issuance of the RNPR in May, 2005. Mercy Hospital further contends the Board has jurisdiction over the appeal because it specifically meets the requirements of 42 C.F.R. § 405.1889, and Adjustment R1-001 adjusted Medicaid Title XIX days on the cost report at Worksheet S-3, Line 1, Column 5.

Analysis and Decision:

The Board finds that the "matter at issue" in the RNPR was the 15,295 Medicaid eligible days examined by the Medicare Contractor during reopening, and the Board's jurisdiction is limited to the Medicare Contractor's adjustment of those claimed days. The Board concludes that it does not have jurisdiction over the additional Medicaid eligible days now sought during the appeal process.

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 Medicare Contractor's determination was mailed to the provider.

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

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

A revised NPR is considered a separate and distinct determination from which the provider may appeal. 42 C.F.R. § 405.1889, effective October 1, 2002, through May 22, 2008, stated:

> [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 as provided in

[1] *See* Provider's Response to MAC's Jurisdictional Challenge at 4.

§ 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.

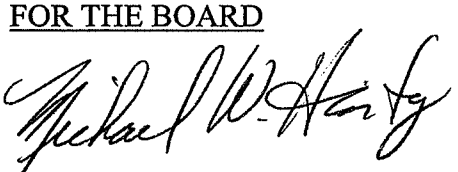
In this appeal, Mercy Hospital is seeking Medicaid eligible days which were not revised in the RNPR, and they were not considered by the Medicare Contractor in the reopening and RNPR process. This case is similar to *Illinois-Masonic Medical Center v. Shalala*, 869 F.Supp.2d 137 (D.D.C. 2012), in which the Court upheld the Board's decision to limit a hospital's appeal of a RNPR to the Medicaid eligible days reviewed by the Medicare contractor during reopening.

The Board notes that while Mercy Hospital argues the Board has jurisdiction under *Barberton Citizens Hosp. vs. CGS Administrators*, PRRB Dec. No. 2015-D5 (March 19, 2015) in its brief (asserting if faced a practical impediment to verify the days), the *Barberton* decision is distinct from this appeal in that it concerns an original NPR.

This case is now closed. Review of this decision may be available under 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, Blue Cross and Blue Shield Association

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

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

Refer to:

09-2036GC

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CERTIFIED MAIL

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

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

RE: Jurisdictional Determination – St. Francis Hospital and Health Center, as a participant in SSM Health Care 2003-2004 SSI Percentage CIRP Group
Provider No.: 14-0118
FYE: 12/31/2003
PRRB Case No.: 09-2036GC

Dear Mr. Blumberg and Mr. Lamprecht:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the jurisdictional documents in this appeal. The decision of the Board with regard to jurisdiction of the above-mentioned provider is set forth below.

Background

The providers filed a request for a common issue related party ("CIRP") group appeal on July 17, 2009. There are 14 participants in the group, including St. Francis Hospital and Health Center, which is listed as Provider No. 2 on the Schedule of Providers.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 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 determination of the Medicare contractor, 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 Medicare contractor determination.

Regarding St. Francis Hospital and Health Center, the provider has failed to support that it filed a jurisdictionally valid appeal because documentation necessary to make such determination was not submitted with the Schedule of Providers. PRRB Rule 20 indicates that the providers in a group appeal must submit a Schedule of Providers to the Board. PRRB Rule 21 outlines what should be included on the Schedule, and specifies the supporting documentation that must be

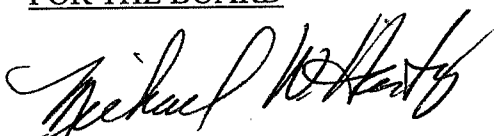
not submitted with the Schedule of Providers. PRRB Rule 20 indicates that the providers in a group appeal must submit a Schedule of Providers to the Board. PRRB Rule 21 outlines what should be included on the Schedule, and specifies the supporting documentation that must be submitted.

The Schedule of Providers is blank in Columns A through E for St. Francis Hospital and Health Center, and the only supporting documentation provided is a "Request for Transfer of SSI Percentage Issue from an Individual Appeal to a Group Appeal." Without having the Notice of Program Reimbursement ("NPR"), the individual appeal request, and the audit adjustment report, the Board is unable to make fundamental determinations such as the timeliness of the appeal, whether the SSI percentage issue was raised, or if the appeal concerned an original or revised NPR, and therefore which standard to apply. Since the provider failed to supply adequate documentation, the Board finds that it does not have jurisdiction over St. Francis Hospital and Health Center (provider no. 14-0118, FYE 12/31/2003) and hereby dismisses this provider from case number 09-2036GC.

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
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: Wilson C. Leong, Esq., CPA, Federal Specialized Services

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

Internet: www.cms.gov/PRRBReview

FAX: 410-786-5298
Phone: 410-786-2671

Refer to: 10-0845

CERTIFIED MAIL

NOV 23 2015

Russell Kramer
Quality Reimbursement Services
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

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

RE: Avera McKennan Hospital
Jurisdictional Challenge
PN: 43-0016
FYE: Multiple Years
PRRB Case Number: 10-0845

Dear Mr. Kramer and Mr. Ward,

The Provider Reimbursement Review Board (the Board) has reviewed the above-captioned appeal in response to the Medicare contractor's jurisdictional challenge concerning the subject provider.

Issue Before the Board:

Avera McKennan Hospital (hereinafter "Avera" or "Provider") is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. On January 20, 2010, Avera's Representative, Quality Reimbursement Services, Inc. ("QRS") submitted a request to transfer an issue from multiple individual appeals and create a new individual appeal with one provider for multiple years.[1] This request transferred the Disproportionate Share Hospital (DSH) SSI (Systemic) issue from various individual appeals to various group appeals.[2] The request asked the Board to transfer and establish an individual appeal for Avera for multiple years for the single issue of "DSH/SSI (Provider Specific) or Realignment".[3] On March 24, 2010, the Board granted Avera's request and created case no. 10-0845.

