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

MAY 19 2016

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

RE: Scottsdale Healthcare Hospitals
Provider No: 03-0123
FYE: 09/30/2013
PRRB Case No: 16-1329

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's March 28, 2016 request for hearing which was received (filed)[1] by the Board on March 29, 2016. The Board's jurisdictional determination is set forth below.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2015), a provider has a right to a hearing before the Board with respect to a cost claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare Contractor, the amount in controversy is $10,000 or more and the request for hearing is received by the Board within 180 days of the date of receipt of the final determination by the provider.

Decision of the Board

In this case, the Provider's appeal was filed from the Notice of Program Reimbursement ("NPR") dated July 27, 2015. The Provider is deemed to have received the final determination 5 days after the issuance of the NPR, which would have been August 1, 2015.[2] Thus, the 180 day filing period expired on January 28, 2016, but the Board received the Provider's request for hearing on March 29, 2016, which is 241 days after the presumed receipt of the NPR. The Provider did not afford any explanation as to why its appeal request was being filed well beyond the deadline for submission of a timely appeal.

[1] *See*, 42 C.F.R. § 405.1835(a)(3) (2015) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt of the final contractor determination.) 42 C.F.R. § 405.1801(a)(2) (2015) (the date of receipt means the date stamped "Received" by the reviewing entity.)

[2] 42 C.F.R. § 405.1801(a)(1)(iii) (the presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that the materials were actually received on a later date.)

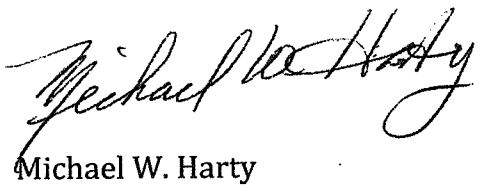
Therefore, the Board finds that the Provider's hearing request was not timely filed within 180 days of the date of receipt of the final determination and hereby dismisses this appeal.

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

Board Members Participating:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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: James R. Ward
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CERTIFIED MAIL

MAY 19 2016

Brooke Bennett Aziere
Foulston Siefkin LLP
1551 N. Waterfront Parkway, Suite 100
Wichita, KS 67206

Byron Lamprecht
Wisconsin Physicians Service
Cost Report Appeals
P.O. Box 8696
Madison, WI 53708-1834

RE: Stormont-Vail Healthcare
Provider No.: 17-0086
FYEs: 9/30/07 and 9/30/08
PRRB Case Nos.: 13-0302 and 13-0303

Dear Ms. Aziere and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the Motion to Recall Final Position Papers in the above-captioned appeals. The Board's determination is set forth below.

Background

CN 13-0302 FYE 9/30/07

The Provider submitted a request for hearing on December 26, 2012, based on a Notice of Program Reimbursement ("NPR") dated July 2, 2012. The hearing request included five issues: 1) DSH/SSI; 2) DSH – Medicaid Eligible Days; 3) DSH – Medicare Managed Care Part C Days; 4) DSH – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days); and 5) Outlier Payments – Operating Cost to Charge Ratio and Outlier Reconciliation Adjustments. In the request, the Provider appointed Quality Reimbursement Services, Inc. ("QRS") as its designated representative. Issue Nos. 1, 3, 4, and 5 were subsequently transferred to group appeals via a letter dated August 22, 2013.

The Provider subsequently submitted an appeal on February 4, 2015 from a Revised Notice of Program Reimbursement ("RNPR") dated August 11, 2014 that the Board incorporated into the original appeal. The Provider appealed all adjustments contained within the RNPR that were based upon the Medicare Contractor's determination that the Provider was not the legal operator of the Baker University School of Nursing, Stormont-Vail Regional Medical Center Campus (the "Nursing Program"). As such, two issues remained in the appeal; Issue No. 2 - DSH – Medicaid Eligible Days and Issue No. 6 - Nursing Program.

