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

JUN 02 2016

McKay Consulting, Inc.
Michael K. McKay, President
8590 Business Park Drive
Shreveport, LA 71105

RE: McKay Post 09/30/2004 - 2007 DSH Dual Eligible Days Group, Case No. 11-0754G
Request for Bifurcation of Part C Days Issue

Dear Mr. McKay:

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 pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts Regarding Case No. 11-0754G:

This group was established on August 9, 2011 as the result of the bifurcation of providers with cost reporting years after 10/1/2004 from case number 09-1169G. The original hearing request in case number 09-1169G, dated March 19, 2009[1], contained a lengthy group issue statement that included the following language:

> " . . .CMS has failed to include all patient days attributable to dual eligible patients in the DSH adjustment computations. Thus, the Medicaid patient days included in the [Contractor's] DSH adjustment calculations were below the number of Medicaid days that should have been included in the calculations.[2]

The Representative identified four categories of days which were excluded from the Medicaid Percentages: Exhausted Benefit Days; Medicare Secondary Payer days; Dual Eligible Part A days and Medicare Part C Days.

All participants transferred or were directly added to case number 09-1169G after the August 2008 Rule change except for:

[1] Original Request in Case No. 09-1169G was dated March 19, 2009 and was received on March 20, 2009.
[2] 09-1169G Group Request for Hearing at 2, March 19, 2009.

Albany Medical Center (33-0013) for the period 10/1/2004-12/31/2004.[3] This provider filed its individual appeal on July 31, 2008 and appealed only Dual Eligible days prior to transferring to case number 09-1169G on November 18, 2009.

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."[4] In case number 09-1169G, the Board found that, although the group was filed seven months after the change in Rules, because the group described the "matter at issue" as Dual Eligible days and clearly includes the category of days where patients are "dually eligible" for Medicaid and Medicare with exhausted benefits and "dually eligible" for Medicaid and Medicare Part C, it seemingly appealed multiple issues (i.e. Exhausted Benefits days and Part C days). ALL of the Providers who filed individual appeals AFTER August 2008, included Part C days in their Dual Eligible issue statement. Therefore all participants for the period prior to 10/1/04 were bifurcated into a new Part C group from 09-1169G (case number 13-2193G).

Note: Participant #18, The Washington Hospital (39-0042), was withdrawn from Dual Eligible (& Part C days) group by letter dated July 2, 2015.

The Medicare Contractor initially challenged jurisdiction over Participant #1, Alamance Regional Medical Center (34-0070) for FYE 12/31/2006, in case no. 09-1169G. The challenge followed the Provider to this group upon bifurcation. The Medicare Contractor alleged that the transfer of this participant to the initial group was not valid because the transfer letter initially submitted referenced Labor & Delivery days, which is not the issue under appeal in this case and which was transferred to another group. The Representative subsequently provided evidence of the transfer of the dual eligible days issue to case number 09-1169G.[5] Therefore, the challenge due to an invalid transfer is moot.

Participant #2, Albany Medical Center (33-0013), did not specifically include Part C Days or HMO days in its July 31, 2008 appeal request. Prior to the 2008 regulatory change, providers would regularly (and simultaneously) add issues to individual appeals and transfer those issues to group appeals. Since Albany Medical Center's appeal was filed prior to the 2008 regulation change and the group to which it was being transferred explicitly defined the issue under appeal as including the Part C days component, 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.

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[3] *See id.* at Schedule A.
[4] 42 C.F.R. § 405.1837(a)(2) (2003).
[5] *See id.* at Schedule tab 1G.

Board Determination

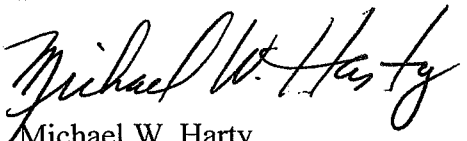
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 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 group issue statement for case number 11-0754G (which was the issue statement in case number 09-1169G – the case from which it was bifurcated) described the "matter at issue" as Dual Eligible days and clearly included the category of days where patients are "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). Therefore, the Board concludes that it will grant the bifurcation of Dual Eligible days and Part C days for the participants in this group.[6] The Part C days issue will be adjudicated in Case No. 16-1708G, the McKay 2005-2007 Part C Days Group. Enclosed, please find the Board's Notice of Bifurcation & Group Acknowledgement and Critical Due Dates which deems the group complete.