Background:

The individual appeal requests for Avera (case nos. 01-0134, 01-0135, 00-1901, 02-0449, 03-0249, 04-0646 and 04-0647) when filed by QRS stated the DSH SSI Proxy issue as:

> "The Provider contends that the Intermediary did not determine Medicare DSH reimbursement in accordance with the statutory instructions ...the intermediary

[1] *See* attached request dated January 20, 2010.
[2] *See* Medicare Contractor's Jurisdictional Challenge Exhibit 1 at 1 of 21 for a complete listing.
[3] *See* attached request dated January 20, 2010.

> did not furnish the matching data from which the SSI proxy had been derived ...The regulations impose restrictive conditions that do not permit the provider to obtain and reconcile the SSI data maintained by CMS with provider records."[4]

On October 15, 2008, QRS requested to add the DSH SSI percentage issue stating the issue as:

> "Avera McKennan Hospital ... contends that the Intermediary did not determine Medicare DSH reimbursement in accordance with the statutory instructions ...the Provider contends that its SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients ... The Provider has analyzed Medicare Part A and South Dakota State records ... The Provider is seeking SSI data from CMS. The Provider seeks to reconcile its records with CMS data ... 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."[5]

Medicare Contractor's Position:

The Medicare Contractor asserts that Avera's SSI "Provider Specific" issue is duplicative of the SSI "Systemic Errors" issue which has been included in various group appeals. The Medicare Contractor cites PRRB Rule 4.5 that states a Provider may not appeal an issue in more than one appeal. The Medicare Contractor notes that the Board has recently issued determinations denying jurisdiction over the SSI Provider Specific as the Board considered the SSI "Provider Specific" and SSI "Systemic Errors" to be one issue. The Medicare Contractor believes a similar decision should be reached in the subject appeal.

The Medicare Contractor states that the SSI realignment issue is not an appealable appeal. The Provider has a September 30 fiscal year end.[6]

Avera's Position:

The Provider argues that the Medicare Contractor specifically adjusted the SSI percentage and as a result its SSI percentage was understated. The Provider contends that it is entitled to appeal an item with which it is dissatisfied. The Provider believes it can identify patients entitled to both Medicare Part A and SSI who were not included in the SSI percentage. The Provider asserts that it is entitled to a correction of these errors of omission to its SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Board's Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2010), a hospital has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if

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[4] *See* Appeal Request for Case No. 03-0249.
[5] *See* attached request dated October 15, 2008 for case no. 03-0249.
[6] It should be noted that the Provider is not seeking SSI realignment. *See* Provider's Jurisdictional Response dated August 11, 2015 at 2.

it is 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 of receipt of the final determination. Additionally, PRRB Rule 6.3 requires that an individual appeal have a **total** amount in controversy of at least $10,000, and that a calculation or support demonstrating the amount in controversy be provided for each issue. PRRB Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

The Board concludes that to the extent the Provider is arguing that the DSH SSI (Provider Specific) is understated, and in need of the underlying data to determine what is or is not included, the issue is the same as the DSH SSI Proxy Percentage (Systemic) issue that was transferred to various group appeals. The basis of both issues is that the SSI percentage is improperly calculated, and the Provider does not have the underlying data and cannot determine if the SSI percentage is accurate. The Board finds that the need for the data in this DSH SSI (Provider Specific) appeal is duplicative of the data need in the corresponding systemic appeals. The corresponding systemic appeals are all subject to CMS Ruling 1498-R and remand for the new SSI%. Therefore, no data will be provided for the SSI% as challenged in this appeal. Since this is the only issue pending in the subject appeal, the Board dismisses the issue and closes case no. 10-0845.

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, 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: Wilson C. Leong, Federal Specialized Services

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:

12-0266

CERTIFIED MAIL

NOV 23 2015

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

Darwin San Luis
Appeals Coordinator – Jurisdiction E
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108

RE: Valley Memorial Hospital
Provider No.: 05-0283
FYE: June 30, 2002
PRRB Case No.: 12-0266

Dear Ms. Lee and Mr. San Luis:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional documents in Valley Memorial Hospital's ("Valley's") above-referenced appeal. The Board has determined that, within its March 16, 2012 request for hearing ("RFH"), Valley has failed to demonstrate dissatisfaction with its capital payment calculation reported within its September 20, 2011 revised notice of program reimbursement ("RNPR") for the fiscal year ending ("FYE") on June 30, 2002. Accordingly, the Board finds that it does not have jurisdiction to hear Valley's appeal of its September 20, 2011 RNPR and hereby dismisses Valley's March 16, 2012 RFH.

Background

1. Original Appeal, PRRB Case No. 05-2109

On September 2, 2005, Valley filed a RFH challenging 12 issues from its June 30, 2002 NPR. All of Valley's original 12 issues were eventually resolved by transfer, withdrawal or within Valley's May 19, 2011 Administrative Resolution ("Administrative Resolution") for PRRB Case No. 05-2109.[1]

The Administrative Resolution lists Valley's Issue #4, "Computation of Capital Payments," as being "Resolved." The text pertaining to Issue #4's resolution states the following:

[1] Valley's March 15, 2013 Response to Jurisdictional Challenge Ex. P-3.

> The Provider's position is that the computation was an error because for the 06/30/02 fiscal year, the Provider was hold harmless, and therefore entitled to Capital [disproportionate share hospital ("DSH")] in the computation.
>
> The [Medicare Contractor] agrees with the Provider that the computation should have included Capital DSH. . .The computation supports that the [C]apital DSH should be increased from $1,667,555 to $1,695,983.[2]

The final page of the Administrative Resolution states that "[t]he provider's signature serves as the provider's request to withdraw this case from appeal." Both of the parties signed the signature page of the Administrative Resolution on May 19, 2011,[3] and the Board received Valley's request to withdraw its appeal on May 24, 2011.

On September 20, 2011, the Medicare Contractor issued Valley's FYE June 30, 2002 RNPR.[4]

2. Current Appeal, PRRB Case No. 12-0266

On March 16, 2012, the Board received Valley's RFH regarding its September 20, 2011 RNPR. Within its RFH, Valley states the following:

> The [Medicare Contractor] adjusted the Provider's capital payment as a result of an administrative resolution [in] Case No. 05-2109. The Provider is dissatisfied with the capital payment because the [Medicare Contractor] did not update all components of the capital payment . . . The Provider contends that the overall capital payment is understated because the Capital DSH component of the capital payment is incorrectly stated . . . To properly calculate the Capital DSH component of the capital payment, it is necessary to ensure that the Provider's overall DSH entitlement payment is properly stated.