In its appeal of the RNPR the Provider designated Foulston Siefkin LLP ("Foulston Siefkin") as its representative. The Board sent a letter to QRS and Foulston Siefkin on February 14, 2015 requesting that they advise the Board in writing as to whom correspondence should be directed in the case as only

one representative per case is permitted under Board Rules. Foulston Siefkin responded via email on March 4, 2015 that QRS shall serve as representative for purposes of the appeal. [1]

In October of 2015, the Board issued a Notice of Hearing (NOH) setting a May 27, 2016 hearing date with the Providers final position paper due date of February 1, 2016. On January 27, 2016, QRS submitted a final position paper on behalf of the Provider wherein the only issue briefed was DSH – Medicaid Eligible Days. The submission was timely as it was filed by the February 1, 2016 due date prescribed in the Board's NOH.

Subsequently, via letter dated March 29, 2016, the Provider withdrew its appointment of QRS as its designated representative for the Nursing Program Issue and designated Foulston Siefkin to represent it with regard to the Nursing Program issue only. On April 1, 2016, Foulston Siefkin submitted a motion to recall the Provider's previously filed final position paper and a request for a pre-hearing conference. Simultaneously, Foulston Siefkin submitted a revised final position paper that briefed the Nursing Program issue. The Medicare Contractor submitted a response/objection to Foulston Siefkin's Motion on April 7, 2016.

CN 13-0303 FYE 9/30/08

The Provider submitted a request for hearing on December 26, 2012, based on a Notice of Program Reimbursement ("NPR") dated July 26, 2012. The hearing request included five issues: 1) DSH/SSI; 2) DSH – Medicaid Eligible Days; 3) DSH – Medicare Managed Care Part C Days; 4) DSH – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days); and 5) Outlier Payments – Operating Cost to Charge Ratio and Outlier Reconciliation Adjustments. In the request, the Provider appointed Quality Reimbursement Services, Inc. ("QRS") as its designated representative. Issue Nos. 1, 3, and 4were subsequently transferred to group appeals via a letter dated August 22, 2013.

By way of letter dated March 26, 2013 and received on March 27, 2013, the Provider added three issues to the appeal; 6) SSI (Provider Specific) includes SSI Realignment; 7) DSH – Exclusion of Part C Days from the Denominator of the Medicare Percentage; and 8) Outlier Payments – Fixed Loss Threshold. Issue No. 8 was subsequently transferred to a group appeal on August 28, 2013.

On July 8, 2013, the Medicare Contractor submitted a jurisdictional challenge on the SSI Realignment aspect of the SSI (Provider Specific) issue. The Provider submitted a jurisdictional response on July 29, 2013.

The Provider subsequently submitted an appeal on February 4, 2015 from a Revised Notice of Program Reimbursement ("RNPR") dated August 11, 2014 that the Board incorporated into the original appeal. The Provider appealed all adjustments contained within the RNPR that were based upon the Medicare Contractor's determination that the Provider was not the legal operator of the Baker University School of Nursing, Stormont-Vail Regional Medical Center Campus (the "Nursing Program"). As such, five issues remained in the appeal; Issue No. 2 - DSH – Medicaid Eligible Days; Issue No. 5 – Outlier Payments – Operating Cost to Charge and Outlier Reconciliation; Issue No. 6 – SSI (Provider Specific)

[1] In a letter dated May 17, 2016, the Provider has designated Foulston Siefkin as the sole representative for the appeal.

includes SSI Realignment; Issue No.7 –DSH – Exclusion of Part C Days from the Denominator of the Medicare Percentage; and Issue No. 9 - Nursing Program.

In its appeal of the RNPR the Provider designated Foulston Siefkin as its representative. The Board sent a letter to QRS and Foulston Siefkin on February 14, 2015 requesting that they advise the Board in writing as to whom correspondence should be directed in the case as only one representative per case is permitted under Board Rules. Foulston Siefkin responded via email on March 4, 2015 that QRS shall serve as representative for purposes of the appeal.[2]

In October of 2015, the Board issued a Notice of Hearing (NOH) setting a May 27, 2016 hearing date with the Providers final position paper due date of February 1, 2016. On January 27, 2016, QRS submitted a final position paper on behalf of the Provider wherein the only issues briefed were DSH – Medicaid Eligible Days and Issue No. 6 – SSI (Provider Specific). The submission was timely as it was filed by the February 1, 2016 due date prescribed in the Board's NOH.