The McKay 2005-2007 Dual Eligible Days Group, case number 11-0754G, will be scheduled for a hearing date. The Parties will receive a Notice of Hearing and Critical Due Dates letter under separate cover.

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: Notice of Bifurcation & Group Acknowledgement and Critical Due Dates
Schedule of Providers

cc: Pam VanArsdale, Appeals Lead , National Government Services, Inc. (w/enclosures)
Wilson C. Leong, Esq., CPA, Federal Specialized Services (w/enclosures)

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[6] The Board grants the bifurcation of the Part C days issue for Participant #2, Albany Medical Center, only to the extent that the 1318 Dual Eligible days appealed by the Provider include any Part C days (See Provider's appeal request dated July 31, 2008 at Schedule of Providers, tab 2B).

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Refer to: 16-1193

JUN 09 2016

CERTIFIED MAIL

Denice Tudor, Chief Nursing Officer
Methodist Hospital of Chicago
5025 North Paulina Street
Chicago, IL 60640

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

RE: Methodist Hospital of Chicago
Provider No.: 14-0197
FYE: September 30, 2016
PRRB Case No.: 16-1193

Dear Ms. Tudor and Ms. Hartley:

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

Background:

By letter dated May 21, 2015, the Centers for Medicare & Medicaid Services ("CMS"), notified Methodist Hospital of Chicago ("Methodist" or "Hospital") that its request for reconsideration of the decision to reduce the Hospital's Phase One FY 2016 Inpatient Prospective Payment System by one fourth of the market basket update payment was denied. The denial letter advised Methodist of its right to appeal the decision, directed the Hospital to the pertinent regulations and Board rules, and highlighted the need to file the appeal within 180 days of the date of the denial letter.

In response, Methodist completed Model Form A, attaching certain documents, and filed the appeal with the Medicare Contractor on June 11, 2015. Methodist failed to file the appeal with the Board.

The appeal came to the attention of the Board when copied on correspondence between the Medicare Contractor and Methodist on March 9, 2016. The correspondence included a copy of the Model Form A and notified Methodist that the Medicare Contractor had the pending appeal but that it had not received the Board's acknowledgement of receipt.

Upon receipt of the appeal request, the Board sent an Acknowledgement and Critical Due Dates Notice on March 10, 2016.

Board Decision:

A provider has the right to a Board hearing following a final contractor determination if the provider has preserved its right to claim dissatisfaction with the amount of the Medicare payment, the amount in controversy is $10,000.00 or more and an appeal is filed with the Board within 180 days of receiving the contractor's final determination. 42 C.F.R. § 405.1835 (2014).

A request for a Board hearing received after the 180 day time limit must be dismissed by the Board unless good cause for the delay is shown by the provider. The provider must demonstrate in writing that it could not have been reasonably expected to file timely due to extraordinary circumstances beyond its control. Examples given in the Regulation of events that may be considered beyond the control of the provider are "natural or other catastrophe, fire or strike." The provider's written request for an extension must be received by the Board within a "reasonable time" after the 180 day time limit. The Board may determine what is considered a "reasonable time" for the extension request. 42 C.F.R. § 405.1836 (2014).

Regulations further provide,

> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order the Board may-
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate
>
> 42 C.F.R. § 405.1868 (2014).

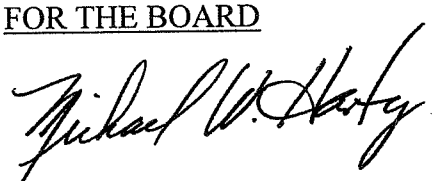
The May 21, 2015, denial letter sent to Methodist by CMS clearly set out the rules and regulations that were to be followed if Methodist wished to appeal the decision, noting specifically the 180 day deadline to appeal to the Board. Methodist's appeal came to the attention of the Board 293 days after the issuance of the denial letter, and even then the Board was made aware of the appeal by the Medicare Contractor not by Methodist.