Based on the above-quoted rationale, Valley challenged five issues within its Capital DSH payment:

1. Additional Medicaid Eligible Days;
2. Dual Eligible Part A Days;
3. Dual Eligible Part C Days;
4. Code 2 and 3 Medicaid Eligible Days; and
5. CMS' development of the Supplemental Security Income ("SSI") Ratio.

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[2] This change reflects an increase in capital DSH of $28,428.
[3] Valley's March 15, 2013 Response to Jurisdictional Challenge Ex. P-3.
[4] This RNPR was the second revision to Valley's FYE June 30, 2002 cost report. The Medicare Contractor issued Valley's previous NPR on August 25, 2011.

For each of these five issues, Valley reports that the Audit Adjustment Number corresponding to the issue is 6. According to the Audit Adjustment Report, Adjustment No. 6 "record[s] the proper reporting of Capital Payment amount[,]" and adjusts Valley's Capital Payment from $1,667,555 to $1,695,983.

On February 27, 2013, the Board received BlueCross and BlueShield Association's ("BCBSA's") Jurisdictional Challenge in which BCBSA argues that, based on the fact that the Medicare Contractor did not adjust Valley's contested issues in Valley's September 20, 2011 RNPR, the Board does not have jurisdiction to hear Valley's appeal.

Within its March 15, 2013 Response to BCBSA's Jurisdictional Challenge, Valley reported that out of its five original issues in the instant appeal, Issues #1 and #4 were "resolved" through Valley's participation in PRRB Case No. 08-1791G, a group appeal connected to Valley's original NPR.[5] In addition, Issue #5, development of the SSI Ratio, was transferred to a group appeal.[6] As such, only Valley's two "Dual Eligible Days Issues" are still being challenged within this appeal.

Valley argues that, within its September 20, 2011 RNPR, the Medicare Contractor adjusted its dual eligible days based on the following analysis:

1. Prior to the September 20, 2011 RNPR, Valley's hold harmless capital payment was $1,667,555 but did not include Capital DSH payments;
2. Within Valley's September 20, 2011 RNPR, the Medicare Contractor added $28,428—all in Capital DSH—to Valley's capital payment as reported on Worksheet L, Part II, Line5;
3. Valley states that the $28,428 in Capital DSH was computed by updating Valley's Medicaid eligible days from 0 to 1,610 and Valley's SSI Ratio from 0 to 4.52%;
4. Valley argues that, due to the above-referenced adjustment, it is challenging its Capital DSH payment and has broken down the larger issue into the five sub-issues that it raised within its RFH.

Valley states that it is disputing the Medicare Contractor's computation of its capital payment because the Medicare Contractor failed to include all of Valley's paid and eligible Medicaid days, as furnished to the Medicare Contractor on May 15, 2009, within its Capital DSH computation.

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[5] Valley states that it noted these two issues as "resolved" in its Preliminary Position Paper dated October 25, 2012. Therefore, the Board considers these two issues withdrawn from the instant appeal.

[6] Valley's SSI Ratio issue from its original appeal was also transferred to group appeal PRRB Case No. 11-0258G and this group appeal was subsequently remanded on April 16, 2014, pursuant to the terms of CMS-1498-R.

Board's Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2011), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more, and the RFH is filed within 180 days of the receipt of the final determination.

In accordance with 42 C.F.R. § 405.1889 (2011), an RNPR is considered a separate and distinct appealable determination to which the above-quoted provisions apply. Further, under 42 C.F.R. § 405.1889(b)(1)-(2), only those matters that are specifically revised in a revised determination are within the scope of any appeal of the revised determination or decision, and any matter that is not specifically revised may not be considered in any appeal of the revised determination or decision.

In the instant case, Valley claims that it is dissatisfied with—and is appealing the sub-components of—its capital payment because its capital DSH calculation is understated. Valley states that on May 15, 2009, it provided the Medicare Contractor with a list of "paid and eligible Medicaid days" for the Medicare Contractor to "incorporate[e] into [Valley's] Medicare cost report."[7] Per the May 19, 2011 Administrative Resolution, Valley and the Medicare Contractor came to an agreement regarding Valley's "Computation of Capital Payments" Issue from its September 2, 2005 RFH. The Administrative Resolution states that the agreement's purpose is to "[set] forth the basis for resolving the issues that are pending before the [PRRB,]" and that "the parties agree to resolve the case as follows . . ." For Valley's Issue #4, Computation of Capital Payments," the Administrative Resolution states that this issue is "Resolved," and that the Medicare Contractor agreed to add $28,428 in Capital DSH to Valley's hold harmless capital payment. The Administrative Resolution also states that "[t]he provider's signature serves as the provider's request to withdraw this case from appeal." Valley signed the Administrative Resolution on May 19, 2011.

On September 20, 2011, the Medicare Contractor issued Valley an RNPR that adjusted Valley's capital payment in the *exact manner and amount* as set out in the agreement.[8] Valley filed its RFH challenging the very amount of the capital payment that the parties agreed upon in the Administrative Resolution. Valley claims that the Medicare Contractor should have included *all* of the Medicaid paid and eligible days that it submitted to the Medicare Contractor back on May 15, 2009.[9] However, Valley signed the Administrative Resolution on May 19, 2011—two years after submitting its paid and eligible Medicaid days listing to the contractor—agreeing to resolve its capital payment issue for the amount listed despite the fact that the Medicare Contractor did not allow all of the paid and eligible Medicaid days originally submitted by Valley.

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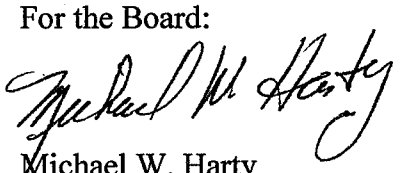
[7] Valley's March 15, 2013 Response to Jurisdictional Challenge Ex. P-6.
[8] *Id.* at Ex. P-3.
[9] Valley's March 15, 2013 Response to Jurisdictional Challenge at 2.