Subsequently, via letter dated March 29, 2016, the Provider withdrew its appointment of QRS as its designated representative and designated Foulston Siefkin LLP to represent it with regard to the Nursing Program issue. On April 1, 2016, Foulston Siefkin LLP submitted a Motion to recall the Provider's final position paper and a request for a pre-hearing conference.

Simultaneously, Foulston Siefkin submitted a revised final position paper that briefed the Nursing Program issue. The Medicare Contractor submitted a response/objection to the Provider's motion on April 7, 2016.

Foulston Siefkin's Motion

In its Motion to recall the Provider's final position paper, Foulston Siefkin LLP states that despite being provided notification from the Board and Foulston Siefkin of the Nursing Program issue, QRS neglected to include the Nursing Program issue in the hospital's final position papers for the FYE 9/30/07 and FYE 9/30/08 appeals. Foulston Siefkin notes that QRS did brief the Nursing Program issue in the Provider's final position paper for its FYE 9/30/09 appeal, PRRB Case No. 13-1203, and the Medicare Contractor addressed the Nursing Program issue in its final position paper for that case. Therefore, Foulston Siefkin argues, the Medicare Contractor has had an opportunity to research and respond to the issue, and is not otherwise prejudiced by the hospital's recall of the final position papers and submission of revised final position papers for the FYE 9/30/07 and 9/30/08 appeals.

Foulston Siefkin states that given the circumstances surrounding the appeals, it is appropriate for Stormont-Vail to submit revised position papers for the FYE 9/30/07 and 9/30/08 appeals under PRRB Rule 27.3. In so doing it is not offering any new positions or arguments. It is the same position and arguments asserted by the hospital in its initial appeals of the Nursing Program issue. It is the same position and arguments asserted by the hospital in the FYE 9/30/09 appeal.

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[2] In a letter dated May 17, 2016, the Provider has designated Foulston Siefkin as the sole representative for the appeal.

Medicare Contractor's Response/Objection to Foulston Siefkin's Motion

The Medicare Contractor objects to Foulston Siefkin's motion to recall the Provider's final position paper on the grounds that that the solely cited PRRB Rule does not support the Provider's motion. The Medicare Contractor notes that QRS, the Provider's designated representative of record, did not brief the Nursing Program issue in the final position papers that it submitted on behalf of the Provider. The Medicare Contractor contends that Foulston Siefkin, on behalf of the Provider, now wants to add a new argument and evidence on the Nursing Program issue, something that was lacking in its final position papers, and something that PRRB Rule 27.3 prohibits. As the revised final position papers have already been submitted, the Medicare Contractor asks that the Board exclude them based on Board Rule 27.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) (2007) and 42 C.F.R. §§ 405.1835 – 405.1841 (2007), a provider has a right to a hearing before the Board with respect to 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 received by the Board within 180 days of the date the notice of the intermediary's determination was mailed to the provider.

Board Rule 5 addresses Provider Case Representatives:

5.1 – Persons
The case representative is the individual with whom the Board maintains contact. A case representative may include a "designated" case representative (e.g., attorney or consultant), or an employee (non-owner or non-officer). If no case representative is designated, the Board will consider the owner or officer who filed the appeal as the case representative. There may be only one case representative per appeal.

Board Rule 41.2 gives the Board the authority to dismiss an issue from a case if it has a reasonable basis to believe that the issue has been fully settled or abandoned.

The Board finds that QRS was the designated Provider representative of record for the FYE 9/3007 and 9/30/08 appeals at the time the final position papers were filed in the appeals. QRS failed to brief the Nursing Program issue in the final position papers that it submitted on behalf of the Provider on January 27, 2016. As such, the Board concludes that the Nursing Program issue was abandoned and dismisses the issue from PRRB Case Nos. 13-0302 and 13-0303. Accordingly, the Board denies Foulston Siefkin's Motion to recall the Provider's final position papers.