Due to the failure of Methodist to comply with the filing requirements, the Board hereby dismisses Methodist's 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.

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

FOR THE BOARD



Michael W. Harty
Chairman

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

cc: Wilson Leong, Federal Specialized Services

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Refer to:

JUN 18 2016

CERTIFIED MAIL

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

RE: Lima Memorial Hospital, Provider No. 36-0009, FYE 12/31/2008, Case No. 13-1759

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal in preparation of scheduling the case for a hearing date. Upon review, the Board notes that most issues in the case have been transferred to group appeals. The pertinent facts and the Board's determination regarding the remaining issues are set forth below.

Pertinent Facts:

Healthcare Reimbursement Services, Inc. (HRS) filed an appeal on behalf of the Provider on April 27, 2013, which included the following issues:

- DSH SSI (Systemic Errors)
- DSH SSI (Provider Specific)
- DSH Medicaid Eligible Days
- DSH Medicare Managed Care Part C Days
- DSH Dual Eligible/Exhausted Part A Days
- Rural Floor Budget Neutrality Adjustment (RFBNA)

The Board assigned case number 13-1759 to the individual appeal in an Acknowledgement letter dated April 30, 2013.

On December 13, 2013 HRS filed Requests to Transfer Issue to A Group Appeal (Model Form D's) for the following issues:

- DSH SSI (Systemic) to case no. 13-3265G
- DSH Dual Eligible Days to case no. 13-3615G
- DSH Medicare Managed Care Part C Days to case no. 13-3619G

Subsequently, on December 31, 2013 HRS filed the cover letter to the preliminary position paper with the Board. In the cover letter, HRS advised that "[a]ll other issues have been

transferred to various groups; therefore we are only briefing Rural Floor Budget Neutrality and SSI Provider Specific."[1]

On March 19, 2014 HRS transferred the RFBNA issue to case no. 14-3005G.

Board Determination:

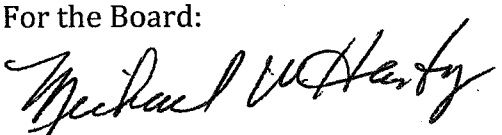
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a hospital has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 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. Regarding Issue No. 2, the DSH SSI Provider Specific issue, the Board finds that it has jurisdiction over this issue as there was an adjustment to the SSI percentage (Adj. 28), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that Issue No. 2 is duplicative of Issue No. 1, the DSH SSI Percentage (systemic Errors) 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 have been consolidated as a single SSI Accuracy issue, which has been transferred to case number 13-3265G. Further, according to the cover letter to the preliminary position paper, the Provider did not brief the Medicaid Eligible Days issue (Issue No. 3). Therefore, this issue is considered to have been abandoned. Since there are no remaining issues in the individual appeal, case number 13-1759 is 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: Judith E. Cummings, CGS Administrators (J-15)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

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[1] Provider Preliminary position paper, December 26, 2013

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CERTIFIED MAIL JUN 18 2016

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

RE: Lima Memorial Hospital, Provider No. 36-0009, FYE 12/31/2007, Case No. 13-1540

Dear Ms. Goron:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal in preparation of scheduling the case for a hearing date. Upon review, the Board notes that most issues in the case have been transferred to group appeals. The pertinent facts and the Board's determination regarding the remaining issues are set forth below.

Pertinent Facts:

Healthcare Reimbursement Services, Inc. (HRS) filed an appeal on behalf of the Provider on April 16, 2013, which included the following issues:

- DSH SSI (Systemic Errors)
- DSH SSI (Provider Specific)
- DSH Medicaid Eligible Days
- DSH Medicare Managed Care Part C Days
- DSH Dual Eligible/Exhausted Part A Days
- Rural Floor Budget Neutrality Adjustment (RFBNA)

The Board assigned case number 13-1540 to the individual appeal in an Acknowledgement letter dated April 16, 2013.

On September 13, 2013 HRS requested expedited judicial review (EJR) of the RFBNA issue which the Board granted in a letter dated September 30, 2013. The appeal remained pending for the other issues.