As Valley's September 20, 2011 RNPR reflects that the Medicare Contractor increased Valley's capital payment in the exact amount that Valley agreed upon within the Administrative Resolution, the Board finds that Valley's claim of dissatisfaction with that capital payment calculation is without merit. As such, Valley has failed to meet the minimum regulatory requirements for a hearing before the Board, and the Board hereby dismisses Valley's RFH for PRRB Case No. 12-0266.

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

cc: Edward Lau, Federal Specialized Services

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

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

Refer to: 09-1325GC

NOV 23 2015

CERTIFIED MAIL

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

Darwin San Luis
Noridian Healthcare Solutions
Appeals Coordinator- Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Jurisdictional Decision
Scripps Health 1998-2004 Dual Eligible CIRP Group
FYEs: 2000, 2002, 2003, 2004
PRRB Case Nos.: 09-1325GC

Dear Mr. Blumberg and Mr. San Luis,

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
There are two appeals from revised Notices of Program Reimbursement (NPR).

Participant 8 on the Schedule of Providers was issued a revised NPR on June 6, 2008. The Provider filed an appeal request from its revised NPR. This Provider later requested to add the dual eligible days issue to its individual appeal and subsequently requested to transfer the issue to this group.

Participant 18 has appealed from both an original and revised NPR. The Board incorporated the Provider's appeals of these final determinations into a single appeal. The Provider also appealed the dual eligible days issue from both final determinations and transferred the issues to this group.

Board's Decision
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2007) provides, in relevant part:

> (a) A determination of an intermediary, a decision by a hearing officer or panel of hearing officers, a decision by the Board, or a decision of the Secretary may be reopened with respect to findings on matters at issue in such determination or decision, by such intermediary officer or panel of hearing officers, Board or Secretary, or on the motion of the provider affected by such determination or decision to revise any matter in issue at any such proceedings. Any such request to reopen must be made within 3 yers of the date of the notice of the intermediary or Board hearing decision, any such request to reopen must be made within 3 years of the date of notice of the intermediary determination. No such determination or decision may be reopened after such 3-year period except as provided in paragraphs (d) and (e) of this section.

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:

> Where a revision is made in a determination or decision on the amount of program reimbursement or decision has been 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.

More recently, 42 C.F.R. § 405.1889 was 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 reconsidered.

Participant 8, Scripps Memorial Hospital Encinitas (9/30/2001), did not file a jurisdictionally valid appeal from the revised NPR because dual eligible days were not specifically adjusted. The Provider's revised NPR indicates that the cost report was reopened in order to adjust Title XIX Medi-Cal Days and there is nothing to indicate that dual eligible days were specifically revised as part of the reopening. Accordingly, Participant 8, Scripps Memorial Hospital- Encinitas (9/30/2001) is hereby dismissed from this appeal.

Participant 18 is appealing an original and revised NPR that were incorporated into the same appeal. The Board has found that it does not have jurisdiction over the revised NPR for this Provider because the Medicare contractor did not specifically adjust dual eligible days when it reopened the cost report. Therefore, pursuant to 42 C.F.R. § 405.1889, dual eligible days are beyond the scope of the appeal of the Provider's revised determination.[1] Accordingly, Participant 18, Scripps Memorial Hospital- Encinitas' (9/30/2004) revised NPR appeal is hereby dismissed from this appeal. The Provider's original NPR appeal remains pending in this group.

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.

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[1] *See also HCA Health Services of Oklahoma, Inc. v. Shalala*, 27 F.3d 614, 615 (D.C. Cir. 1994) (holding that a provider's appeal of that reopening is limited to the specific issues revisited on reopening).

Participating Board Members
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 405.1877

cc: Wilson C. Leong, Esq., CPA
Federal Specialized Services
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4508

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

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

Refer to: 08-1411

CERTIFIED MAIL

NOV 23 2015

Thomas P. Knight, CPA
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: Provider: Glenn Medical Center
Provider No.: 05-1306
FYE: 06/30/2005
PRRB Case No.: 08-1411

Dear Mr. Knight and Mr. Lowe:

The Provider, Glenn Medical Center ("Glenn"), appealed several issues to the Provider Reimbursement Review Board ("Board") related to its Notice of Program Reimbursement ("NPR") for fiscal year 2005. Glenn appealed two issues in its original appeal request: (1) crossover bad debt and (2) inclusion of idle space square footage in a non-reimbursable cost center.[1] Glenn later added and transferred the issue of fee-based bad debt.[2] Subsequently, Glenn and the Medicare Contractor, Cahaba Safeguard Administrators, LLC ("Cahaba"), entered into an Administrative Resolution ("AR"). The AR resolved the square footage issue; however, the bad debts issue remained unresolved because the parties were awaiting the outcome of Cahaba's Jurisdictional Challenge.[3]

Glenn's Appeal Request describes the Crossover Bad Debt issue as follows:

> In the filed Medicare cost report[,] the Provider reported Medicare bad debt as a protest issue. The Provider did not report any allowable Medicare crossover bad debt because the necessary documentation provided by the State of California was not available at the time of Medicare cost report preparation. Subsequently[,] the State of California provided the hospital's Medicare crossover bad debt information. The [Medicare Contractor] did not incorporate the allowable Medicare crossover bad debt information into the Provider's Medicare cost report. The

[1] Glenn Medical Center's Appeal Request, Mar. 7, 2008.
[2] Glenn Medical Center's Add/Transfer Request, Jun. 16, 2008.
[3] Administrative Resolution between Glenn and Cahaba, May 7, 2013.

> Provider is dissatisfied with [its] final NPR because it excludes Medicare bad debt reimbursement due the hospital.[4]

Glenn referenced audit adjustment number 9—Protested Items—for the Crossover Bad Debt issue.[5] In its Appeal Request, Glenn did not include a breakdown of its protested items.