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 appeals.

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

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
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Chicago, IL 60608-4058

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CERTIFIED MAIL

MAY 19 2016

HCA, Inc.
H. Anne Browne
Sr. Appeals Analyst Reimbursement Dept.
One Park Plaza, Building II, 5 East
Nashville, TN 37203

RE: Tulane University Hospital
Provider No: 19-0176
FYE: 12/31/2013
PRRB Case No: 16-0380

Dear Ms. Browne:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's December 8, 2015 request for hearing which was received (filed)[1] by the Board on December 9, 2015. The Board's jurisdictional determination is set forth below.

The Code of Federal Regulations provides for a right to hearing based on an untimely contractor determination. The definition of untimely is explained by 42 C.F.R. § 405.1835(c)(1) (2015), which states:

> (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.

Furthermore, 42 C.F.R. § 405.1835(c)(2) (2015) explains the timeframe in which the provider is able to file an appeal from an untimely determination:

> (2) Unless the provider qualifies for a good cause extension under

[1] *See*, 42 C.F.R. § 405.1835(a)(3) (2015) (a provider has a right to hearing before the Board if, among other things, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the date of receipt of the final contractor determination.) 42 C.F.R. § 405.1801(a)(2) (2015) (the date of receipt means the date stamped "Received" by the reviewing entity.)

§ 405.1836, 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).

Decision of the Board

In this case, the Provider's cost report was received by the Medicare Contractor on June 3, 2014. The expiration of the 12 month period for issuance of the final contractor determination was June 3, 2015. Per the regulations, a cost report hearing request must have been received by the Board within 180 days of the expiration of the 12 month period for issuance of the final contractor determination, or November 30, 2015. The Provider's appeal was received 189 days later on December 9, 2015.

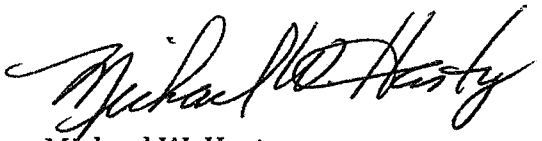
Therefore, the Board finds that the Provider's hearing request was not timely filed within 180 days of the expiration of the 12 month period for issuance of the final contractor determination and hereby dismisses this appeal.

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

Board Members Participating:

Michael W. Harty
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
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: Bill Tisdale
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Refer to: 16-0079
Certified Mail

MAY 24 2016

Kenneth R. Marcus, Esq.
Honigman Miller Schwartz & Cohn
660 Woodward Avenue
Suite 2290
Detroit, MI 48226-3506

RE: Edward W. Sparrow Hospital
Provider No. 23-0230
FFY 2016
PRRB Case No. 16-0079
Request for Expedited Judicial Review

Dear Mr. Marcus:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's April 25, 2016 request for expedited judicial review (EJR) (received April 26, 2016). The Board's decision with respect to the EJR is set forth below.

Issue

Whether the action of the Centers for Medicare and Medicaid Services (CMS) to reduce inpatient hospital prospective payment system (IPPS) payment rates by 0.2% effective as of Federal Fiscal Year [FFY] 2016 (i.e., October 1, 2015 – September 30, 2016) is consistent with the law.[1]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (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 of the Department of Health and Human Services (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

[1] Provider's April 25, 2016 EJR request at 2-3.
[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).

advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[4]

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

Medicare Part A

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

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

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

benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[9]

Medicare Part B

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

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

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[9] 78 Fed. Reg. at 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.

The 2-Midnight Rule

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

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

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

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

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] 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 2016 period.[19]

Provider's Position

The Provider explains that when the Secretary promulgated the FFY 2014 IPPS final rule, she implemented a 0.2% reduction in the FFY 2014 IPPS rate. This reduction in 2014 was not reversed in FFYs 2015 and 2016, consequently, IPPS providers' reimbursement was lower that it would have been without the 2014 action. This action was taken although the Secretary received comments challenging the soundness of the actuarial analysis on which CMS relied.