On December 13, 2013 HRS filed Requests to Transfer Issue to A Group Appeal (Model Form D's) for the following issues:

- DSH SSI (Systemic) to case no. 14-0365G
- DSH Dual Eligible Days to case no. 14-0366G
- DSH Medicare Managed Care Part C Days to case no. 14-0369G

Subsequently, on December 30, 2013, HRS filed the cover letter to the preliminary position paper with the Board. In the cover letter, HRS advised that "[a]ll other issues have been transferred to various groups; therefore we are only briefing SSI Provider Specific."[1]

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. 2, the DSH SSI Provider Specific issue, that it has jurisdiction over this issue as there was an adjustment to the SSI percentage (Adj. 32), and the appeal meets the amount in controversy and timely filing requirements. However, the Board also finds that Issue No. 2 is duplicative of Issue No. 1, the DSH SSI Percentage (Systemic Errors) 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 should be consolidated as a single SSI Accuracy issue, which has already been transferred to case number 14-0365G. Further, according to the cover letter to the preliminary position paper, the Provider did not brief the Medicaid Eligible Days issue (Issue No. 3). Therefore, this issue is considered to have been abandoned. Since there are no remaining issues in the individual appeal, case number 13-1540 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: Judith E. Cummings, CGS Administrators (J-15)
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[1] Provider Preliminary position paper, December 26, 2013

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Refer to:

CERTIFIED MAIL JUN 30 2016

Lucile Packard Children's Hospital
Long Nguyen
4700 Bohannon Drive
Second Floor
Menlo Park, CA 94025

RE: Lucile Packard Children's Hospital,Provider No.: 05-3305, FYE 8/31/2012
PRRB Case No. 14-3817

Dear Ms. Nguyen:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned appeal and has determined the appeal is premature. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

The Medicare Contractor issued a Notice of Program Reimbursement (NPR) for FYE 8/31/2012 to the Provider on January 21, 2014. On July 14, 2014, the Provider filed a request for TEFRA Exception Relief with the Medicare Contractor. One week later, on July 22, 2014, the Board received Lucile Packard Children's Hospital appeal request in which it appealed one issue: TEFRA Target Amount per Discharge and Related Medicare Days and Discharges.

On February 11, 2016 the Provider allegedly filed appeals of the TEFRA Limit for FYEs 2011 and 2012 based on Final Determinations of Adjustments to the TEFRA Limit (Exception Request). Staff is currently developing these appeals (i.e. proof of delivery to the Board and authorization of representation letters have been requested, as we had no record of the two appeals.) Once we have proof of delivery new case numbers will be established for these appeals.

Provider's Position:

In its preliminary position paper, the Provider believes this issue is resolvable once the Medicare Contractor performs the TEFRA Exception Relief review.

Board Determination:

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 intermediary, the amount in

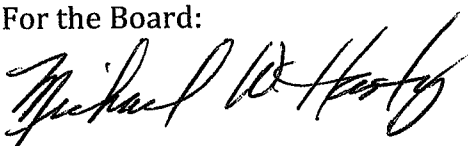
controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

In this case, the Board finds that the appeal is premature because the Medicare Contractor had not yet issued a final determination at the time the Provider filed its hearing request. 42 C.F.R. § 413.40(e) requires the Provider to request the TEFRA exception within 180 days of the date of the issuance of the NPR. The Medicare Contractor then submits a recommendation to CMS and CMS must issue a decision within 180 days of receipt of the recommendation. After the Medicare Contractor notifies the Provider of CMS's decision, the Provider has 180 days to appeal the decision directly to the PRRB. The Provider requested a hearing one week after requesting a TEFRA exception with the Medicare Contractor. The request was premature because the Provider had not yet received the final determination of the TEFRA exception from the Medicare Contractor prior to requesting a hearing with the Board as required by 42 C.F.R. § 413.40(e). As the TEFRA Target Amount issue is the only issue in the appeal, case number 14-3817 is hereby dismissed.

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: Evaline Alcantara, Noridian Healthcare Solutions, LLC (J-E)
Wilson C. Leong, Esq., CPA, Federal Specialized Services