On January 11, 2013, Cahaba submitted its Jurisdictional Challenge to the Board. Cahaba argues that, "[t]he Provider neglected to include the claimed bad debts on the as-submitted cost report and the [Medicare Contractor] never made a determination concerning them."[6] Cahaba elaborates:

> In the case at issue, the Provider claimed Medicare bad debt on its as-filed cost report and now claims additional bad debt that was not previously included. The [Medicare Contractor] did not make an adjustment to bad debt on the final settled cost report. The [Medicare Contractor] asserts that the Provider failed to claim Medicare bad debt in its as-filed cost report or seek a reopening or file an amended cost report within the regulatory guidelines.[7]

Cahaba also addresses the protested items:

> The Provider's appeal request . . . notes bad debt was included on the as-filed cost report as a protested item that was removed at audit with adjustment number 9. However, the Provider's schedule of protested items included with the as-filed cost report documentation (Exhibit I-3) verifies that the protested amounts for this fiscal year end do not represent Medicare bad debt. The bad debt omission was not noted on the as-submitted cost report as a protest item.[8]

Exhibit I-3 of Cahaba's Jurisdictional Challenge shows that the $10,000.00 in protested amounts was for "Nominal Lease Depreciation Expense."[9] Cahaba also argues that Crossover Bad Debt was not a self-disallowed cost pursuant to *Bethesda*; therefore, Glenn was not barred from claiming these debts on its cost report.[10] Further, Cahaba argues that it was not an "inadvertent omission" as in *Loma Linda*.[11] Cahaba cites to the Board's decisions in Case No. 06-0969 and

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[4] Appeal Request at 1.
[5] *Id.*
[6] Cahaba's Jurisdictional Challenge at 1, Jan. 11, 2013.
[7] *Id.* at 2.
[8] *Id.* at 3.
[9] *Id.* at Ex. I-3.
[10] Cahaba's Jurisdictional Challenge at 3 (citing *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988)).
[11] *Id.* (citing *Loma Linda Univ. Med. Ctr. v. Leavitt*, 492 F.3d 1065 (9th Cir. 2007)).

Case No. 05-0041, which Cahaba states involve similar circumstances, in which the Board denied jurisdiction when the providers did not include additional bad debt amounts on their as-filed cost reports.[12] Cahaba requests that the Board dismiss this issue from the appeal.[13]

Glenn submitted its Jurisdictional Response to the Board on February 4, 2013. Glenn argues that Cahaba:

> . . . has "stretched" its interpretation of jurisdiction set forth in 42 C.F.R. § 405.1835(a) to be consistent with "today's" jurisdiction regulations, not the jurisdiction regulations in place at the time the Provider's appeal was filed. Specifically, the [Medicare Contractor] argues an adjustment to an amount claimed in a cost report must be present before the Board is allowed to have jurisdiction. [Glenn] contends such an interpretation is not present in 42 C.F.R. § 405.1835(a). The Provider argues any aspect of the final determination can be corrected under 42 C.F.R. § 405.1835(a) as long as the appeal is filed timely and it meets the amount in controversy requirements.[14]

Glenn also argues that it self-disallowed the bad debts in order to avoid over- or under- stating its bad debts.[15] Glenn states it self-disallowed crossover bad debts due to California's rate freeze, which "ultimately . . . reflected . . . a reduced Medi-Cal payment . . . . " and " . . . called into question whether the State was paying their obligated portion of unpaid Medicare deductible and coinsurance amounts."[16] Glenn reasserts that Cahaba is relying on new law (42 C.F.R. § 405.1835(a)(1)(i), which did not exist until August 21, 2008) and that " . . . any change in filing requirements cannot be applied retrospectively."[17]

Board Determination

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 (1) dissatisfied with the final determination of the Medicare contractor, (2) the amount in controversy is $10,000.00 or more, and (3) the request for a hearing is filed within 180 days of the date that the notice of the Medicare contractor's determination was mailed to the provider.

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[12] *Id.* (In the cases cited, the Board declined to take discretionary jurisdiction under 42 U.S.C. § 1395oo(d).)
[13] *Id.* at 4.
[14] Glenn's Jurisdictional Response at 2, Feb. 4, 2013.
[15] *See id.* at 2-3.
[16] *Id.*
[17] *Id.* at 4.

42 U.S.C. § 1395oo(a) dictates that to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the Medicare contractor. Thus, it follows that a provider must have claimed reimbursement for items and services in order for the Medicare contractor to make a "final determination" regarding such items and services. The Board generally has interpreted 42 U.S.C. § 1395oo(a) as the gateway to establishing Board jurisdiction to hear an appeal and requiring a provider to establish a right to appeal on a claim-by-claim or issue-specific basis. In *Saint Vincent Indianapolis Hospital v. Sebelius,* No. 1:13-cv-01769-RDM (D.D.C. filed Sept. 29, 2015), the U.S. District Court for the District of Columbia recently upheld the Board's interpretation of the dissatisfaction requirement.

The failure to claim bad debts was addressed by *MaineGeneral Medical Center v. Shalala*, 205 F.3d 498 (1st Cir. 2000) and *St. Luke's Hospital v. Secretary*, 810 F.3d 325 (1st Cir. 1987). *MaineGeneral* involved hospitals that listed zero for reimbursable bad debts on their cost reports. The mistake was not discovered until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also included a claim for bad debts. The Board dismissed the bad debts claim for lack of jurisdiction because they had not been disclosed on the cost report, despite there being no legal impediment to doing so. The *MaineGeneral* court relied on its prior decision in *St. Luke's* in which costs were self-disallowed. It found that the *St. Luke's* court had addressed the question of whether the Board has the power to decide an issue that was not first raised before the Medicare contractor and held that it does, but that the power is discretionary. The *St. Luke's* court expressly rejected the provider's assertion that the court should order the Board to hear the case, even though it found the hospitals had a strong equitable argument favoring review.[18] Using this analysis, the *MaineGeneral* court advised that the Board could adopt a policy of hearing such claims by either refusing to hear them, or opting to decide on a case-by-case basis. The court further noted that, "a rule of consistently refusing to hear inadvertently omitted claims would be rational; given the ability of providers to request the [Medicare contractor] to reopen an NPR up to three years after it has been issued."[19]