The Provider explains that the resolution of the legal issue presented in this appeal requires adjudication of the validity of the IPPS rate reduction for FFY 2016. This is a legal question and the Board lacks the authority to grant the relief requested.[20]

Decision of the Board

The Board has reviewed the submissions of the Provider pertaining to the requests for hearing and expedited judicial review. The appeal was timely filed from the issuance of the August 17, 2015 Federal Register.[21] The documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal, although subject to recalculation by the Medicare Contractor for the actual final amount.

The Board finds that:

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

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 80 Fed. Reg. 49,326, 49,519 (Aug. 17, 2015).
[20] Provider's April 25, 2016 EJR request at 7.
[21] *See Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, CMS Adm'r. Dec., Medicare and Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

2) based upon the Provider's 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, 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 Provider's request for expedited judicial review for the issue and the subject year. The Provider has 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.

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: Byron Lamprecht, WPS (J-8)
Wilson Leong, FFS

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Refer to: 16-0711GC

MAY 24 2016

Certified Mail

Cynthia F. Wisner, Esq.
Associate Counsel
Trinity Health
20555 Victor Parkway
Livonia, MI 48152

RE: Trinity Health 2016 PPS Rate Reduction Group
Provider Nos. Various
FFY 2016
PRRB Case No. 16-0711GC
Request for Expedited Judicial Review

Dear Ms. Wisner:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's April 26, 2016 request for expedited judicial review (EJR) (received April 27, 2016). The Board's decision with respect to the EJR is set forth below.

Issue

Whether the action of the Centers for Medicare and Medicaid Services (CMS) to reduce inpatient hospital prospective payment system (IPPS) payment rates by 0.2% effective as of Federal Fiscal Year [FFY] 2016 (i.e., October 1, 2015 – September 30, 2016) is consistent with the law.[1]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (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 of the Department of Health and Human Services (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

[1] Providers' April 26, 2016 EJR request at 3.
[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).

inpatient claim is denied because the Medicare review contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[4]

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

Medicare Part A

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

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

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

contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[9]

Medicare Part B

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

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

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[9] 78 Fed. Reg. at 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.

The 2-Midnight Rule

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

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

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

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

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] 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 2016 period.[19]

Providers' Position

The Provider explains that when the Secretary promulgated the FFY 2014 IPPS final rule, she implemented a 0.2% reduction in the FFY 2014 IPPS rate. This reduction in 2014 was not reversed in FFYs 2015 and 2016, consequently, IPPS providers' reimbursement was lower that it would have been without the 2014 action. This action was taken although the Secretary received comments challenging the soundness of the actuarial analysis on which CMS relied.

The Provider explains that the resolution of the legal issue presented in this appeal requires adjudication of the validity of the IPPS rate reduction for FFY 2016. This is a legal question and the Board lacks the authority to grant the relief requested.[20]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the request for hearing and expedited judicial review. The appeal was timely filed from the issuance of the August 17, 2015 Federal Register.[21] The documentation shows that the estimated amount in controversy exceeds $15,000, as required for a group appeal, although subject to recalculation by the Medicare Contractor for the actual final amount.

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;

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 80 Fed. Reg. 49,326, 49,519 (Aug. 17, 2015).
[20] Provider's April 26, 2016 EJR request at 7.
[21] *See Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, CMS Adm'r. Dec., Medicare and Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

2) 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, 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.

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, WPS (J-5)
Wilson Leong, FFS

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Refer to: 16-0017GC
Certified Mail

MAY 24 2016

Kenneth R. Marcus, Esq.
Honigman Miller Schwartz & Cohn
660 Woodward Avenue
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Detroit, MI 48226-3506

RE: Baptist Memorial Healthcare Corporation FFY 2016
0.2% IPPS Reduction
Provider Nos. Various
FFY 2016
PRRB Case No. 16-0017GC
Request for Expedited Judicial Review

Dear Mr. Marcus:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's April 25, 2016 request for expedited judicial review (EJR) (received April 26, 2016). The Board's decision with respect to the EJR is set forth below.

Issue

Whether the action of the Centers for Medicare and Medicaid Services (CMS) to reduce inpatient hospital prospective payment system (IPPS) payment rates by 0.2% effective as of Federal Fiscal Year [FFY] 2016 (i.e., October 1, 2015 – September 30, 2016) is consistent with the law.[1]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (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 of the Department of Health and Human Services (Secretary) noted that the trend towards the extended observation services may be attributable, in part, to hospitals' concerns

[1] Providers' April 25, 2016 EJR request at 3.
[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).

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

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

Medicare Part A

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

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

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

for inpatient admission and inpatient payment (known as the "2-midnight rule"). Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[9]

Medicare Part B

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

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

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[9] 78 Fed. Reg. at 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.

The 2-Midnight Rule

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

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

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

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

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] 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 2016 period.[19]

Providers' Position

The Provider explains that when the Secretary promulgated the FFY 2014 IPPS final rule, she implemented a 0.2% reduction in the FFY 2014 IPPS rate. This reduction in 2014 was not reversed in FFYs 2015 and 2016, consequently, IPPS providers' reimbursement was lower that it would have been without the 2014 action. This action was taken although the Secretary received comments challenging the soundness of the actuarial analysis on which CMS relied.

The Provider explains that the resolution of the legal issue presented in this appeal requires adjudication of the validity of the IPPS rate reduction for FFY 2016. This is a legal question and the Board lacks the authority to grant the relief requested.[20]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the request for hearing and expedited judicial review. The appeal was timely filed from the issuance of the August 17, 2015 Federal Register.[21] The documentation shows that the estimated amount in controversy exceeds $15,000, as required for a group appeal, although subject to recalculation by the Medicare Contractor for the actual final amount.

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;

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 80 Fed. Reg. 49,326, 49,519 (Aug. 17, 2015).
[20] Provider's April 25, 2016 EJR request at 7.
[21] *See Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, CMS Adm'r. Dec., Medicare and Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

2) 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, 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.

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: Barb Hinkle, Cahaba GBA c/o National Government Services
Wilson Leong, FFS

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Refer to: 15-3424GC

MAY 24 2016

Certified Mail

Robert S. Plaskey
V.P., Reimbursement & Revenue Integrity
Oakwood Corporate Services
15500 Lundy Parkway
Dearborn, MI 48126

RE: Oakwood Healthcare Center FFY 2016 0.2% IPPS Reduction Group
Provider Nos. Various
FFY 2016
PRRB Case No. 15-3424GC
Request for Expedited Judicial Review

Dear Mr. Plaskey:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's April 28, 2016 request for expedited judicial review (EJR) (received April 29, 2016). The Board's decision with respect to the EJR is set forth below.

Issue

Whether the action of the Centers for Medicare and Medicaid Services (CMS) to reduce inpatient hospital prospective payment system (IPPS) payment rates by 0.2% effective as of Federal Fiscal Year [FFY] 2016 (i.e., October 1, 2015 – September 30, 2016) is consistent with the law.[1]

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014, the Secretary indicated that she had expressed concern in the proposed calendar year (CY) Outpatient PPS (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 of the Department of Health and Human Services (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

[1] Providers' April 28, 2016 EJR request at 3.
[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).

inpatient claim is denied because the Medicare review contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS has been advised by stakeholders that the hospitals appear to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays, that may later be denied upon contractor review, by electing to treat beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. These hospitals believe that Medicare's standards for inpatient admission were not clear.[4]

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

Medicare Part A

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

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

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

contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[9]

Medicare Part B

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

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

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[9] 78 Fed. Reg. at 50,908.
[10] *Id.*
[11] *See* 78 Fed. Reg. 16,614 (Mar. 18, 2013), http://www.cms.gov/Regulations-and-Guidance/Guidance/Rulings/CMS-Rulings.html.
[12] 78 Fed. Reg. at 50,909.
[13] *Id.* at 50,927.