Here, Glenn states in its appeal request that it " . . . did not report any allowable Medicare crossover bad debt because the necessary documentation provided by the State of California was not available at the time of Medicare cost report preparation."[20] But, it is up to the provider to maintain its records for reporting bad debts. Glenn could have claimed crossover bad debts on its cost report after it billed the state Medicaid agency. The Board finds that this is true despite Glenn's argument that the bill containing a Medicaid rate freeze, effective July 1, 2004 (this case

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[18] *St. Luke's* at 322.
[19] *MaineGeneral* at 501.
[20] Glenn's Appeal Request at 1.

is for FYE 06/30/2005), was a "legitimate reason for not filing Medicare crossover bad debt."[21] Glenn argues that its position is consistent with the Supreme Court's decision in *Bethesda Hospital Association v. Bowen*, 485 U.S. 399 (1988), and that, instead of claiming crossover bad debts on its cost report, it self-disallowed its crossover bad debts.[22]

The operation of the jurisdictional gateway established by 42 U.S.C § 1395oo(a) was addressed by the Supreme Court in the seminal Medicare case of *Bethesda Hospital Association v. Bowen.* The narrow facts of the *Bethesda* controversy dealt with the self-disallowed apportionment of malpractice insurance costs.[23] The provider failed to claim the cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Court wrote:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[24]

The Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the [Medicare contractor] reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the [Medicare contractor], those circumstances are not presented here.[25]

The Board finds that California's rates had no effect on the process of identifying and reporting crossover bad debts on a provider's cost report. Accordingly, the Board further finds that there

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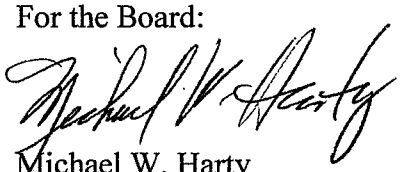
[21] Glenn's Jurisdictional Response at 3; *see also* Glenn's Jurisdictional Response Ex. P3 (summary of California bill SB 1103) ("Freezes the Medi-Cal reimbursement rates for non-contract hospitals for FY 2004-2005 and also reduces their interim rates by 10%.").
[22] Glenn's Jurisdictional Response at 2.
[23] *Bethesda* at 401-402.
[24] *Id.* at 404 (emphasis added).
[25] *Id.* at 404-405 (emphasis added).

was no legal impediment, as in *Bethesda*, to Glenn reporting crossover bad debts on its cost report.

The Board determines that it lacks jurisdiction in this case since there is no evidence that Glenn claimed crossover bad debts on its cost report, or was barred from claiming these items.[26] The Board hereby closes this 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: Wilson C. Leong, Esq., CPA, Federal Specialized Services (without enclosures)

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[26] Glenn also argues that it protested its crossover bad debts and that the jurisdictional regulations cited by the Medicare Contractor do not apply to this case; however, the Board disagrees. The only protested item submitted with Glenn's as-filed cost report was for "Nominal Lease Depreciation Expense" for $10,000.00. Cahaba's Jurisdictional Challenge at Ex. I-3. Additionally, the Board need not consider Glenn's argument regarding the dates of the jurisdictional regulations cited by the Medicare Contractor because the Board's decision is based on 2007 regulations, which applied at the time of Glenn's appeal.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD
2520 Lord Baltimore Drive, Suite L
Baltimore MD 21244-2670
FAX: 410-786-5298
Internet: www.cms.gov/PRRBReview
Phone: 410-786-2671

Refer to: 08-2621GC

CERTIFIED MAIL

NOV 25 2015

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

Noridian Healthcare Solutions, LLC
Darwin San Luis
Appeals Coordinator Jurisdiction E
P.O. Box 6782
Fargo, ND 58108-6782

RE: Request for Case Bifurcation
St. Joseph Health System 2001 DSH Dual Eligible Days CIRP Group
PRRB Case No.: 08-2621GC

Dear Mr. Knight and Mr. San Luis:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to St. Joseph Health System 2001 [Disproportionate Share Hospital ("DSH")] Dual Eligible Days [Common Issue Related Provider's ("CIRP")] Group's ("St. Joseph's") request for case bifurcation. The Board hereby grants St. Joseph's request for case bifurcation of the dual eligible and Part C/HMO[1] days issues as set forth below.

Background

On July 25, 2008, the Board received St. Joseph's request to form a CIRP group comprised of two providers[2] within Toyon's 2001 DSH Dual Eligible Days Group Appeal, PRRB Case No. 04-1732G. The Board received St. Joseph's jurisdictional documentation for these two providers on July 29, 2010 ("July 29, 2010 Jurisdictional Documentation").

On December 26, 2012, the Board received Toyon Associates, Inc.'s ("Toyon's")[3] request for, among other things, case bifurcation in the instant appeal ("Request"). In its Request, Toyon asks the Board to "segregate the Part C days at issue . . . from the other Part A dual eligible patient days at issue."

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[1] Any individual who was enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act was considered to be enrolled under Part C as of January 1, 1999. 42 U.S.C. § 1395w-21. Therefore, the Board will refer to the issue as HMO days for periods before January 1, 1999 and as Part C days for periods after January 1, 1999. It should be noted, however, that the Providers have used the terms HMO days and Part C Days interchangeably for both time periods.

[2] The two providers are Queen of the Valley Hospital, Provider No. 05-0009, and Santa Rosa Memorial Hospital, Provider No. 05-0174.

[3] Toyon is the representative for St. Joseph's appeal.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1841 (2003), 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 hearing is filed within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

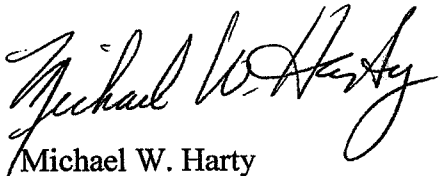
The Board acknowledges that at the time that St. Joseph's individual appeals, transfer requests and group appeals were filed, the issue of whether a Medicaid patient that was "dually eligible" for Medicare was not necessarily subdivided by Medicare Part A or Part C days. Federal courts later ruled differently on the "dual eligibility" related to Part A and Part C days therefore necessitating the Board to bifurcate these issues. In this case, the Board finds that the providers' individual appeals and the original optional group appeal added the dual eligible days issue using a broad issue statement that encompassed both Part A non-covered days and Part C days.

Accordingly, the Board finds that there are two issues pending within PRRB Case No. 08-2621GC in violation of 42 C.F.R. § 1837(a)(2) and PRRB Rule 13.[4] The Board is, therefore, bifurcating the dual eligible Part A non-covered and Part C days issues into separate group appeals. The providers' Part C issue is now within newly formed PRRB Case No. 16-0255GC. The providers' dual eligible Part A non-covered days issue remains in the instant appeal and is subject to remand under the Centers for Medicare and Medicaid Services' Ruling 1498-R. The Board's Remand Letter for the instant appeal and the Board's Acknowledgment Letter for PRRB Case No. 16-0255GC are included as enclosures along with this determination.

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
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
Schedule of Providers dated July 20, 2010
Group Acknowledgment Letter for PRRB Case No. 16-0255GC
Standard Remand Letter for PRRB Case No. 08-2621GC

cc: Wilson Leong, Federal Specialized Services

[4] Both the regulation and Board Rule clearly state that a group appeal can only contain one issue.

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

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

Refer to: 15-0355GC

NOV 25 2015

CERTIFIED MAIL

Stephen P. Nash
Patton Boggs LLP
1801 California Street
Suite 4900
Denver, CO 80202

RE: PRRB Decision
Request for Expedited Judicial Review dated Oct. 28, 2015
Squire Patton Boggs 2012 Medicare Outliers – Banner Health
PRRB Case No. 15-0355GC

Dear Mr. Nash:

The Provider Reimbursement Review Board's ("PRRB or Board") findings with respect to the above referenced request are set forth below.

Background

The Providers in this CIRP group appeal assert they have not been paid the full amount of supplemental Medicare outlier payments to which they are entitled under 42 U.S.C. § 1395ww(d)(5)(A)(i)-(iv) and (d)(3)(B). Medicare hospitals paid under the inpatient prospective payment system ("IPPS") can receive an additional payment for patients that incurred unusually expensive costs of care, and this payment is referred to as an "outlier payment." To qualify for an outlier payment, the inpatient stay must have costs that exceed the IPPS payment plus a fixed-loss threshold established by the Secretary of the Department of Health and Human Services. Specifically regarding the outlier payment calculation, "[t]he Providers assert that the FLTs [fixed-loss thresholds]...are invalid for numerous reasons..."[1]

The Providers' Representative originally advised the Board that this CIRP Group was complete on July 28, 2015, and thereafter requested an Expedited Judicial Review ("EJR") of the case on August 24, 2014. The Board deemed the request for EJR incomplete and merged Case No. 15-1469GC into this appeal.[2] The Providers subsequently notified the Board that the consolidated appeal (going by the remaining Case No. of 15-0335GC) is now complete and they have supplied jurisdictional documents for all providers. The Providers have also renewed their request for Expedited Judicial Review as of October 28, 2015.

[1] Provider's Request for Expedited Judicial Review (October 27, 2015) at 14.
[2] *See* Board's Response (dated September 21, 2015) to Providers' August 21, 2015 EJR Request.

The Providers request that the Board grant their request for EJR with respect to the following legal question:

> Whether the specific regulations governing Outlier Case Payments as set forth in the two regulatory sources – the Outlier Payment Regulations[3] and the fixed loss threshold ("FLT") Regulations[4] (collectively, the "Medicare Outlier Regulations") – as promulgated by the Secretary of Health and Human Services ("HHS" or the "Secretary") and the Centers for Medicare and Medicaid Services ("CMS"), and as in effect for the appealed years, are contrary to the Outlier Statute and/or are otherwise substantively or procedurally invalid?

There are thirteen Providers in this group. Twelve providers have filed appeals from not receiving a timely NPR under 42 C.F.R. § 405.1835(c)(2014). One provider in the group filed an appeal from a timely received NPR under 42 C.F.R. § 405.1835(a)(2014).

Analysis and Decision

42 U.S.C. § 1395oo(f)(1) (2013) and the regulation at 42 C.F.R. § 405.1842(f)(1) (2013) require the Board to grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdiction

Pursuant to 42 U.S.C. § 1395oo(a), 42 C.F.R. § 405.1837 and 42 C.F.R. § 405.1835(c), the Board has jurisdiction to conduct a hearing on a specific cost item at issue if the provider has not received its final determination from the Medicare contractor on a timely basis, the amount in controversy is $50,000 or more, and the provider has filed a request for hearing within 180 days after its final determination would have been timely received. An provider has a right to a hearing if it has not timely received its final determination if –

> A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor the provider's perfected cost report or amended cost report…"[5]

The Board finds it has jurisdiction to conduct a hearing on the specific matter at issue for the twelve providers who have appealed based upon an untimely NPR. These twelve Providers have timely requested a hearing within 180 days after the period to timely receive a contractor

[3] *See* Providers' Request for Expedited Judicial Review (October 27, 2015), Page 2, n. 2.
[4] *Id.* at n. 3.
[5] 42 C.F.R. § 405.1835(c).

determination (12 months after the Medicare contractor's receipt of the Providers' cost reports), the amount in controversy has been met, and there is no applicable dissatisfaction requirement.

Pursuant to 42 U.S.C. § 1395oo(a), 42 C.F.R. § 405.1837 and 42 C.F.R. § 405.1835(a), the Board has jurisdiction to conduct a hearing on cost issues where the provider timely received its NPR if the amount in controversy is $50,000 or more, the provider has filed a request for hearing within 180 days after the date of receipt of the final contractor determination, and the provider has either 1) claimed the specific item on their cost report, or 2) self-disallowed the item by filing the cost report under protest.