The 2-Midnight Rule

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

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

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

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

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] 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 2016 period.[19]

Providers' Position

The Provider explains that when the Secretary promulgated the FFY 2014 IPPS final rule, she implemented a 0.2% reduction in the FFY 2014 IPPS rate. This reduction in 2014 was not reversed in FFYs 2015 and 2016, consequently, IPPS providers' reimbursement was lower that it would have been without the 2014 action. This action was taken although the Secretary received comments challenging the soundness of the actuarial analysis on which CMS relied.

The Provider explains that the resolution of the legal issue presented in this appeal requires adjudication of the validity of the IPPS rate reduction for FFY 2016. This is a legal question and the Board lacks the authority to grant the relief requested.[20]

Decision of the Board

The Board has reviewed the submissions of the Providers pertaining to the request for hearing and expedited judicial review. The appeal was timely filed from the issuance of the August 17, 2015 Federal Register.[21] The documentation shows that the estimated amount in controversy exceeds $15,000, as required for a group appeal, although subject to recalculation by the Medicare Contractor for the actual final amount.

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;

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[17] *Id.* at 50,952-53.
[18] *Id.* at 50,990.
[19] 80 Fed. Reg. 49,326, 49,519 (Aug. 17, 2015).
[20] Provider's April 28, 2016 EJR request at 7.
[21] *See Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, CMS Adm'r. Dec., Medicare and Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (the Administrator held that the publication of the wage index in the Federal Register was a final determination which can be appealed to the Board).

2) 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

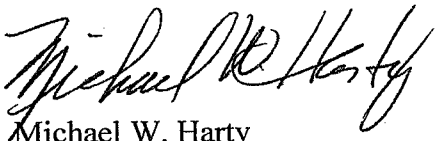
4) it is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, is valid.

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.

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, WPS (J-8)
Wilson Leong, FFS

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

MAY 31 2016

CERTIFIED MAIL

Nancy Repine
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Assistant Vice President
Finance Planning & Reimbursement
3040 University Avenue
Morgantown, WV 26505

RE: City Hospital
Provider No. 51-0008
FYE 12/31/2010
PRRB Case No. 15-3299

Dear Ms. Repine:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal in order to schedule a hearing date. The Board notes that the sole remaining issue involves the SSI (Provider Specific) issue. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

The Provider filed an individual appeal on September 4, 2015, which included the following issues:

- DSH SSI (Provider Specific)
- DSH SSI
- DSH SSI Fraction Medicare Managed Care Part C Days
- DSH SSI Fraction Dual Eligible/Exhausted Part A Days
- DSH Medicaid Fraction Medicare Managed Care Part C Days
- DSH Medicaid Fraction Dual Eligible/Exhausted Part A Days
- DSH Medicare Managed Care Part C Days
- DSH Dual Eligible/Exhausted Part A Days

On April 27, 2016, the Provider authorized Quality Reimbursement Services, Inc. (QRS) to transfer various issues to group appeals. On April 29, 2016, the Provider filed its preliminary position paper with the Board. In the cover letter to the preliminary paper, the Provider advises that "[a]ll issues, other than the SSI Provider Specific issue . . . are being transferred to relevant QRS group appeals."

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital 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 (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 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal.

The Board finds, regarding Issue No. 1 - the DSH SSI Provider Specific issue, that it has jurisdiction over this issue as there was an adjustment to the SSI percentage (Adj. 15), and the appeal meets the amount in controversy and timely filing requirements. However, the Board finds that Issue No. 1 is duplicative of Issue No. 2, the DSH SSI Percentage issue that was transferred to a group case. The basis of both Issue Nos. 1 and 2 in this appeal is that the SSI percentage is improperly calculated due to errors in accumulating the underlying data. Therefore, the SSI (Provider Specific) and the SSI Percentage issues are being consolidated as a single SSI Accuracy issue, which has been transferred to case number 16-1532GC. Since there are no remaining issues in the individual appeal, case number 15-3299 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
John Gary Bowers, CPA
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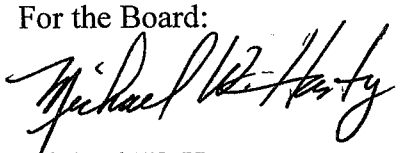
For the Board:



Michael W. Harty
Chairman

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

cc: Laurie Polson, Palmetto GBA c/o National Government Services, Inc.
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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MAY 31 2016

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Appeals Coordinator – Jurisdiction E
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RE: EL Camino Hospital
Provider No.: 05-0308
FYE: 6/30/07
PRRB Case No.: 09-1656

Dear Ms. Oliva and Ms. Alcantara,

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

Background

The Provider submitted a request for hearing on May 6, 2009, based on a Notice of Program Reimbursement ("NPR") dated November 24, 2008. The hearing request included six issues. Subsequently, the Provider submitted a request for hearing on January 14, 2013 from a Revised Notice of Program Reimbursement ("RNPR") dated July 27, 2012. The hearing request included four issues. The new request was incorporated into Case No. 09-1656 on January 31, 2013. As such there were ten issues in total. Subsequently, seven issues were transferred to group appeals and two issues were withdrawn. The sole issue remaining in the appeal is as follows: Medicare Disproportionate Share Hospital (DSH) Payments – SSI Ratio Alignment to Provider's Cost Reporting Year. This was the only issue briefed by the parties in their final position papers. The Medicare Contractor filed a jurisdictional challenge on the issue on April 6, 2016. The Provider filed a responsive brief on May 2, 2016.

Medicare Contractor's Position

The Medicare Contractor explains that the SSI percentage is computed by CMS on the federal fiscal year end, unless a hospital makes an election to use its own fiscal year end. Hospitals can request realignment of their SSI percentage of the DSH adjustment to conform with their own fiscal year ends instead of the federal fiscal year end, pursuant to 42 C.F.R. § 412.106(b)(3). The decision to request a realignment is the Provider's decision. The Provider must send a written request to the Medicare Contractor and CMS requesting the change.[1]

[1] Medicare Contractor's jurisdictional challenge at 3.

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

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

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

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

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

Provider's Position

The Provider contends that it has appealed audit adjustment numbers 22, 23, 24, 26 and 47 from its NPR, in conjunction with the SSI Ratio Realignment issue. Each one of these audit adjustments revises the Provider's as-filed SSI ratio to agree with CMS' published SSI ratio, which is developed and published by CMS on a federal fiscal year basis. The Provider has a clear right to appeal the adjustments made and has done so because the SSI ratio used by the Medicare Contractor is understated. The Provider contends that the ratio should have been developed on a hospital fiscal year basis.[3]

The Provider argues that the Medicare Contractor clearly issued a final determination on the Provider's SSI ratio with which the Provider is dissatisfied. The Provider contends that it has a right to be dissatisfied with any aspect of the Contractor audit adjustments, including the aspect of the Contractor's adjustment implementing a SSI ratio that has been developed on a federal fiscal year basis because all other DSH payment elements for this Provider are developed upon a cost reporting period basis.[4]

The Provider explains that it submitted an SSI realignment request to the Medicare Contractor on March 19, 2013. The Provider contends that it has a right to pursue the issue through the appeals process because CMS has taken no action on the request.[5]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2010), 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.

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[2] *Id.* at 4.
[3] Provider's responsive brief at 2 (Emphasis included).
[4] *Id.* (Emphasis included).
[5] *Id.* at 4.

The Board concludes that it does not have jurisdiction over the SSI Ratio Realignment issue in the appeal because there is no final determination from which the Provider is appealing. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospitals alone, which then must submit a written request to the Medicare Contractor. Furthermore, even if a Provider had requested a realignment from the federal fiscal year to its cost reporting year, as was the case in the instant appeal, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.

As this was the sole issue remaining in the appeal, the Board closes the appeal and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:
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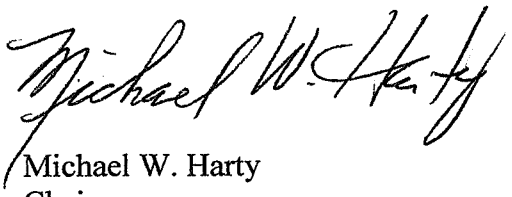
FOR THE BOARD



Michael W. Harty
Chairman

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

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