The thirteenth provider in this group appeal, Banner Casa Grande Community Hospital, appealed from a timely received NPR and fails to meet the dissatisfaction requirement of 42 C.F.R. § 405.1835(a)(1). Banner Casa Grande Community Hospital cites to three audit adjustment numbers with regards to its claim for dissatisfaction – Nos. 22, 27, and 37. However, these adjustments do not address the outlier payments fixed loss threshold, nor could they as this threshold is set by Secretary of the Department of Health and Human Services and cannot be adjusted by the Medicare contractor. Additionally, there is no evidence in the record that Banner Casa Grande Community Hospital claimed the outlier payment fixed loss threshold as self-disallowed by protesting the item on its cost report. Therefore, the Provider failed to preserve its rights, and lacks any legal basis to appeal the item to the Board under 42 C.F.R. § 405.1835(a)(1). Banner Casa Grande Community Hospital is dismissed from the appeal and EJR for this Provider is denied.

Board Finding Regarding Authority

Pursuant to 42 C.F.R. § 405.1867, the Board must comply with Title XVIII of the Act and its supporting regulations. The Providers allege the Medicare outlier regulations are substantively and procedurally invalid for a variety of reasons. The Board finds it lacks the authority to examine this legal question as it pertains to the twelve Providers that have appealed from untimely received NPRs.

The Board finds it unnecessary to address this second prong of the EJR analysis regarding Banner Casa Grande Community Hospital as the Board does not have jurisdiction over this Provider.

Conclusion

With regard to Provider Nos. 1 through 12 and the Providers' October 28, 2015 request for EJR, 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 assertions regarding the outlier regulations, 42 C.F.R. §§ 412.80-412.86, there are no findings of fact for resolution by the Board;

3) it is bound by the regulations; and

4) it is without the authority to decide the legal question of whether the outlier regulations are valid.

With regard to Provider No. 13, Banner Casa Grande Community Hospital, and its request for EJR, the Board finds it does not have jurisdiction over this Provider. The Provider is hereby dismissed from this appeal, and since jurisdiction is a prerequisite to EJR, its request for EJR is denied.

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)(1) and 42 C.F.R. §§ 405.1875 and 405.1877
Schedule of Providers

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

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

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

Internet: www.cms.gov/PRRBReview

FAX: 410-786-5298
Phone: 410-786-2671

Refer to: 15-0850

NOV 25 2015

CERTIFIED MAIL

Healthcare Reimbursement Services, Inc.
Corinna Goron,
President
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

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

RE: Jurisdictional Decision – Wooster Community Hospital
Provider No.: 36-0036
FYE: 12/31/2012
PRRB Case No.: 15-0850

Dear Ms. Goron and Ms. Cummings:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced appeal. The Board finds that Wooster Community Hospital's appeal was not timely filed. The decision of the Board is set forth below.

Background

On May 31, 2013, the Medicare Contractor received Wooster Community Hospital's cost report. On December 1, 2014, Wooster Community Hospital filed an individual appeal request with the Board from the lack of a timely issued Notice of Program Reimbursement ("NPR"). The Provider later requested to transfer six issues from this appeal into optional appeals, including case numbers 15-0549G; 15-0479G; 15-0554G; 15-0555G; 15-0556G; 15-0570G.

Medicare Contractor's Contentions

The Medicare Contractor contends that the Board does not have jurisdiction because the Provider did not file a timely appeal request. The due date to appeal a lack of timely issued NPR is 180 days after the expiration of the 12 month period for issuance of the contractor determination. The Medicare Contractor received the cost report on May 31, 2013. Twelve months later was May 31, 2014 and 180 days from that date was November 27, 2014. The Board received the Provider's appeal request on December 1, 2014, 184 days after the expiration of the 12 month period. There is no 5 day mailing presumption for appealing from a lack of a timely issued NPR

as no determination had been mailed. The Medicare Contractor maintains that the Provider's appeal was not timely and the Board should dismiss the case.

Provider's Contentions

The Provider contends that its request for an appeal was timely because the deadline was a Federal holiday. The Provider cites 42 C.F.R. § 405.1801(a), (d), stating that if the deadline falls on a Federal holiday, the deadline becomes the next business day. The Provider maintains since November 27, 2014, and November 28, 2014 were holidays due to Thanksgiving, the deadline was extended to December 1, 2014. Therefore, the Provider maintains the appeal was timely filed and the Board should find jurisdiction.

Board's Decision

The Board finds that it does not have jurisdiction over this appeal because the appeal was not timely filed in accordance with 42 C.F.R. § 405.1835(c), as required, within 180 days of the non-issuance of the NPR.[1] The Medicare Contractor has 12 months from the date of the receipt of the Provider cost report to issue a final determination. Upon expiration of this 12 month period, the Provider has 180 days to file an appeal with the Board from the lack of issuance of an NPR.[2] Pursuant to 42 C.F.R. § 405.1801(d)(3)

> If the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days.

In this case, the Medicare Contractor received the Provider's cost report on May 31, 2013. The Medicare Contractor had 12 months (until May 31, 2014) to issue its NPR, but did not do so. Therefore, the Provider's deadline to file its appeal with the Board was November 27, 2014. Since, November 27, 2014, was Thanksgiving, a Federal holiday, the due date was extended to the next business day. The Board was open and conducting business on November 28, 2014. Therefore, the next business day and the filing deadline was Friday November 28, 2014.

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[1] 42 C.F.R. 405.1835(c) [O]n untimely contractor determination . . . a provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if—(1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.

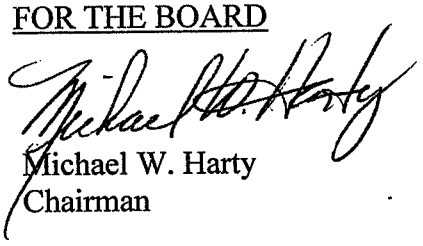
[2] 42 C.F.R. §§ 405.1835 (a)(3) the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section)

The Board received the Provider's appeal on December 1, 2014, which is 184 days after the expiration of 12 months which is beyond the permissible 180 days. Therefore, even with the one day extension for the holiday, the Provider did not file a timely appeal request. The Board finds that it does not have jurisdiction and dismisses this Provider's individual appeal. Accordingly, the Board hereby denies the Provider's request to transfer issues to case numbers 15-0459G; 15-0479G; 15-0554G; 15-0555G; 15-0556G; 15-0570G.

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

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

FOR THE BOARD



Michael W. Harty
Chairman

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

Cc Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058